Dedication

This thesis is dedicated to my father’s soul, Dr Soulaiman Obeidat “may Allah be merciful to him” who encouraged me all the time to pursue my graduate studies. I also dedicate this thesis to my mother, Zuhreyah, for her continuous prayers and supplications to succeed.

I will not forget my lovely wife, Mays, from this dedication who has been supporting me during my study. I appreciate her endurance during my long periods of absence from home. I also dedicate this thesis to my children, Farah, Adam and Raslan.

I would like to dedicate this thesis to my brothers and sisters for their support and encouragement.

Finally, this thesis is also dedicated to all who believe that ethics is their top priority in their work and relationship.
Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and to the best of my knowledge and belief this thesis contains no material previously published or written by another person, except where due reference is made in the text.

Signature:

Ala Soulaiman Obeidat

Date: 5th June 2019
Abstract

Background. Like other Arab countries, Jordan has to find ways of responding to the rapid processes of change that are affecting many aspects of social life. The need to do this is particularly urgent in health care, where the effects of social and technical change are often manifested in tensions about ethical decision-making in the clinic.

The overwhelming majority of the population of Jordan follows the Muslim faith. In spite of its rich history and the extensive ethical resources it encompasses, Islam has not yet developed a comprehensive body of theory covering ethical issues in clinical practice. In Jordan, many health care practitioners have obtained their medical education in Western countries and may have limited awareness of the traditions of Islamic thought and scholarship. In addition, Jordan, like other Arab countries, is increasingly subject to the effects of cultural and economic globalisation. In this setting, tensions have often been experienced within the Jordanian health care system regarding the management of ethical issues, including in both well-established areas—such as end of life care—and in fields where new scientific insights or technical innovations have occurred.

Objective. In response to these considerations, this study has sought to clarify certain aspects of Islamic thought insofar as they pertain to clinical ethics, to compare these with Western approaches to bioethics and, through empirical studies, to explore the nature and content of ethical decision making in Jordanian hospitals.

Methods. The study has comprised a conceptual part and two empirical parts. The conceptual part takes the form of a review of selected topics in Western bioethics and a reflection on these from an Islamic point of view. The empirical studies have included a quantitative assessment of the attitudes, experiences and concerns of a range of medical professionals in Jordanian hospitals and a qualitative study exploring, in depth, specific issues, challenges and potential responses to the concerns raised.

Results. The conceptual study identified both similarities and differences between Western bioethics and Islamic thought. The Western body of thought is significantly more developed than the Islamic one, covers a much wider array of issues and provides much more extensive guidance. While Western bioethics tends to focus on the experiences and rights of individuals, Islamic thought is communally-based. In addition, while Western thought often focuses on principles and outcomes, ethical discourse in Islamic is conceived in procedural terms, which link it to ongoing dialogues framed in relation to sacred texts and the record of previous ethical determinations.

The quantitative study identified a wide range of concerns and problems among health professionals in Jordan, including discomfort about certain aspects of the organisation and functioning of the health care system, uncertainty about specific issues such as the respective roles of religion and science, end of life care, organ donation and transplantation, the role of women, the importance of ethics committees, and the need for ethics education.

The qualitative study identified five themes, relating to the ethical background, particular ethical issues, religion, the sources of clinical ethics, and obstacles and difficulties. Participants were able to elaborate concerns about specific issues, including consent, confidentiality and the management of privacy, many of the topics identified in the quantitative study, deficiencies in the administration of the Jordanian health care system, the pressures and uncertainties
associated with changing attitudes to religion and science, and the impact of the globalised culture and renewed discussions about traditional issues such as the role of women and the family.

**Conclusions.** The study has demonstrated the complexity and fluid nature of ethical decision-making in Jordan in a time of rapid change and multiple social, cultural and economic challenges. Health professionals recognise that they need to accommodate the—sometimes contradictory—needs of patients, opinions of doctors and patients’ families, views of religious authorities, demands of management, and local, national and international standards. Health professionals struggle with three sets of tensions that emerge out of the struggle between traditional, community-embedded forms of social organisation and the demands generated by globalisation and the influence of Western culture: the tensions between tradition and modernity, conservatism and pragmatism, and religion and secularism. Doctors in Jordan prefer approaches to ethical decision making that realise a balance between the extremes, although the exact nature of where that balance should lie remains uncertain.

The study concludes with the recognition that the Western and Islamic perspectives have a great deal to offer each other, and that fruitful dialogues are both possible and necessary. Notwithstanding this, there are multiple outstanding tasks within Islam to improve and extend ethical awareness, education and practice in the clinical domain.
Publication and submission during enrolment


Acknowledgements

Above all, I thank Allah SWT for giving me the strength to pursue my PhD studies. This thesis would not have been possible without Allah’s will and blessing.

I am grateful to my principal supervisor, one of the most popular ethicists in the world and Australia in particular, Professor Paul Komesaroff, who has been very supportive and knowledgeable. I acknowledge the detailed assistance he has provided me both in the formation of my ideas and in the actual development of this thesis. He has assisted me with every single sentence in this thesis and I recognise that in this sense many of the ideas expressed herein are shared between us. I also thank him for his tangible and continuous assistance to my family and me during our stay in Australia. I keen to follow his methodology and philosophy of ethical thinking in all life aspects and health care decisions.

I am grateful to my co-supervisor Dr Marina Kunin for her contribution, particularly to the qualitative part. I thank her for her directions and her advice to encourage me to follow the most rigorous criteria of qualitative research.

I acknowledge the generosity of Monash University for the financial support it has provided. I acknowledge the compassion of Professor Margaret Gardner, the Vice Chancellor, and of the Head of the School of Primary Health Care, Professor Terry Haines, who also provided professional and academic support.

I would like to express my deep appreciation to all staff members and PhD students in the Department of General Practice at Monash University for their kindness and support.

Finally, I would like to thank the Ministry of Health in Jordan, the Managements of four Jordanian hospitals and all the participants in Jordanian hospitals for their valuable participation in both survey completion and interviews.
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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BCE</td>
<td>Before Christian Era</td>
</tr>
<tr>
<td>CE</td>
<td>Common Era</td>
</tr>
<tr>
<td>CER</td>
<td>Comparative Effectiveness Research</td>
</tr>
<tr>
<td>CMA</td>
<td>Canadian Medical Association</td>
</tr>
<tr>
<td>DOS</td>
<td>Department of Statistics</td>
</tr>
<tr>
<td>FIMA</td>
<td>Federation of Islamic Medical Association</td>
</tr>
<tr>
<td>IMANA</td>
<td>Islamic Medical Association of North America</td>
</tr>
<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
</tr>
<tr>
<td>JUH</td>
<td>Jordan University Hospital</td>
</tr>
<tr>
<td>KAH</td>
<td>King Abdullah Hospital</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>PBUH</td>
<td>Peace Be Upon Him</td>
</tr>
<tr>
<td>RECs</td>
<td>Research Ethical Committees</td>
</tr>
<tr>
<td>RMS</td>
<td>Royal Medical Service</td>
</tr>
<tr>
<td>SWT</td>
<td>“Subhanahu Wa Ta’ala” or “Glory to Him, the Exalted”</td>
</tr>
<tr>
<td>UDDA</td>
<td>The Uniform Determination of Death Act</td>
</tr>
<tr>
<td>UN-ECOSOC</td>
<td>United Nations Economic and Social Council</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNRWA</td>
<td>United Nations Relief and Works Agency UNRWA</td>
</tr>
<tr>
<td>WMA</td>
<td>World Medical Association</td>
</tr>
</tbody>
</table>
## Glossary of Arabic words

<table>
<thead>
<tr>
<th>Arabic transcript</th>
<th>Transliteration</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>أدب الطبيب</td>
<td>adab al-tabib</td>
<td>conduct of a physician</td>
</tr>
<tr>
<td>أهل المنازل</td>
<td>ahl al-manazil</td>
<td>man’s behaviour to the members of his family</td>
</tr>
<tr>
<td>أخلاقي</td>
<td>akhlaq</td>
<td>morals</td>
</tr>
<tr>
<td>الإمام الغزالي</td>
<td>Al imam Al-Ghazali</td>
<td>Persian Muslim theologian and philosopher</td>
</tr>
<tr>
<td>اللّه</td>
<td>Allah SWT</td>
<td>the standard Arabic word for God</td>
</tr>
<tr>
<td>المصالح المرسلة</td>
<td>al-masālih al mursala</td>
<td>a process of the application of rules arising on the basis of reasoned judgments</td>
</tr>
<tr>
<td>عمل صالح</td>
<td>amal salih</td>
<td>morally good</td>
</tr>
<tr>
<td>عقل</td>
<td>aql</td>
<td>mind</td>
</tr>
<tr>
<td>أثار الصحابة</td>
<td>athar alsahaba</td>
<td>the companions’ traditions</td>
</tr>
<tr>
<td>عورة</td>
<td>avrah</td>
<td>intimate parts</td>
</tr>
<tr>
<td>دائرة الإفتاء العام</td>
<td>daerat al efta al amm</td>
<td>the department for issuing opinions on Islam and sharī`ah</td>
</tr>
<tr>
<td>درء المفسدة</td>
<td>dar` al-mafāsid</td>
<td>the avoidance of, and protection against, harm</td>
</tr>
<tr>
<td>دين</td>
<td>deen</td>
<td>religion</td>
</tr>
<tr>
<td>قتوى</td>
<td>fatwa</td>
<td>a formal legal opinion given by an expert in Islamic Law</td>
</tr>
<tr>
<td>فقه</td>
<td>fiqh</td>
<td>guidance with a focus primarily on processes and duties rather than on presupposed outcomes or consequences</td>
</tr>
<tr>
<td>قطرة</td>
<td>fitrah</td>
<td>an Arabic word that is usually translated as &quot;original disposition,&quot; &quot;natural constitution,&quot; or &quot;innate nature.&quot;</td>
</tr>
<tr>
<td>غير الشرعية</td>
<td>ghayr sharī`ah</td>
<td>non-religious, which is learned by reason, as in mathematics or by experiments</td>
</tr>
<tr>
<td>حديث</td>
<td>hadith</td>
<td>a collection of traditions containing sayings of the prophet Muhammad</td>
</tr>
<tr>
<td>حكيم</td>
<td>hakim</td>
<td>&quot;The All-Wise&quot;</td>
</tr>
<tr>
<td>حلال</td>
<td>halal</td>
<td>permissible</td>
</tr>
<tr>
<td>حرام</td>
<td>haram</td>
<td>prohibited</td>
</tr>
<tr>
<td>حسنات</td>
<td>hasanat</td>
<td>balance sheet at the end of life as rewards</td>
</tr>
<tr>
<td>حجاب</td>
<td>hijab</td>
<td>a veil worn by Muslim women in the</td>
</tr>
<tr>
<td>Arabic Term</td>
<td>English Term</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>إفتاء</td>
<td>iftaa</td>
<td>presence of any male outside of their immediate family</td>
</tr>
<tr>
<td>إحسان</td>
<td>ihsan</td>
<td>to worship <em>Allah SWT</em> as if you could see him, but if you cannot see him, then learn that he does see you</td>
</tr>
<tr>
<td>إحياء</td>
<td><em>Ihya‘a</em></td>
<td><em>al-Ghazali’s</em> first book</td>
</tr>
<tr>
<td>إجماع</td>
<td><em>ijma</em></td>
<td>the Muslims’ consensus</td>
</tr>
<tr>
<td>إجتهاد</td>
<td><em>ijtihad</em></td>
<td>a dynamic source discussing issues not mentioned in the <em>Qur’an</em> and <em>Sunnah</em></td>
</tr>
<tr>
<td>علم الأخلاق</td>
<td><em>ilm al-akhlaq</em></td>
<td>ethics</td>
</tr>
<tr>
<td>علم عملي</td>
<td><em>ilm amali</em></td>
<td>practical science</td>
</tr>
<tr>
<td>علم نظري</td>
<td><em>ilm nazari</em></td>
<td>theoretical science</td>
</tr>
<tr>
<td>إيمان</td>
<td><em>iman</em></td>
<td>faith</td>
</tr>
<tr>
<td>جلب المصالح</td>
<td><em>jalb al-masālih</em></td>
<td>the promotion and preservation of the common good and benefit</td>
</tr>
<tr>
<td>لا ضرر ولا ضرار في الإسلام</td>
<td><em>la darar wa la dirarfi al islam</em></td>
<td>in Islam there shall be no harm inflicted or reciprocated (no harm, no harassment)</td>
</tr>
<tr>
<td>معضزة</td>
<td><em>madarra</em></td>
<td>forestalling harm</td>
</tr>
<tr>
<td>مقاسد</td>
<td><em>mafāsid</em></td>
<td>evil</td>
</tr>
<tr>
<td>مكروه</td>
<td><em>makruh</em></td>
<td>reprehensible</td>
</tr>
<tr>
<td>مال</td>
<td><em>mal</em></td>
<td>wealth</td>
</tr>
<tr>
<td>منفعة</td>
<td><em>manfaa</em></td>
<td>benefit</td>
</tr>
<tr>
<td>مقاصد الشريعة</td>
<td><em>maqāsid al-Sharī‘ah</em></td>
<td>the broader context of Islamic jurisprudence</td>
</tr>
<tr>
<td>مصالح</td>
<td><em>masālih</em></td>
<td>principle of public good</td>
</tr>
<tr>
<td>مصلحة</td>
<td><em>maslaha</em></td>
<td>public interest</td>
</tr>
<tr>
<td>مباح</td>
<td><em>mubah</em></td>
<td>permitted</td>
</tr>
<tr>
<td>مفتى</td>
<td><em>mufti</em></td>
<td>answers to problems related to Islamic laws, the answers are given by muftis</td>
</tr>
<tr>
<td>مستفتي</td>
<td><em>mustafti</em></td>
<td>one who seeks the legal opinion of a mufti</td>
</tr>
<tr>
<td>مستحب</td>
<td><em>mustahabb</em></td>
<td>recommended</td>
</tr>
<tr>
<td>نفس</td>
<td><em>nafs</em></td>
<td>life</td>
</tr>
<tr>
<td>نسل</td>
<td><em>nasl</em></td>
<td>progeny</td>
</tr>
<tr>
<td>نيئة حسنة</td>
<td><em>niyyyah hasanah</em></td>
<td>carried out with good motives</td>
</tr>
<tr>
<td>نصوص الشريعة</td>
<td><em>nusus al-Sharī‘ah</em></td>
<td>divine texts</td>
</tr>
<tr>
<td>القرآن</td>
<td><em>Al-Qur‘an</em></td>
<td>the central religious text of Islam, which Muslims believe to be a revelation from God (<em>Allah SWT</em>).</td>
</tr>
<tr>
<td>روح</td>
<td><em>ruh</em></td>
<td>soul</td>
</tr>
<tr>
<td>شريعة</td>
<td><em>sharī‘ah</em></td>
<td>an Islamic religious law</td>
</tr>
<tr>
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<tr>
<td>السنة</td>
<td><em>Sunnah</em></td>
<td>the account of the prophet Mohammad’s <em>(PBUH)</em> practices</td>
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<tr>
<td>أصول</td>
<td><em>usul</em></td>
<td>roots</td>
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<td>أصول الفقه</td>
<td><em>usul al-fiqh</em></td>
<td>Islamic legal theory, principle of public good.</td>
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<td>واجب</td>
<td><em>wajib</em></td>
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Section 1
Chapter 1
Introduction

1.1 Introduction
The research reported in this thesis explores the nature of ethics from an Islamic perspective and the awareness of ethical issues of doctors working in Jordanian hospitals.

The work starts from the assumption that the development of effective clinical ethics processes in Jordan may help improve the quality of health care and support government policies seeking to strengthen the accreditation of health care professionals and enhance the country’s alignment to international standards. The health sector clearly requires a robust and effective framework that regulates the behaviour of health care professionals, particularly in their relationships with patients and their families. This framework should include ethical criteria that recognise the importance of respect, confidentiality, privacy, dignity and justice. Although all these concepts have a long history in Islam their contemporary meanings are philosophically and culturally complex and to introduce them into a formal code requires careful clarification and widespread consultation.

As will be explained below, this thesis is also composed from a Muslim perspective. The writer is an adherent of the Islamic faith and is committed to adapting and interpreting the rich history of his tradition for the purposes of enhancing ethical practices and health care outcomes, both in his own country and across the Islamic world. While it is hoped that the work will make a contribution to the corpus of literature in both bioethics and religion the deep truth of the sacred texts on which the Islamic tradition is based is accepted as its most fundamental point of origin. It is acknowledged that this may be regarded as unsettling to some readers; if that is the case the author apologises in advance.¹

¹ As mentioned in the Acknowledgments, the author also expresses his grateful debt to his principal supervisor, Professor Komesaroff, who provided detailed assistance with respect to all aspects of the preparation of the thesis, including both the formation of the ideas and their presentation in English.
This introductory chapter discusses some aspects of the background of ethics and bioethics with particular reference to their relevance for the Islamic region and culture. It also provides an outline of the health care system in Jordan and briefly describes the intended significance of this study.

1.2 Background to the research

For more than 1400 years, Islam has existed as a monotheistic religion with a strong emphasis on ethics (Hedayat, 2007). The Islamic legacy of ethics long predates the appearance of academic teaching and theorising in the forms familiar today in the West (Padela et al., 2011a).

As Allah SWT (God) says in the most sacred work of the Islamic religion, the Qur’an: “The noblest of you in the sight of Allah is the best of you in conduct” (Qur’an Kareem 49: 13). In addition, His messenger, Prophet Mohammad (PBUH), says, “I didn’t come except to perfect good character” (al-Muwatṭa’ 1614). The religion of Islam offers a comprehensive discussion that embraces the full range of concepts, worship and civil affairs (Ali, 1973).

Bioethics is an academic discipline which originated in the United States and which investigates the ethical issues in health care around the world, in relation to its social, cultural, legal and economic aspects (Serour et al, 1995). Bioethics may be defined as “a specific domain of ethics focused on moral issues in the field of health care”. (Rich, 2013, p.33)

However, as Padela et al. (2011a) emphasise, while bioethics in the West was developed by physicians, in Islamic countries the development of ethics in the health care sector has been driven less by clinicians and more by experts in law, religion and history. Because Muslims believe that all healing comes from God,

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2 Where appropriate in this thesis, references will be made to the sacred texts of Islam, in order both to frame the theoretical discussion and to emphasise the context within which the issues referred to will be understood, in Jordan and other Arab countries. As discussed, the validity of the holy texts will be taken for granted, although the manner in which they are interpreted will be an implicit topic for analysis and questioning throughout.
for them religion cannot be separated from medical care and treatment, which is understood as a sacred task (Hassan and Ali, 2018). For this reason, in dealing with bioethical issues, Muslims adopt a theological basis for reasoning that is similar to the broader strategy of case discussion that lies at the heart of the long tradition of Islamic thought (Ahaddour et al, 2018).

From the Islamic point of view, ethics is not understood as a purely theoretical or “philosophical” discipline, as is sometimes the case in the West. Rather, it is seen as a process of conversation, taking place in the context of an agreed framework of spiritual truths and cultural assumptions, involving multiple participants. In the health care setting these participants include the patient, the health professionals, family and community members, scholars in religion and law, and maybe others. The issues discussed include the patient’s medical condition, his or her background, religion and culture, the physician’s opinion, the law of the country and the conditions within families (Clarfield et al, 2003).

In Islamic culture, reflections on ethics have a long tradition and multiple sources. It incorporates contributions from a great many esteemed philosophical and theological commentators, many of which are preserved in the vast textual resources from which religious scholars draw authority. In this sense, “bioethics” in the Muslim world represents a hybrid discipline that brings together Western ideas of ethics and law and the higher objectives of the divine law of Islam (Maqasid al-Sharī`ah) (Ibrahim et al., 2018).

Despite its richness and wide scope, some specific issues relevant to contemporary health care ethics are not mentioned in the main resources of Islam, the Qur’an and Prophet Mohammad’s Sunnah (Atighetchi, 2017). In addition, when patients follow certain religious considerations as a basis of medical treatment and health care they may encounter actual moral conflicts (Gjukaj et al, 2018). These conflicts arise from the discrepancies between the scriptural sources and ethical “principles” as accepted in society or else widely discussed in the international bioethical literature (Rattani and Hyder, 2019)—for example, principles such as the supposed obligation to protect or maximise “autonomy”,
which has been extensively adopted in the United States (Beauchamp and Childress, 2013).

In cases where the traditional texts are deficient or incomplete religious interpretations or *fatawa* may be developed in an attempt to match modern techniques and diagnoses. *Fatawa* in this context may be understood as “answers to problems related to Islamic laws, [where] …the answers are given by muftis” (Khairuldin et al., 2018, p.518).

As it happens, many of the great Arab philosophers were also physicians and were deeply affected by, and contributed to, Western approaches to ethics. The first formal statement of clinical ethics was written by Ishaq ibn 'Ali al-Ruhawi (died 931 CE), in the *adab al-tabib* (Conduct of a Physician), which departed from the premise that “the virtuous physician can improve body and soul” (Padela et al., 2011b). Great Islamic thinkers on ethics have also included Rhazes (Razi d. 925 CE), Al-Majusi (d. 994 CE), Ibn Sina (also known as Avicenna, d. 1037 CE), al-Ghazali (d. 1111 CE), and Ibn Rush’d (also known as Averroes, d. 1198 CE) (Abul Qasem, 1975).

However, Islam does not provide a comprehensive theory of medical ethics or a specific agenda covering all clinical considerations which offers solutions to Muslims pondering ethical dilemmas or trying to match their beliefs and practices (Zahedi and Larijani, 2008). In such cases it is necessary to rely on the well-defined processes of ethical consideration described above to generate possible solutions. These processes call on the system of jurisprudence regulating all life aspects for Muslims (Khadduri, 2017). In some cases, the outcomes will reflect fundamental differences between Islamic perspectives and those that would have resulted from the systems of thought that prevail in Western countries.

### 1.3 The health care system in Jordan

Jordan, also known as the Hashemite Kingdom of Jordan, is a Middle Eastern nation state which is a former British colony with continuing close cultural and political links to both the East and the West. Its government is a constitutional
monarchy in which the King has wide legislative and executive powers (Hashemite Royal Court).

Jordan (population 10.3 million) is located in south-west Asia (Department of Statistics DOS, 2018). The overwhelming majority of the population is Muslim (Department of Statistics DOS, 2017). The life expectancy is 73 years for males and 76 years for females (WHO, 2016). Despite its limited resources, Jordan has a very advanced health care system (see Table 4.1 in chapter four), which compares favourably with others across the world and is ranked as the most advanced in the Arab region (WHO, Amman Jordan, 2015). Jordan is the main destination for Arab and Middle Eastern patients who require critical surgery and clinical investigations at a reasonable cost (WHO, Amman Jordan, 2015). Jordanian doctors are respected across the region and many consultants and specialists there have graduated from Western countries such as the USA, the UK, Australia, Germany, Canada and different European countries.

Jordan has 104 hospitals and about 22,000 doctors, giving a ratio of 22.2 doctors/10,000 people (MoH, 2015). Local factors, such as stability and high quality, mean that Jordan attracts patients from all over the world and from Middle Eastern countries in particular (WHO, 2015).

Despite its strengths, the health care system in Jordan faces many challenges that limit the development. These challenges include: increasing population and health care cost, lack of governmental planning for health services, and emigration of qualified health care employees (Al-Oun and Smadi, 2011).

Even though its population is overwhelmingly Muslim, the country prides itself on its tolerance of diverse cultural, religious and political perspectives. Opposing ideologies are also accepted, including Arab nationalism, Islamic conservatism, pro-Western modernism, and tribalism (Munson, 2003). Nonetheless, Jordanian people often rely heavily for advice and guidance on religious authorities in relation to medical procedures and interventions. Indeed, in the year 2018 alone the Iftaa Department issued 203,272 fatwas (judgements) in relation to questions
posed on wide range of topics (Department of *iftaa* Jordan, 2018).¹

Relatively few scholars work in the field of medical ethics, and very few studies have examined clinical ethics in relation to the behaviour of health professionals and their understanding of ethical practice. The development of competency in the field of ethics is no doubt made more difficult by the fact that such competency requires skills and knowledge in a wide range of disciplines and draws on facts and ideas traversing multiple domains of knowledge and experience. In addition, as the complexity of medical practice continues to increase, so also do the issues that need to be negotiated. These include the challenges presented by new and emerging technologies and treatments, and the increasing complexity of the relationship between the health care system and the wider society (Al-Oun and Smadi, 2011). Issues raised by the latter include increasing rates of financial abuse against poorer patients who may experience difficulties pay for medical services, the high cost of health care in the private sector and the practice of some private doctors to make decisions on behalf of their patients for commercial purposes (Al-Oun and Smadi, 2011).

The lack of written protocols or practical guidelines covering the application of religious and social approaches to clinical dilemmas often makes it difficult for health professionals to know how to proceed when they are faced with novel circumstances. This is exacerbated by the weakness of government control and legal regulation of the private sector and the frequent absence of leadership from medical association (Al-Oun and Smadi (2011). These problems are especially acute in relation to the operation of the rapidly growing private health sector, which is becoming increasingly commercialised and business oriented.

A manifestation of these problems is the fact that because medical decision-makers, including especially health care managers have limited awareness of Islamic background and scholarship, even though they are Muslims and worship daily, they frequently try to adopt Western practices and guidelines without question. Where this is inappropriate for social, cultural or spiritual reasons, this

¹ *Iftaa* is a formal legal opinion given by an expert in Islamic Law (Ebrahim et al., 2013).
leads to uncertainty among health professionals, confusion about patients and their families, and conflicts involving doctors, hospitals and religious authorities. This undermines public confidence in the health system as a whole and diminishes the reputation of those who work within it.

1.4 Problem statement
This study seeks to address some of the issues raised by these circumstances. It seeks to assist with the development of Islamic perspectives for modern health care purposes, recognising that “Islamic perspectives” in this context refer not just to faith-based propositions but to the wider ethos associated Islamic thought and culture. It seeks to lay the basis for an enhanced educational resource in relation to the ethical and social challenges facing contemporary Jordanian society. It seeks to identify what is distinctive and essential to health care ethics in an Islamic society and how this differs from the attitudes and thought systems of the West. And it seeks to explore the relevance of guidelines about ethics proclaimed as universally applicable by international organisations and within American bioethics itself.

Broadly speaking, the study aims to address the problems presented by the lack of a clear understanding of the features of Islamic ethical thought that are essential and distinctive for the health care domain and by the lack of an organisational and educational infrastructure to support the practice of clinical ethics in Arab countries and in Jordan in particular.

The work aims to achieve these objectives by undertaking a theoretical scan of the resources available from the Islamic tradition for clinical ethics and two empirical studies of the attitudes, beliefs and concerns of health care professionals within Jordan itself.

1.5 Significance of the study
There have been no previous studies of the ways in which ethical considerations are managed in clinical settings in Jordan. It is hoped that the results of this project will provide a resource that will facilitate the development of curricula in that country which will assist health professionals to manage the ethical issues they confront more effectively.
It is also hoped that the empirical findings and the analysis will be useful for academic institutions and professional associations in clarifying how they can respond systematically to the challenges presented by social and technological change. It is hoped that the study may be used in hospitals and health centres in Jordan and the Arab world to provide guidance in the field of clinical ethics.

1.6 Research aim and questions

Full details of the aims and methodology will be presented later in this thesis. In this introduction, the main objective and the research questions will be mentioned.

The main aim of this research is to explore the nature and content of ethical decision-making in Jordanian hospitals.

Consistent with this aim, the researcher proposes five research questions arising from gaps in the research literature and the situation of Jordanian culture in health care. The research questions are as follows:

1. How do doctors think about ethical issues in clinical settings in Jordanian hospitals?

2. What ethical issues do clinicians encounter in their practice in Jordanian hospitals?

3. What is the role of religion in clinical decision-making in Jordanian hospitals?

4. What resources shape clinical ethics in Jordan?

5. What are the obstacles and challenges facing doctors with respect to ethical decision-making in Jordanian hospitals?
1.7 Summary of the structure of this study

This thesis comprises eight main chapters divided into five sections, as described below.

The first section comprises the introduction and literature review. Chapter 1 (the present chapter) has discussed the purpose and significance of this study and the importance of clinical ethics in health care. Chapter 2 will examine some aspects of clinical ethics from a Western viewpoint.

The second section discussed methodological and design issues. Chapter 3 will present the aims of the project and the research questions the study seeks to address. Chapter 4 will address some issues relevant to the methodology that will be adopted for both the quantitative and the qualitative studies.

The third section, which comprises Chapter 5, discusses the Islamic approach to ethics and examines the differences between the ways in which the concepts of consent, confidentiality and privacy are understood in Western and Islamic ethical thought.

The fourth section, comprising Chapter 6 and Chapter 7, describes the quantitative and qualitative studies. Chapter 6 involves an investigation of the opinions of doctors in Jordanian hospitals about clinical ethics and its obstacles and challenges they face. This study concludes that the Arab and Islamic world is in flux: a flux of ideas, cultures, political forces and ethics. There are pressures of globalisation, including the permeation of ideas from outside Islam, as well as the persistence of ancient ideas and concepts that continue to permeate the cultural frameworks. Doctors in Jordan are perturbed by the current circumstances and beset by many problems. However, they are seeking to resolve them through debate and discussion about ethics. This is a useful forum in which to gain clarity about the powerful forces sweeping the culture.
Chapter 7 reports the qualitative study. It describes the results of a series of semi-structured interviews with Jordanian doctors. Five main themes are derived from this study and are linked with three philosophical axes showing that Islamic culture is open to Western culture in terms of clinical ethics with some adjustments. This study draws attention to the fact that ethical decision-making needs to take into account technical, religious, social, managerial, legal and academic issues that have some unique and distinctive features in Jordan.

The final section, comprising Chapter 8, presents the conclusion to the thesis. This will provide an overview of the main findings and an assessment of their significance for the understanding and development of clinical ethics in Jordan.

1.8 Further note on the use of the religious tradition

As indicated above, the author of this thesis writes as a committed Muslim who accepts the deep truth and validity not only of the sacred texts of his religion but also of its entire intellectual structure. The nature of the latter will be explained in more detail in Chapter 5. However, in order to avoid misunderstandings it may be helpful to mention in this introductory chapter six fundamental points:

1. Like other religions, Islam is not just a collection of assertions and claims. It comprises a comprehensive way of thinking and acting, of interacting with others and of responding to social and cultural conditions. In other words, in the context of this thesis “Islam” is taken to refer to a broad field of thought and action that encompasses knowledge, ethics and other modalities of experience.

2. Islam draws on three primary textual resources: the Qur’an, the Sunnah and the Ijtihad as will be discussed in Chapter 5, which together provide a set of principles and their interpretations and applications to a wide variety of circumstances. This body of wisdom was developed over many hundreds of years and establishes the basic framework for all ethical statements within Islam.

3. As extensive as it is, the corpus of written texts is not complete, because
the world keeps changing and new problems keep emerging. This means that new circumstances have to be considered in the light of the existing body of thought and any solution has to be fashioned in such a way that it is consistent with it.

4. Often in this process deep scholarship and knowledge of the Islamic tradition is needed, much of which is beyond the abilities of this author. Similarly, in clinical circumstances where a difficult problem of religion or ethics arises it may be necessary to call on religious scholars to provide guidance and advice.

5. These points demonstrate that ethical thought in Islam is both conservative—depending on the sacred texts—and flexible—able to be adapted to changing circumstances.

6. It also emphasises that ethical decision-making in Islam depends more on process than on outcomes. This process consists of the public dialogues that involve multiple participants, often from different backgrounds and disciplines, which seek to make connections with, and ensure continuity with, the historical body of wisdom.

These points are stated here to assist the reader in recognising that the thesis is consciously constructed within a tradition of thought to which it seeks to remain faithful. The author is also committed to following Western standards of scholarship, on which he draws for the powerful resources it offers to help the Arab world address the deep challenges it faces.
Chapter 2
Literature review

2.1 Introduction

This review of “Bioethical thought in Islam and the West” summarises some aspects of the literature relevant to bioethics from Western and Islamic perspectives. It has four main objectives:

1. to highlight key conceptual components of each tradition;
2. to identify areas of overlap and difference;
3. to draw attention to areas of deficiency or need in the Islamic tradition; and
4. to establish the basis for later, more detailed, philosophical discussions within this thesis about a number of topics and issues in Islamic bioethics.

The review does not seek to provide a comprehensive account of the philosophical content of either Western or Islamic thought. There are many overviews and introductory presentations of Western bioethics. However, by comparison, there is relatively little literature of this nature, either in English or in Arabic, dealing with bioethics from an Islamic perspective.3

In view of the disproportion between the state of the two cultures this review will focus on some selected issues and topics. Specifically, it will focus on: general discussion about the role of ethics in Islam and the West; theories of ethics; cultural issues; and some specific topics in clinical ethics.

Further and more detailed discussion of particular topics from an Islamic point of view will be presented in Chapter 5. Because of the relatively rudimentary nature of the Islamic bioethics literature this will require a more extended presentation

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3 Three sources that have been of particular value for this account are: FIMA Yearbook (2005-2017); Sachedina, “Islamic biomedical ethics: principles and application” (2009); and Abul Quasem “The Ethics of Al-Ghazali: A Composite Ethics in Islam” (1975).
of the context of ethical thinking in that tradition. The topics of specific concern in Chapter 5 will include confidentiality, privacy, consent and autonomy.

This review focuses almost entirely on non-Arabic sources. This is because the bioethical literature in the Arabic language is extremely rudimentary. Apart from the existence of a number of “codes”, there is limited material in Arabic to provide guidance to clinicians and especially in relation to the teaching and practice of clinical ethics. It is one of the objectives of this thesis to lay the basis for a contribution to an expansion of teaching and practice in clinical ethics in Islamic contexts.

2.2 Role of bioethics in Islam and the West

2.2.1 Western perspective

From the point of view of Western thinkers and clinical practitioners, the study of ethics in the clinical disciplines has achieved increasing importance since the conclusion of the Second World War. The approaches to ethics that have been incorporated into bioethics have largely reflected the Western traditions of philosophical ethics, with a focus on individual freedom and reason (Russell et al., 2010; and Rich, 2013).

Within medicine, ethics has been regarded as providing an important regulatory process that ensured the smooth functioning not only of medicine itself but also of its relationship with the broader society. Drawing on the rationalist traditions of Western philosophy, bioethics—especially in its American forms—has to a significant degree focused on high-level “principles”, which have enabled identification and classification of the ethical issues that arise in different contexts (Banks, 2009). The broader value contexts, including the nature of “virtue” and the character qualities that make a good clinician, have also received attention, although for the most part in a secular manner that has emphasised the independence of the health professions from the realms of religion and spirituality (Field and Behrman, 2004; and Silverman, 2017).
Ultimately, Western approaches to bioethics have sought to provide practical guidance to allow clinicians to address or resolve dilemmas that may arise in the course of their practice, although more recent theories have moved away from narrow formulations that focus on the “resolution” of “dilemmas” (Komesaroff, 2008; and Banks, 2009).

Bioethics has been concerned to help clarify the goals of specific, proposed, technical interventions. It has helped regulate those aspects of decision-making that relate to the non-technical or non-instrumental components of the clinic. It has helped organise the relationships between society, on the one hand—including both government and civil society—and the particular domains of practice that occur in medicine, on the other.

Various writers have drawn attention to the broader functions of bioethics. It can be taken as a process to cope with different challenges in the community such as daily activities which can be either professional or social (Lillemrnoen and Pedersen, 2015). The perceived need for ethical guidance in relation to clinical issues can be seen to represent a response to social pressures that often derive from shared perceptions and varying collective evaluations of what is right behaviour within a given context and how it influences work and decision-making (Candy, 2014). Ethics should help establish, and support, everyday social values necessary for different areas of practice or action, such as academia, research, training courses, and actual clinical practice. (Habets et al., 2014).

Ethics both reflects and responds to changing expectations (Hussein, 2009) within society following technological and social developments (Banks, 2009). Clinical ethics supports a process of adjustment through broad, even global, conversations about health care among researchers and practitioners by allowing them to share new scientific knowledge and to examine ways of applying it (Stein et al., 2006).

Ethics also supports dialogues across disciplines, which can bring together science, philosophy, health economics, political science and reflections on health technologies (Littlejohns et al., 2012). In this way, clinical ethics can help clarify
the goals of health care (Zieske and Abbott, 2011), while continuing to draw attention to the importance of patients’ rights and their necessary involvement in decision-making.

2.2.2 Islamic perspective

The Islamic approach to ethics in general and bioethics in particular deviates in fundamental respects from that taken in the West. In Islam, the goals and purposes of ethics are derived from the fundamental duty to Allah SWT (God). The task of ethics in medicine is first of all to ensure that these duties are carried out in the service of health practices. Ethics is regarded as imposing or ensuring order in the chaos of everyday life (Zahedi and Larijani, 2008; Sachedina, 2009; and Abul Quasem, 1975). The elementary unit of ethical decision-making is typically not the “autonomous” individual but the community or network of relationships within which an individual is embedded. The method of Islamic thinking that is applied focuses primarily on juridical process rather than consequences or individual or personal qualities.

According to Sachedina (2009), the Qur’an lays down the golden rule about moderation. Allah SWT says in the holy Qur’an:

O children of Adam. Eat and drink the good things you desire, but do not become wasteful (7:31)

From the Islamic perspective, in order to ensure happiness and a good life, humans draw on ethics to regulate and review their relationships with family and others and even with their innermost selves (Misha'î, 2017). For example, ethics provides guidance in carrying out ritual obligations, such as performing five daily prayers at stipulated times, the manner in which the Qur’an is recited, how ablutions are carried out etc. To its adherents, it is part of the beauty of Islam that everything should be done in a proper way (Rahim, 2013).

A key thinker in the development of Islamic ethics, to whom repeated reference will be made in this chapter, was the philosopher Abu Hamid al-Ghazali (d 505...
AH; 1111CE). He articulated a mystical philosophy that aimed to facilitate the achievement of happiness by avoiding abandonment by God and gaining nearness to him. During al-Ghazali’s Sufi period, his main concern became well-being in the hereafter and the escape from punishment in hell (Abul Quasem, 1975).

Resonances of al-Ghazali’s thought continue to be felt in the present, where the management of moral and physical evil by a culture is understood to contribute to the quest to understand the reasons for human suffering and pain (Sachedina, 2009). From this perspective, Islamic bioethics has come to require that medical professionals and other health care providers ascertain the implications of a given medical procedure for a patient and a patient’s family, with the focus being on overall spiritual and physical well-being (Sachedina, 2009). Islamic ethics therefore seeks to protect both medical practitioners and patients from the sins of worldly standards and ensure that divine standards are met (Khan et al., 2009a).

2.3 Theories of ethics in Islam and the West

2.3.1 Western perspective

No attempt will be made in this thesis to summarise comprehensively the many theories of and approaches to ethics within the Western perspective. Instead, a mere indication of the nature and range of these theories will be provided, with some—at times eclectic—comments regarding particular notable features. The proliferation of theories in the West is in contrast with the Islamic tradition, which is much more homogeneous.

For the purposes of this discussion, ethics may be regarded as “the study of morals and values; that is, the study of right and wrong, justice and injustice, virtue and vice, good and bad, and related concepts and principles” (Field and Behrman, 2004, p.63).

Conventional accounts of ethical theory, such as that of Banks (2009), classify ethical theories in the Western tradition in terms of “deontological” theory, which is duty-based following Immanuel Kant, and “consequentialist” (utilitarian) theory, following the British philosophers Jeremy Bentham and John Stewart Mill, according to which all actions should be judged by their consequences for general
welfare, and should be based on professional principles. Some recognition is also given to the role of Aristotelian, virtue-based theories, and the variety of philosophical approaches that arose within the framework of post-Enlightenment modernity, such as existentialism, discourse ethics, intuitionism etc (Jeffrey, 2006 and Noble, 2007).

For Noble (2007), utilitarianism provides an empirical solution to ethical dilemmas by eliminating abstract philosophical argumentation. For Foster (2001) it is better to consider the consequences of an action than the “contents”, such as faith, laws and regulations, codes and beliefs. As with many utilitarian thinkers this view favours the focus on the balance between benefits and harms at the expense of the content of moral principles and the knowledge and duties of clinicians.

Komesaroff (2008) provides an overview of the discipline of “bioethics”, arguing that it encompasses a wide variety of theories spanning a broad historical period in the Western philosophical tradition, including Aristotelianism, deontology, utilitarianism, neo-Aristotelianism, principlism, narrative theory, discourse theory, and feminist theory. All of these theories have been subjected to critique in relation to their ability to respond to the contemporary cultural and philosophical demands of modernity and the recognition of the limitations of Enlightenment-based concepts of reason and the role of individual subjectivity.

Komesaroff himself expounds a “postmodern” view of ethics, in which there are no “grand narratives” of right or wrong, there are no formal, normative rules that direct or pre-specify solutions for problems or unique decisions, and there is no general law to organise or justify behaviours. Drawing on postmodern and phenomenological thinkers, including Emmanuel Levinas and Jurgen Habermas, he argues for an approach to ethics that is focused on process, and linked to dialogue and community-based meaning construction (Komesaroff, 2008 and 2014). This is a view that has striking parallels with that of Islam, as discussed below.
2.3.2 Islamic perspective

In Islamic culture, the Qur’an Kareem, the holy book for Muslims, discusses many issues relating to ethical rules and guidelines valid for all life aspects:

Righteousness is this that one should believe in Allah . . . and give away wealth out of love for Him to the near of kin and the orphans and the needy and the wayfarer and the beggars and for the emancipation of the captives (2: 177).

Abu Hamid al-Ghazali described the “problem” of good character as consisting of an array of four virtues: wisdom, courage, temperance and justice, together with their sub-divisions. Character in his view is not knowledge of good and evil or capacity for good and evil, or action of good and evil, but it is instead an established state of the soul. Good character is reflected in both man's inward and outer forms (Abul Quasem, 1975).

Islamic ethics or akhlaq has been described as “a science that studies the state of the human soul” (Rahim, 2013). The definition of akhlaq as the science of the human soul was elaborated by successive writers and philosophers on Islamic ethics, such as, al-Ghazali, Fakhruddin al-Razi (d. 1209), al-Tusi (d. 1274), al-Dawani (d. 1502), and others. Overall, these thinkers defined ethics or ilm al-akhlaq as “the science of the human soul which defines the characteristics and qualities of the soul as well as the methods of how to control and moderate them”. Al-Farabi, Ibn Miskawayh (d. 1030), in his work Tahzib al-AkhlAQ, defined akhlaq as “a state of the soul which causes it to perform its actions without thought or deliberation” (Rahim, 2013, p.508).

Islamic ethics is founded on the tenets of the Maqasid al-Sharī`ah. It is all encompassing and comprehensive and remains dynamic and flexible (Khan and Iqbal, 2017). Maqasid al-Sharī`ah encompasses a deontological ethical norm according to which the rightness or wrongness of actions is determined without
regard to the consequences produced by performing such actions (Sachedina, 2009).

Following this approach, Abu Hamid al-Ghazali and his followers adopted the view that the rightness and wrongness of action were linked to the purpose of practice and were not directed towards the mere acquisition of pure knowledge. al-Ghazali divided wisdom into two parts. The first dealt with human action, called “practical science” (*ilm amali*) and referred to well being in this life as well as in the next. The other related to existence, called “theoretical science” (*ilm nazari*). The practical was divided into three parts: (i) science which regulates man’s dealings with others in society that may cause him well-being in his life, which entails perfection of political science; (ii) man’s behaviour to the members of his family (*ahl almanazil*); and (iii) ethics (*ilm alakhlaq*) the good qualities and virtues of character-traits and qualities (Abul Quasem, 1975).

From an Islamic point of view there are three theories of ethics (Abul Quasem, 1975: Abu Hamid al-Ghazali): (i) a purely theoretical study of the nature of morality; (ii) a practical discipline aiming to influence actual conduct, where the aim of practice is to improve the state of the soul, as defined within the *Qur’anic* verses and the prophetic tradition; and (iii) a process of discovery of the truth about moral matters through an ethical investigation and constant criticism of existing standards of morality (Abul Quasem, 1975).

al-Ghazali’s concerns directed the development of his moral theory and fashioned his ethics as “religious” and “mystical”, in contrast to “secular” theory, which is exclusively concerned with human good in this life. al-Ghazali called his ethics the “science of the path of the hereafter” because ethics for him cannot be separated from the study of religious beliefs (Abul Quasem, 1975).

The thinkers in the tradition following al-Ghazali strongly emphasised the links between the theoretical aspects of ethics and its practical meanings by focusing on the good associated with the family and the whole community rather than on the interests of individuals. Indeed, this is now considered to be the accepted
meaning of ethics in the Arabic language (akhlaq). These thinkers accept that the Qur’an and the Sunnah (the account of the prophet Mohammad’s practices) are the main source of ethics, in addition to the reasoning sources called Analogy or (qiyas) (Abul Quasem, 1975).

The establishment of the irreducible dependence of ethics in Islam on the processes of interpretation of the holy texts which formed the basis of the “theoretical science”, shows its inherent nature to be one of legal process, or rather of a process of dialogue around the sacred texts and traditions. Within Islamic legal theory (usul al-fiqh) the “principle of public good” (Sachedina, 2009) is identified as al- masālih al mursala, that is a process of the application of rules arising on the basis of reasoned judgments that interact with guidelines in the context of a cultural matrix external to the Qur’an or the traditions.

From the perspective of this approach Islamic thinkers have criticised the various Western theories (Al-Aidaros et al., 2013). Examples of such critiques are as follows:

- **Relativism:** This holds that ethical standards are relative to a particular environment, that different societies may have different ethical codes and that there is no universal truth in ethical principles that can be held by all peoples at all times. This is rejected by Islam, for which the founding principles are universal and everlasting (Al-Aidaros et al., 2013).

- **Utilitarianism:** This is rejected because consequences are only one component of a moral act and do not define it in its entirety (Al-Aidaros et al., 2013).

- **Individualism:** According to this view a person must always perform in his/her own interest, and an action is considered to be ethically right only when it promotes a person’s self-interests. This is rejected because Islam sees human identity and personality as being inherently communal,
deriving its unity and coherence from the link with God (Al-Aidaros et al., 2013).

- **Deontology**: This is rejected because the theory is not clear about the source of these “universal ethics” or is purely rational in origin. In Islam by contrast the only source for an ethical system is the Islamic principles (Al-Aidaros et al., 2013).

- **Virtue ethics**: This theory focuses on what makes a good individual or person rather than what makes a good action. There are specific virtue traits that every person must have such as: civility, cooperativeness, courage, fairness, friendliness, generosity, honesty, justice, loyalty, self-confidence, self-control, modesty, fairness, and tolerance. This approach is rejected because the claims about virtues are considered to be without ultimate foundation and therefore ultimately merely gratuitous (Al-Aidaros et al., 2013).

2.4 **Principles of ethics**

2.4.1 **Western perspectives**

“Principles” of ethics have often been attributed to have considerable importance in the West, especially in the post-Enlightenment period. They have been especially influential in biomedical ethics. As previously noted, it is not intended here to provide a comprehensive account of Western perspectives on ethics, but rather to highlight some key features that will be of relevance for future discussions.

In American bioethics, the approach popularised by Beauchamp and Childress (2013) which focused on four “principles” of “autonomy”, “beneficence”, “non-maleficence” and “justice”, has had a disproportionate influence, although that influence has been less in European and non-Western societies (Levine, 1988; Noble, 2007; Snyder and Gauthier, 2008; Silverman, 2017; Field and Behrman, 2004; Komesaroff, 2005; Murphy, 2018 and Leeper, 1996).

Within the theories based on “principlism”, Levine (1988) claimed that ethical
principles could be considered as the main “tools” of ethics. According to Snyder and Gauthier (2008), the principles of clinical ethics also refer to emotions and relationships, such as privacy and bodily integrity, religious, social, and cultural differences and communication skills. Field and Behrman (2004) consider that ethical principles require clinicians to maximise patients’ benefits and minimise the harms they experience. This may be accompanied by a principle of protecting patients from physical, psychological, social and economic distress. They add that a principle is necessary to maintain the distribution of benefits to patients and protect them from concerns and burdens. In this approach, patients’ rights may be embodied in certain principles, such as receiving medical treatment regardless of their ethnicity, religion, education, language or culture. Hunter et al. (2017) argue that principles guiding ethical behaviour are “universal”, exceeding all traditions and cultural boundaries.

2.4.2 Islamic perspective

Islam adopts a quite different approach to the concept, nature and status of principles. Islamic jurisprudence is a fluid source of ethical discourse which is not subject to fixed principles. Muslim jurists like al-Ghazali, Ibn Abd al-Salam (d. 1262), Abu Ishaq al-Shatibi (d. 1388) have discussed the objective of al-Sharī`ah (Islamic Law). Al-Shatibi, for instance, stated:

The rules of the Sharī`ah have been designed to produce goods (masālih) and remove evil (almafāsid) and these are certainly their ends and objects. And the masālih are those which promote the preservation and fulfillment of human life, and the realization of all that the human nature, animal and rational demands, till one is happy in every aspect (Rahim, 2013, p.509).

“Principles” can from this perspective be seen within the broader context of Islamic jurisprudence (Maqāsid al-Sharī`ah), the goal of which is the promotion and preservation of the common good and benefit (jalb al-masālih) and the avoidance of, and protection against, harm (dar’ almafāsid), the preservation of public interest (maslahah `āmmah) and the transformation towards justice (Nordin, 2017).
Islamic jurisprudence is characterized by a holistic view (Misha’l, 2007) that takes into consideration the “principles” of Islamic Sharī`ah, that is protection of the human body, soul and mind, which in turn has five purposes: protection of religion (deen), life (nafs), progeny (Nasl), mind (aql), and wealth (Mal). These purposes of al-Sharī`ah provide a holistic relationship to preserve sanctity, dignity, and safety of humankind (Misha’l, 2007).

al-Ghazali in his first book, Ihya, classified ethics into two types: religious (al-Sharī`ah) which is received from prophets, and non-religious (ghayr al-Sharī`ah), which is learned by reason, as in mathematics or by experiments in medicine. He claimed that there are four roots of Islam: 1. the Qur’anic roots (isul); 2. the Sunnah (Prophet Mohammad’s principles, behaviours and creed) of standard practice; 3. the Muslims’ consensus (ijma); and 4. the companions’ traditions (athar alsahaba) (Abul Quasem, 1975).

Islam itself therefore provides a comprehensive set of norms, values and laws that together make up the Islamic way of life. These emerge jointly out of iman (faith), akhlaq (ethics), and fiqh, which is the legal rulings that govern the acts of human beings. The first two components—iman (faith) and akhlaq (ethics)—are permanent and fixed for all times and for all societies. In contrast, the last component—fiqh—can be modified and changed consistently with time and place. Islam offers different systematic approaches in various areas of science, finance, and society and is flexible in the complex environments generated by changing times (Al-Aidaros et al., 2013).

2.4.2.1 Convergences between Islamic and Western theories of ethics

Some authors have drawn parallels between Islamic processes and Western ones. Islamic principles are directly and indirectly derived from the general principles of maslaha, that is "public good". For Sachedina, “maslaha is actually an expression for bringing about benefit (manfaa) or forestalling harm (madarra)”. Principles of ethics indicate that Muslim ethics tries to make sense of human moral instincts, institutions and traditions in order to provide a foundation of normative rules that can govern a virtuous life (Sachedina, 2009).
Sachedina (2009) argued that the role of ethical principles in deriving moral judgments was articulated in greater detail by the theologians who were also divided along the same lines as the jurists: those who supported the substantive role of reason in knowing what is right and obligatory; and those who argued in favour of the revelation as the primary source of ethical knowledge. The *Sharī‘ah* categories (obligatory, recommended, permitted, disapproved and forbidden) are defined in relation to actual divine command and prohibition, the reward and punishments by God in the next life. These principles generated rules that allowed the determination of the ethical evaluation of acts so that they could be declared as incumbent or necessary (*wajib*), prohibited (*haram*), permitted (*mubah*), recommended (*mustahabb*) or reprehensible (*makruh*) in the context of specific circumstances (Sachedina, 2009, p.46).

Islamic juridical methodology was firmly founded on moral principles, such as the rejection of harm and promotion of public good, in deriving solutions that Muslims encountered in their everyday life. Gradually, the judicial opinions were formulated without explicit reference to the ethical dimensions of the cases under consideration. Thus a *fatwa* is defined as a formal legal opinion given by an expert in Islamic Law. An expert in Islamic Law is known as a mufti, an inquirer (i.e. one who seeks the legal opinion of a mufti) is known as a *mustafti*, and the act of issuing *fatwa* is known as *iftaa* (Ebrahim et al., 2013).

The two distinct obligations of beneficence and nonmaleficence in some Western systems (Sachedina, 2009, p.49) are viewed as a single principle of nonmaleficence in Islam on the basis of the overlapping of the two obligations in the famous traditions: in Islam there shall be no harm inflicted or reciprocated (*la darar wa la dirar fi al islam*). This is the principle of no harm, no harassment.

### 2.4.3 Summary

Accordingly, there are some features that make Islamic ethics unique (Hashi, 2011):
1. Islamic ethics is mystical; this is so because the distinction between what is ethical and what is not, and what is proper and what is improper, arises inherently and primarily from the human struggle to gain nearness to God and to avoid abandonment by him (Abul Quasem, 1975).

2. In the Islamic ethical system, man’s nature is not evil or graceless, but good (*fitrah*).

3. As a universal code of conduct, Islamic moral standards teach universal justice and human equality.

4. Human conducts are judged to be ethical or otherwise, depending on the intention of the individual and in accordance with the divine texts (*nusus al-Sharī`ah*). Human conduct is considered morally good (*amal salih*) by fulfilling two conditions: the conduct must be carried out with good motives (*niyyah hasanah*); and it must be in accordance with the norms of the *Sharī`ah*.

5. Islam grants to all the ability to enjoy natural rights such as freedom and liberty, but “not at the expense of accountability and justice” (Hashi, 2011). It is possible to evaluate individual behaviour in relation to accountability and public interest.

6. Islam offers “an open system approach to ethics, not a self-oriented system” (Hashi, 2011). The individual interest and personal satisfaction are very much related to the public welfare and collective interest. Egoism has no place in the Islamic moral system.

7. In Islamic ethics, decisions that benefit the majority or minority are not necessarily ethical in themselves. In the Islamic conception, ethics is not a numbers game; and therefore, Islam rejects the utilitarian contention that says ethics is whatever brings the greatest happiness to the greatest number of people.
Ethical values aim to realise human interest (jål al-maslahah) and to prevent hardship (dår’ al-mafsadah).

2.5 Ethics and culture

2.5.1 Western perspective

A health service must combine values from two broad categories: the first includes substantive values like clinical effectiveness, justice, solidarity and autonomy; the second category covers process values, including transparency, accountability and participation (Littlejohns et al., 2012). The culture of clinical practice reflects the values of the community it serves. This culture is also the source of core meanings arising within the clinic, such as those of illness, treatment, pain and death, as well as styles of communication between doctors, patients and their families (Powell, 2006).

In Western settings the diversity of cultures is regarded as a value in itself (Congress, 2005). Health care organisations are expected to consider the diversity of cultural perspectives in relation to treatment, diagnosis, communication with patients and follow up. In addition, clinicians apply deep knowledge about diversity in relation to health beliefs, crisis events, religions, values about education and awareness, family structures and rules, holidays and key community events (Congress, 2005).

It is claimed that the relationship between culture and health services can be developed by ensuring that community views are accurately reflected in the policies and processes of institutions and professional associations (Polsa et al., 2013).

2.5.2 Islamic perspective

In Islam, preservation of life is a fundamental Maqsad (goal) of al-Sharī`ah (Fadel et al., 2013). In Islamic jurisprudence ethical values are integral to the prescriptive action guide that the system provides to the community (Sachedina, 2009). al-Ghazali separates politics from the scope of ethics, arguing that the ideal
government is based on Islamic jurisprudence, which sets out a series of processes that generate ethical outcomes (Abul Quasem, 1975).

Sachedina (2009) argued that there are numerous instances of health care in Muslim societies in which the principle of autonomy highly rated in the West displays less force than the commitment to family and community resources. For example, physicians must strive for the optimisation of pain control, nutrition, mental and spiritual stability at the end of life through close cooperation with both patients, their families and community members (Misha’l, 2005). Another example illustrates the manner in which medical values reflect the attitudes of society, subject to the views of the sacred texts (Sachedina, 2009). In Islam, corrective cosmetic procedures to enhance one's beauty are not permissible if they lead to deception about one's true identity and if they cause corrupt social behaviour (Sachedina, 2009).

Muslim physicians and laypersons alike recognise that Islam does not always provide a complete guide for all phenomena arising from modern scientific insights. In this view, adaptation to novel circumstances requires the application of reason, taking into account long-standing religious and cultural norms and an interpretation of Islamic law (Moazam and Jafarey 2005). In these cases, guidelines developed in Western settings may provide valuable assistance (Shaharom, 2009).

Nonetheless, it may still be the case that clinical care is discordant with values demanded by society. This is generally taken to signify that the principles underpinning Islam's ethical framework applied to routine clinical scenarios have been insufficiently understood by clinicians, leading to culturally insensitive health care (Mustafa, 2014).

Because of the sensitivity of relationships between ethics and culture, the direct adoption of protocols or guidelines from Western bioethics by Muslim medical and health care workers is often insufficient to deliver ethically appropriate outcomes. Instead, the application of such guidelines in Islamic settings should
only be attempted following a detailed assessment of relevant epistemic and cultural conditions (Sachedina, 2009).

2.6 Specific topics in bioethics

2.6.1 Western perspective

2.6.1.1 Law

In Western ethical thought there is a fundamental difference between ethics and law (Brookes, 2013). Ethics is considered not to refer to rules, formulae or laws (Noble, 2007) but rather to ideas, issues, principles, and problems concerning values. Ethical views can vary according to domains of experience, personal perspectives, and available evidence, and standards or criteria for ethical judgment can vary widely.

Medicine needs to be able to carry the force of authority within a community. Gillett (2006) argues that the location of such authority within ethics is preferable to a reliance on political or economic factors, which are subject to ideological, scientific and other biases.

2.6.1.2 Guidelines

Jeffrey (2006) has described ethical codes as “standards of practice that establish baselines but do not often help to provide an answer to an ethical dilemma”. In this context, an “ethical dilemma” is taken to mean “a situation in which an individual is compelled to choose between two actions that will affect the welfare of a sentient being, and both actions are reasonably justified as being good, neither action is readily justified as being good, or the goodness of the actions is uncertain” (Rich, 2013).

Codes of ethics are considered to assist with identification of appropriate and inappropriate behaviour, to provide guidance to decision-making in difficult contexts and to help clarify professional responsibilities (Jennings et al., 2007). Sanctions and rewards linked to codes are supported by some authors but not by all (McDonald, 2009). Some codes are limited to a very high level of abstraction. For example, the International Code of Medical Ethics states:
a physician shall act only in the parent’s interest when providing medical 
care which might have the effect of weakening the physical and mental 
condition of the patient (Field and Behrman, 2004).

Other codes are very detailed and specific, even including protocols to guide 
decision-making (Banks, 2009). Typically, a series of questions is posed to 
formalise a systematic series of steps towards a clinical decision, such as: “What 
are the facts? Whose interests are at stake? What is the dilemma about? What are 
the alternatives? What is the conclusion? How to carry out the decision? Then 
evaluation and reflection” (Banks, 2009).

Some clinical and ethical codes are linked to local requirements of health care 
services and procedures, which may require specific training or provision of 
additional resources (Lakhan et al., 2009).

For Komesaroff (2008, 2014), ethical discourse is radically distinguished from 
“rules”, “norms” and “protocols”, with one of its primary tasks being to question 
the assumptions on which such injunctions are based. From this viewpoint, ethical 
dialogue is distinguished as a dynamic, self-reflective process that generates and 
interrogates values. Francer et al. (2014) consider that codes of ethics are 
professional and behavioural guidelines directing the health service for patients 
and their families in the belief that patient should come first. They also argue that 
they are standards for interactions between health care providers and health care 
management in relation to fees, promotion, hospitality, procedures, 
responsibilities, communication, research, approvals, and certifications, different 
types of knowledge, training, donations and grants (Francer et al., 2014).

### 2.6.1.3 Curriculum, training and education

It is widely accepted in European and Western environments that training in ethics 
is important for health care professionals (Mayeda and Takase, 2005). Many 
authors believe that clinical ethics should be a core subject in medical curricula, 
although the extent to which this has actually become the case varies widely
(Ypinazar and Margolis, 2004; Mayeda and Takase, 2005; and Hariharan et al., 2006).

The contents of ethics curricula often include reference to needs of local communities and health care services, thereby ensuring that they reflect the norms and traditions of the societies the health professionals are serving (Hariharan et al., 2006). To ensure that this remains the case ongoing dialogues and adjustments may be necessary: for example in the form of monthly or quarterly discussion meetings of hospital staff with different scholars, both clinical and non-clinical (Ross et al., 1993).

In addition to educational institutions such as universities, it is widely considered that ethics training is the responsibility of clinical institutions (Ghias et al., 2014) and professional associations. Hospitals have a responsibility for maintaining the quality of their clinical services and for ensuring that management practices are consistent with ethical standards (Schnoor et al., 2015).

Similarly, it is a key function of medical associations to provide training and guidance to their members (Furler and Palmer, 2010). This can take the form of guidelines and codes, as discussed above, or actual training courses, as conducted by many medical colleges (Schnoor et al., 2015).

In both universities and professional societies, the Hippocratic Oath is sometimes adopted as a high-level statement of aspirations and standards (Gillett, 2006). From this point of view it can be seen as a guide to conceptualization, intervention, and monitoring of results to refine clinical theories and enhance medical practice. In this way, the Oath can be employed as an educational tool, to help shape relationships between doctors and their patients (Zilber, 2014) and providing guidance to medical students in relation to decisions and critical judgements in clinical contexts (Lakhan et al., 2009 and Jennings et al, 2007).
2.6.1.4 Autonomy and paternalism

“Autonomy” is a fundamental category of ethics in the West. According to Russell et al. (2010), professional autonomy means focusing on individual patients and their desire for self-regulation. It also entails sharing health-care decisions, such as diagnostic procedures and treatments, as well as registration and admission with patients (Jennings et al, 2007). Others such as Field and Behrman (2004) consider that autonomy means respecting the capacity of patients and their self-determination. More specifically, autonomy is:

the freedom and ability to act in a self-determined manner. It represents the right of a rational person to express personal decisions independent of outside interference and to have these decisions honoured (Rich, 2013, p.36).

According to Snyder and Gauthier (2008), the principle of respect for autonomy means that the patient can make a decision according to his ability to communicate with health care providers about accepting or refusing a health care plan. This also needs rational decisions relying on trust and enough information. Jeffrey (2006) emphasises that both psychological and physical care need to be given to patients and their families while respecting their autonomy and privacy. Naji et al. (2017) add that various controversies about individual autonomy mean different decision-making outcomes by health workers.

Paternalism in clinical settings means that doctors always know what is best for their patients (Noble, 2007). In reality, doctors should make mutual decisions with their patients and respect their autonomy. This could be defined as “the deliberate overriding of a patient’s opportunity to exercise autonomy because of a perceived obligation of beneficence” (Rich, 2013).

In the doctor-patient relationship, the partnership should reflect the professional and social responsibility for improving the patient’s interests (Medical Council Dublin, 2009).
2.6.1.5 Research and clinical ethics committees

It is universally accepted in Western settings that all research involving human subjects must be subject to review and surveillance by ethics committees. The history of ethics committees is well-described, along with the many guidance documents that have been developed to serve cultural and ethical requirements in all relevant legal jurisdictions (Perneger, 2004; Nagao et al., 2014; and Ross et al., 1993). The details of the research ethics systems and processes in Western countries will not be repeated here.

The role of committees in relation to clinical ethics issues commands much less agreement. Clinical ethics committees operate in many settings, according to varying terms of reference and levels of authority and influence (Perneger, 2004; and Nagao et al., 2014). However, the role and utility of such committees has also been questioned (Sleem et al., 2010). It has even been suggested that the introduction of a committee into the clinical process may actually undermine relationships between doctors and their patients, thus leading to worse rather than improved ethical outcomes (Perneger, 2004; and Ross et al., 1993).

Where they do exist, clinical ethics committees can act as consultative bodies to assess the behaviours of clinicians, along with patients’ demands and interests (Perneger, 2004). According to Nagao et al (2014), ethics committees or ethics consultants can perform a valuable service for patients and their families in terms of decisions and ethical considerations as well as helping resolve dispute or conciliate in difficult circumstances. However, they also note that occasionally conflicts can arise between health professionals and ethics consultants (Nagao et al., 2014).

Clinical and institutional ethics committees can also assist in developing and revising policies relating to clinical practice (Ross et al., 1993). They can provide settings in which managers and heads of clinical departments of medicine and nursing can discuss concerns and problems arising in relation to health care services and can provide forums for community representatives to express any
concerns they may have. The National Research Ethics Service (2009) in the UK provides an example of the success of such a process.

Ethics committees can face difficulties owing to financial issues and problems, leading to weak decisions, and a lack of independence and monitoring protocols (Sleem et al., 2010). Additionally, the absent of diversity in both knowledge and experiences for their members may also limit their effectiveness (Sleem et al., 2010).

2.6.2 Islamic perspective

2.6.2.1 Law

The role of “law” and forms of thought linked to judicial considerations and dispositions in Islamic approaches to ethics differ fundamentally from the approaches favoured in much of Western bioethics. Indeed, in Islam, ethical and legal thinking are closely linked. The legal structures set out the processes that define the nature and dynamics of ethical judgment. It is the outcomes of these processes that constitute the substantive nature of ethical decision-making.

Islamic law is concerned with human welfare, broadly conceived—that is, not merely with governance in the narrow sense (Sachedina, 2009). It incorporates practical judgments or legal opinions, known as *fatawa*, reflecting the insights of jurists who have been able to connect cases to appropriate sets of linguistics and rational principles (Sachedina, 2009) as well as rules that can provide a basis for valid conclusions in specific cases. Muslim jurists have also discussed *urf* (custom) in the context of legal methodologies and legal-ethical decision making (Sachedina, 2009).

Unlike in Western legal and political theory traditions, from the Islamic perspective no clear distinction is made between the civil and religious domains (Zahedi and Larijani, 2008 and Khan, 2005). In particular, there is no clear distinction between religion and the state. This means that the private and public areas of experience are subject to a consistent set of principles and processes. It does not prevent the establishment of different jurisdictions of law, analogous to
modern categories of civil, criminal, property and personal law. However, it does lead to a unified moral framework that is ultimately subject to testing in relation to the central array of moral precepts in the sacred texts (Khan, 2005).

A key, abiding objective of Islamic legal discourses is to establish rulings that support a classification of phenomena as either “obligatory” or “prohibited”, which in itself provides a function of marking experiences, actions and thoughts as charged with value.

Such legal judgments are not, however, purely abstract or formal. They are dependent on processes of interpretation based on a defined set of texts. These texts include the Qur’an and Sunnah and the preserved archive of ethical and legal decisions that have been taken over time. While this common law tradition of Islam is based on an inherent trust in the processes of communal dialogue and reasoned deliberation, it also assumes a central set of tenets understood as divine commands which had to be obeyed even if the reasons behind them remained unfathomable to human reason (Sachedina, 2009).

The fixed nature of the sacred texts therefore provides a unified moral context for all law. However, it also has the effect of limiting the capacity of the system to innovate or respond to novel demands and circumstances. This is particularly apparent in the areas of medicine, where changes in knowledge and technological capacity have generated demands and problems not previously anticipated.

In relation to medical issues, Islamic law fosters interactions between government, business, academia, medical practitioners and the public to formulate the discourse and develop therapeutic responses (Khan, 2005). Because advances in medical technology have far outpaced laws that regulate its use there is a need to develop fresh perspectives as well as the opportunity to draw on resources from other cultures and traditions.
2.6.2.2 Guidelines

Because of the emphasis on process in Islamic thought there is much less emphasis on “guidelines” than there is in the West. This is because guidelines tend to focus on the outcomes or consequences of dialogues rather than on the process of dialogue itself.

This does not mean that the ethical positions that are often effectively articulated in Western guidelines are necessarily at odds with views that are held in Arab settings. On the contrary, there is in most cases very considerable overlap between the two bodies of thought in relation to substantive issues.

Bioethical codes are, to a large extent, in conformity with the Islamic ethical standards, established and applied since the very early years of Islamic civilization (Chamsi-Pasha et al., 2017b). There are, however, significant differences in ideological and moral standpoints. However, bioethics in the Muslim world is a relatively new field of inquiry and there have not yet been detailed attempts to define the epistemic parameters of the field as it relates to Muslim culture (Sachedina, 2009).

Islamic bioethics is both holistic and faith-oriented (Chamsi-Pasha et al., 2017a). Through it, the spirit of Islam is translated into the practice of medicine and research, through codification of divine revelations, into principle regulations referred to as al-Shar‘iah, or Islamic Law. Islamic bioethics cannot be divorced from morality and cannot be separated from Islamic Law.

Although guidelines or books of fixed rules are not fundamental to Islamic thought in the field of bioethics, perhaps following the lead of Western thought and to a significant extent drawing directly on this discipline, various codes have been formulated and are in more or less common use. These codes include (but are not limited to) the following: the definition of Islamic Medicine, characteristics of the doctor, relationships between doctors, relationships between doctors and patients, professional secrecy, responsibilities of doctors during war, doctors and the sanctity of human life, doctors and society, doctors and the
development of modern medical science, medical education, and the Oath of the Muslim doctor (Shaharom, 2009).

2.6.2.3 Curriculum, training and education

Although education and the transmission of knowledge and culture are fundamental to Islam—as they are in all religions—very little attention has been paid to the question of teaching ethics in the field of clinical practice.

The works of both Al-Rāzī (Kitāb Al-Hāwī) and Ibn Sīnā (Al-Qānūn) were standard texts in the European medical curriculum in the sixteenth century. Dr. William Osler, the famous Canadian physician, referred to Al-Qānūn as "a medical Bible for a longer time than any other work." (Nordin, 2017)

The vision of medical education and tarbiyah (training in the light of Islamic teaching) is to mould medical practitioners and researchers with balanced, dynamic and wholesome personalities, owing total allegiance to Allah SWT and imbuing in themselves the sense of responsibility and accountability (Khan et al., 2009b). In this context, Zabidi-Hussin (2006) has added that it is difficult to understand community health problems via paper cases in a classroom without first-hand experience in the field, that learning about health, wellness and disease in communities requires students to listen and observe critically, and that self-directed learning is a necessity.

Among Islamic thinkers, Abu Hamid al-Ghazali developed a comprehensive pedagogical philosophy. For al-Ghazali, ethics was derived from the writings of Sufis, the teachings and experiences of the revealed scriptures, and the contributions of philosophers (Abul Quasem, 1975), which, together, ensure that an individual attains good character, good management of his life, self-control and patience. The devotional acts are very important tools for Muslims, enabling them to develop ideal characters and to create commitments towards themselves and the surrounding communities, as well as working for the hereafter (Abul Quasem, 1975). Educational institutions in Muslim countries have similarly incorporated these new teaching paradigms and educational methodologies, with significant progress and success (Khan, 2009).
The Islamic approach to medical education incorporates professionalism and divine injunctions of perfection and competence, together with a holistic approach towards patients, family, society, disease, health, life and death. Unlike the Western biomedical model, in the Islamic approach Allah SWT is the ultimate source of healing. Medical professionals possess only the means of healing transferred to them by the Creator. However, the perspective is a “holistic” one—that is, attention must be paid not only to physiological issues but also to factors like nutrition, care, education, and a clean environment (Sachedina, 2009).

Various tertiary educational institutions in Muslim countries, including in Malaysia and Indonesia, have adopted this teaching approach, which is infused with Islamic values and cultural practices (Shaharom, 2009).

The Muslim medical practitioner and researcher (Misha’l, 2009) proposes the need for a balance between teaching medical sciences and proper upbringing, referred to as Tarbiyah. Tarbiyah derives its roots from the Tawhid paradigm of Islam which integrates harmony of matter and soul, body and mind, and emphasizes thinking, contemplation and discovery of new knowledge. From this perspective, a Muslim curriculum must balance behavioural changes based on truthful understanding of Islamic medical ethical values (Khan et al., 2009a).

Despite these broad principles, Muslim scientists working in biomedical research lack effective team work ethics and training (Khattak, 2017). A general atmosphere of lack of trust and fear of accountability prevails, irrespective of discipline or position in the academic hierarchy.

2.6.2.4 Autonomy and paternalism
As will be discussed further in Chapter 5, the Islamic perspective on autonomy and paternalism is quite different from that which predominates in contemporary American bioethical thought. Islam is a communal religion, according to which the unit of ethical decision-making is not primarily the isolated individual who stands (potentially or in fact) in opposition to all other members of society. Rather,
it is the individual as embedded in networks of relationships, within family, community, and the broader society (Tavaokkoli et al., 2015 and Serour, 1993).

The primary authority for this view of the individual as inherently “ethical” is to be found in the sacred texts of Islam, according to which personal identity is formed through the unity of all people with God. This has been explained by Sachedina (2009) as follows:

Muslim jurists make a fine distinction between God's right (haq- Allah SWT) and the right of the human (haq al-abd) as it pertains to one personhood (nafs). In jurisprudence, God's right is defined as that in which a human being has no option but submission, whether that right make sense or not, where as the right of human being is defined as that which reverts to promoting human interests (masālih) while in this world” (Sachedina, 2009).

This conception of individual identity and moral personhood as depending on an inherent connectedness ultimately traceable to God has deep consequences for all aspects of ethical thought and action. Some of these have already been discussed. They include the focus in ethical thought in Islam on processes involving dialogues formed in relation to the sacred texts. They include the central role of the family and community with respect to ethical concepts such as consent and confidentiality.

They also include the manner in which the relationship between men and women are conceptualised in Islam (Ezzat, 2008). Women play an active role in society and are respected for their distinguished contributions to the intellectual, cultural, economic and political life of Islamic societies. Within Islam, the difference between the genders is also identified as a fundamental source of the construction of social meanings and so plays a foundational role in the construction of values (Mernissi, 1987). Although the role of women in Islam is often criticised from Western perspectives, from within Islam it is often seen as liberating (Ezzat, 2008). This is not to deny that in some settings, such as Wahhabism, the role of women
is linked to differences in power and status in a manner that is the subject of much critical comment and debate within the Islamic world.

A contrary effect of the opposition within Islamic thinking to Western concepts of autonomy is a tendency in the Muslim world for medical practice to lean towards authoritarianism and paternalism (Sachedina, 2009). Patients and their families may be deprived of any substantial role in decision-making. This too has generated critical comment within Islamic societies and has led to calls for the adoption of some aspects of biomedical ethics as understood in the West (Sachedina, 2009). In response to these discussions some authors have argued that in the future, it is likely that the value of patient autonomy will be increasingly recognised in Islamic societies (Malek et al., 2018).

2.6.2.5 Research and clinical ethics committees in Islam

Knowledge and research are highly valued in Islam, and Muslim physicians are expected to update their knowledge and skills regularly (Ebrahim et al., 2013). *Allah SWT* says in the *Qur’an*:

O my Lord! Advance me in knowledge (20:114).

Similarly, the Prophet Muhammad says that seeking of knowledge is considered to be an act of ‘*ibadah* (worship) in Islam:

The seeking of knowledge is incumbent upon every male and female (Sunan Ibn Mājah 224).

Judicial opinions (*fatwa*) on issues to confront human health and medical research in Muslim societies are always inherently ethical. It is recognised that detailed consultation involving key stakeholders, including researchers, clinicians, patients, families, and legal representatives, is necessary to ensure a proper alignment of clinical practice with the prevailing religious and social values (Sachedina, 2009).
Despite this acceptance of the importance of detailed, systematic consultation in relation to both the conduct of research and clinical decision making, only limited progress has been made in establishing a formal ethical committee process in many Arab countries. Resources for research overall are limited and there is no mechanism for ensuring the accountability of researchers (Shaharom, 2017). Further, in Malaysia, among the major challenges in clinical research is to ensure adequate research collaborations between researchers and institutions. High level collaboration between Ministries of Higher Education, Health, Science, Technology and Innovations and NGOs are said to be needed to ensure adequate coordination within the research sector (Zabidi-Hussin, 2007).

In the clinic, despite the Islamic tradition of engaging in processes of communal dialogue about contentious issues, there has also been little progress in establishing formal processes to assist when issues of unexpected complexity arise.

2.7 Overview and conclusion

This brief review of some of the similarities and differences between perspectives on ethics in Islam and the West has drawn attention to the relative lack of dialogue between this aspect of the two cultures. Both cultures draw on rich traditions of ethical thinking, and in both, religious themes have played an important role in the development of systems of medicine and healing (Levine, 1993).

Despite the depth and strength of the Muslim tradition, Western approaches to ethics in medicine and health care have developed more rigorously and comprehensively than they have in Islam. They have given rise to multiple statements and codes that carry great influence across the world (Loughlin, 2006). These include guidelines issued by the World Health Organisation, in its definition of the meaning of health as encompassing the full dimensions of physical and mental health and the social settings in which they occur (Habersack and Luschin, 2013), and in its recommendations for improving the safety of patients in health care organizations (World Health Organization, 2013). It includes multiple declarations and guidelines about ethical practices in research
There are many parallels between the ethical approaches of the West and Islam. Komesaroff (2008), discussing contemporary Western perspectives on bioethics, has drawn attention to the recognition of the foundational role of ethics, underlying all aspects of thought and knowledge, and of the key role of processes of dialogue in generating theories of value and principles. He has also highlighted the need to recognise the microethical experiences of patients and their families, in addition to the large-scale contexts of ethical judgments, and the importance of respecting multiple, diverse approaches to theories of, and dialogues about, the role of values in health care settings.

While discussion about ethics in health care has been much less vigorous in Islamic societies it has, of course, not been lacking altogether. In addition to the attempts to adapt and develop the deep traditions of Islamic thought referred to above, there has also been a recognition of the need to address specific problems and inequalities in Islamic societies. For example, attention has been drawn to the importance of poverty in undermining the possibility of achieving ethical outcomes in health care (Laman et al., 2013). In addition, there has been recognition that health care policy in developing countries and poor political structures may limit freedom and negatively affect other ethical values in developing and poor countries (Hussein, 2009).

The Universal Islamic Declaration of Human Rights states in its first article, “Right to Life”: “Human life is sacred and inviolable and every effort shall be made to protect it” (Van Bommel, 1999). Nonetheless, the neglect of Islamic ethical resources to support work toward to an inclusive, universal morality has limited the application of human rights articles promulgated by public commitments (such as the Cairo Declaration of 1994) to protection of fundamental human rights in accordance with the provisions of al-Sharī‘ah (Sachedina, 2009).
The remainder of this thesis will be directed towards developing topics in ethical thought and practice from an Islamic perspective that have been identified in this chapter as representing areas of need.
Section 2
Chapter 3
Aims and research questions

3.1 Introduction

In the introductory chapter it was pointed out that, despite its many strengths, the health care system in Jordan faces significant challenges limiting its development. The challenges discussed there included:

- increasing population and demand on services;
- lack of governmental planning for health services;
- increasing health care costs, especially in the private sector;
- increasing commercialisation of service delivery;
- financial abuse of poorer patients;
- weakness of government control and legal regulation of the private sector;
- migration overseas of qualified health care employees;
- tensions within Jordanian society about the role of Islam and its ability of Islam to resolve problems;
- limited awareness by medical decision-makers and managers of Islamic scholarship;
- lack of education of medical students and health professionals in relation to ethics;
- uncertainty about the role and status of Western positions about ethics;
- lack of written protocols or practical guidelines covering the application of religious and social approaches to clinical dilemmas.

It was pointed out that, in response to these problems, this study was seeking:

- to lay the basis for an enhanced educational resource in relation to the ethical and social challenges facing contemporary Jordanian society;
- to assist with the development of Islamic perspectives for modern health care purposes;
• to identify what is distinctive and essential to health care ethics in an Islamic society and how this differs from the attitudes and thought systems of the West;
• to explore the relevance of guidelines about ethics proclaimed as universally applicable by international organisations and within Western bioethics.

It would seek to achieve these objectives by undertaking;

• a theoretical scan of the resources available from the Islamic tradition for clinical ethics;
• a quantitative study and a qualitative study of the attitudes, beliefs and concerns of health care professionals within Jordan itself.

3.2 Aims of this study

Expressed more formally, this study has the following primary aim:

• To explore the nature and content of ethical decision-making in Jordanian hospitals.

It also has the following specific objectives:

• To review the Western bioethical literature and undertake a critique from an Islamic perspective;
• To identify what is distinctive about Islamic perspectives on ethics in health care;
• To characterise differences between the concepts of consent, confidentiality and privacy between Western ethical perspectives and those of Islam
• To undertake a quantitative study of the attitudes, beliefs and concerns of health care professionals in Jordan;
• To undertake a qualitative study of the attitudes, beliefs and concerns of health care professionals in Jordan.
3.3 Research questions

To proceed towards the achievement of these objectives five research questions have been proposed, arising from gaps in existing knowledge and the predicament of the Jordanian health care system.

These are as follows:

1. What do doctors think about ethical issues in clinical settings in Jordanian hospitals?
2. What ethical issues do clinicians encounter in their practice in Jordanian hospitals?
3. What is the role of religion in clinical decision-making in Jordanian hospitals?
4. What resources shape clinical ethics in Jordan?
5. What are the obstacles and challenges facing doctors with respect to ethical decision-making in Jordanian hospitals?

These context to which these questions refer can be explained in more detail as follows:

1. **What do doctors think about ethical issues in clinical settings in Jordanian hospitals?**

   Like doctors elsewhere, doctors in Jordan have to make medical decisions of a technical nature, to conduct themselves in an ethical manner, and to respond to ethical challenges as they arise.

   Doctors will consider the ethical issues with which they are faced in their clinical encounters. They will also be likely to be concerned about the serious challenges facing the Jordanian health care system broadly, as described above. These challenges will most likely include their relationships with hospital managements and increasing commercial pressures faced by doctors across the country.
2. What ethical issues do clinicians encounter in their practices in Jordanian hospitals?

Many of the ethical issues faced by Jordanian doctors will inevitably be similar to, or overlap with, those that are familiar in the West, such as the issues associated with end of life, consent, confidentiality, privacy, organ donation, abortion, assisted reproduction, distribution of scarce resources etc.

However, the ways in which Jordanian doctors think about these issues will be conditioned by the specific cultural conditions of Jordan and their own personal backgrounds and education. Many doctors have been trained in Western countries and will have been exposed to the ethical views that are accepted there. Most of them also have an Islamic background and will feel bound by the ways in which their religion approaches these issues.

Both in Islam and Jordan more generally, there are assumptions that may deviate from those in the West. For example, in Islamic societies individuals are never considered in isolation from their family and community settings and “paternalistic” approaches to decision-making are commonly accepted.

Jordanian doctors will need to come to terms with these multiple tensions.

3. What is the role of religion in clinical decision-making in Jordanian hospitals?

Jordan is an overwhelmingly Muslim society. Islam is understood as a comprehensive religion that pervades every aspect of life, including the ethical issues that arise in clinical practice.

These means that it is likely that doctors in Jordan will seek to take into account Islamic ideas and perspectives in relation to ethical issues. However, because most of them were trained in the West they will also be familiar with the ethical views expressed there.
In Islam, there are three principle textual resources: the Qur'an, Sunnah and Ijtihad. In relation to any particular issues these are applied in a well-established manner through a process of dialogue about the interests of the various parties.

In relation to many contemporary ethical issues there is no traditional authority. Accordingly, it is necessary to think these through from the beginning, using the sacred texts as a resource. It is natural that for many doctors a starting point in this process will be the philosophical decisions and guidelines that have been so comprehensively developed in the West.

Some Western views are directly in opposition with Islamic ideas, such as those relating to the role of women and the relationships between the sexes.

This work is seeking to establish how the Islamic principles and processes are applied in practice.

4. What practical and theoretical resources are needed to enhance clinical ethics

Jordanian doctors have available to them the entire Western bioethics literature as well as the materials that arise from their own history and culture.

At present, there is little formal education in the ethical aspects of clinical decision-making. It is likely that this will contribute to uncertainty among both students and health professionals about how to respond to the ethical dilemmas they face.

One of the aims of this work is to establish the theoretical resources that can be used to develop educational materials to assist and guide doctors in responding to ethical challenges in a manner they consider to be appropriate to their personal needs and those of their patients and the relevant communities.
5. *What obstacles and challenges face doctors with respect to ethical decision-making in Jordanian hospitals?*

Some of the background to this question has been presented above. The challenges extend from those that arise in the clinical encounter to those inherent in the nature and operation of the health care system itself.

The challenges are likely also to include the tensions and debates within Jordanian society itself, pressures from the West and the global community, the role of different cultural traditions in ethics and the popular culture, the traditional role of religion and the pressures being exerted in it.

Identification of the obstacles and challenges will assist in the development of response strategies to help overcome them.
4.1 Introduction

This project has three parts: a theoretical part and two empirical parts. The theoretical component comprises an analysis of approaches to ethics in Islamic societies and the West. The empirical parts comprise quantitative and qualitative studies of the attitudes of Jordanian health professionals towards ethical issues arising in relation to the health care system and their beliefs and concerns about them.

Detailed information about the methodologies that are applied will be provided in the relevant chapters. Here some comments are offered in relation to the methodological approach of the project as a whole.

4.2 Theoretical study

The theoretical study consists of a review of the nature of ethics from an Islamic point of view and its similarities to and differences from Western bioethics.

No theoretical investigation is neutral or fully objective. Rather, all commence from a point of view that makes assumptions about the nature of the problems to be investigated and the concepts of truth and validity that are to be applied. As has already been explained, this thesis proceeds from a committed Muslim perspective. This means that both the key substantive claims of Islam and the process according to which it undertakes analysis are taken as the starting point for the entire endeavour.

The significance of these assumptions will be made clear as the work proceeds. However, in the theoretical discussion, this means that the author is seeking to undertake an explanation of Islamic ethical thought as well as an appreciation of Western thought from the Islamic perspective. This approach requires that in each
case the problem domain is derived from a combination of literary and religious sources and the personal experience of the author, who is himself a member of Jordanian society.

As will be explained, key features of the Islamic perspective include its commitment to the sacred texts (which are based on metaphysical and ontological beliefs) and to the manner and style of thinking according to which both old and new problems are mapped against the historical writings and authoritative texts. In addition, Islam is a community-based religion, in which all ethical values are linked to family, the local community and the wider national community. Individuals are understood as embedded in relationships with others, and not as isolated, autonomous individuals as is the basic starting point for much ethical thought in Western countries.

There are some strengths and weaknesses to this approach. It is strong, because it is able to address its questions in a manner that retains clarity about the nature of the starting point and the theoretical lens it applies. On the other hand, it is limited, because, as with all theoretical perspectives, it is able to see only what it is able to bring into view. It is acknowledged that a committed religious perspective does not allow the questioning of its most basic assumptions. The author acknowledges this as a condition of the entire work.

Within this framework, the theoretical chapter presents an overview of some of the key themes of ethical thinking in Islam, followed by a description of how Islam responds to certain ethical issues arising in health care and the difficulties it finds itself facing when new issues arise. In these settings Islam turns to other bodies of thought—specifically, in this case to Western bioethics—for assistance in addressing these new issues. Sometimes this is helpful, because there are substantial overlaps between Islamic and Western thought. However, sometimes there are profound differences because of the opposite starting points for the two systems of thought. Examples of both similarities and differences will be presented. The differences will be highlighted by an analysis of the concepts of consent, confidentiality and privacy.
4.3 Empirical studies

This section provides some information about the institutional setting for the empirical investigations, information about the study population and sampling strategy for the two studies, and some further information about data management and logistics.

4.3.1 Institutional context

The empirical studies have focused especially on doctors working in different Jordanian hospitals, stratified in relation to a variety of factors. Health sector bodies in Jordan can be classified as follows:

1. Ministry of Health, which includes the Jordanian Medical Council, the Higher Health Council, hospitals of the Ministry of Health, various health centres and the Jordan Food and Drug Administration
2. Royal medical services (Military Hospitals)
3. Government university hospitals
4. The National Centre for Diabetes, Endocrinology and Genetics
5. Private hospitals
6. United Nations Relief and Works Agency (UNRWA)

The number of hospitals and hospital beds in Jordan are as shown in the Table 4.1.

**Table 4.1: Hospitals in Jordan according to health sector (2015)**

<table>
<thead>
<tr>
<th>Sector</th>
<th>No. of Hospitals</th>
<th>No. of Beds</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOH</td>
<td>31</td>
<td>5029</td>
<td>38.5</td>
</tr>
<tr>
<td>RMS</td>
<td>12</td>
<td>2551</td>
<td>19.5</td>
</tr>
<tr>
<td>JUH</td>
<td>1</td>
<td>599</td>
<td>4.6</td>
</tr>
<tr>
<td>KAH</td>
<td>1</td>
<td>538</td>
<td>4.1</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>59</td>
<td>4350</td>
<td>33.3</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>13067</td>
<td>100.0</td>
</tr>
</tbody>
</table>

(MOH: Ministry of Health; RMS: Royal Medical Services; JUH: Jordan University Hospital; KAH: King Abdullah Hospital)
The total number of doctors working in Jordan in all sectors and different areas and specialisation is 22,000 (MOH, 2017).

4.3.2 Study population
The study population has consisted of doctors and medical students working in multiple settings in four hospitals in Amman. All clinical, academic, research and managerial settings are included. Medical students involvement was limited to those in years 4 to 6 of their courses.

The hospitals have included a large public hospital, a large and highly esteemed academic hospital, an Islamic hospital, and a private hospital with a strong professional reputation in the Arabian health care market. The total population of the four hospitals is 1710 doctors (public 850; academic 500; Islamic 200 and the private 160 doctors).

4.3.3 Logistical issues and recruitment
Once approval was obtained to proceed with the study from the Monash University Ethics Committee (Appendix1) letters were written to senior administrators of Jordanian hospitals by the researcher and his supervisor seeking permission to conduct the studies in their hospitals (Appendices 2). These letters explained the purpose of the research and some details about the proposed questionnaire and interview schedule.

In each case, the ethics approval from Monash University was communicated to the hospital administration which considered the proposed studies and provided their own approval. It is the researcher’s understanding that specific process of further ethical review within Jordan was required or undertaken.

Favourable responses were obtained, which were followed up by approaches to multiple hospital administrators, managers, and heads of departments and clinical services, seeking support and participation.
The researcher then travelled to Jordan and met personally with the relevant hospital managers and decision makers, during which time full details were provided about the studies, including the likely demands on the participants, the nature of the data to be collected and the way in which the data were to be managed.

It was agreed with the hospital managers that the survey (Appendix 3 and 4) would be delivered in a self-administered form so that respondents could complete it by hand. In accordance with the Ethics Committee requirements all were informed that the data were being collected for academic research purposes only and would not be shared with hospital or other officials. Participants were asked to seal their complete surveys in the envelopes and either to hand them to the researcher personally or put them in a collection box that was provided.

Recruitment was then undertaken in each individual hospital by the researcher distributing widely pamphlets and letters about the study in all departments and academic and social settings. Individuals who were interested in participating were encouraged to contact the researcher by phone or email.

In some cases it was considered that it would be difficult for the researcher to approach some potential participants who worked in administrative positions because of the sensitivity of their work. In these cases, additional letters of recommendation were provided by the managers of the hospitals supporting their participation.

Individuals who did agree to participate were asked to support the studies by distributing materials provided to them and encouraging their colleagues also to join. For the qualitative study a purposive approach was adopted to ensure reasonable representation of different specialties, levels of experience and authority, and both genders.

In this manner participants were recruited for both the quantitative and qualitative studies as described in the relevant chapters later in this thesis.
4.3.4 Data management and analysis
All personal data were stored in a secure form. The data from the quantitative studies were transcribed into electronic form with the identities of the respondents expressed in a coded manner. The data and the codes were stored separately in a password-protected manner and the original paper records destroyed.

The data from the semi-structured interviews (Appendix 5) were recorded and then transcribed in Arabic (Appendix 6). The identities of the participants were recorded in a coded form and the codes stored separately from the transcripts and the original recordings then deleted. All data were stored in a secure, password-protected form.

Language issues were handled as described below. Specifically, data analysis was undertaken first in Arabic and then translated into English. The qualitative data were presented in English as a series of extended statements and quotations in relation to the questions asked. Subsequent data analysis, including formation of categories and themes, verification, triangulation and other forms of checking, was carried out in English.

In the presentation of the data particular care was taken to avoid the possibility of identification of individual participants, either through reference to the hospitals in which they worked or to their specialities.

4.3.5 Language issues
The studies were conducted in Arabic and English. The questionnaire and semi-structured interview information statement (Appendix 7) were prepared in the Arabic language, the first language for Jordanian people. However, English is also widely used in hospitals in technical discussions involving clinicians and doctors. As a result, many doctors have a working understanding of English.

The researcher in this study speaks Arabic as his native language, in which he undertakes most of his primary work. He therefore took responsibility for translation of all relevant documents in both directions between the two languages.
This included technical, ethical, religious, social and administrative documents, and resources. After translation, into both English and Arabic, he sought a review of the documents in question by individuals with relevant expertise, in order to obtain independent opinions regarding expression and, where appropriate, content.

Some notes about the preparation of the survey and the interview protocol
The quantitative study examined the attitudes, beliefs and concerns of Islamic doctors through the application of a survey which was been developed specially for the purpose. Details of the nature and content of the survey will be presented in Chapter 6. Here, some remarks will be made about how the survey and interview schedule were constructed and validated.

The questionnaire and interview schedule were developed on the basis of an analysis of the literature and consultation with experts knowledgeable in the field in both Jordan and Australia.

Both the draft survey and the schedule were then submitted to a review and piloting process. This involved seeking comments from experienced researchers trained in Western countries with knowledge and experience about Australia and Jordan. The latter were asked to assess the quality of the study in relation to the content and knowledge, as well as the extent to which it reflected the literature embodied in concepts and theories. Those from whom such opinions were sought included doctors working in Jordanian hospitals (n=48) and fellow PhD students at Monash University (n=5). The feedback at this stage related to readability, understandability and language.

The survey and interview schedule were then subjected to a validation process. Content validity was assessed via the pilot interviews to ensure that the questions accurately represented the characteristics or attitudes they were intended to measure. Construct validity was ensured by the (qualitative) inclusion of reference to an adequate range of ethical concepts and theories. Statistical validity was verified for the quantitative sample population to the extent possible through
a post hoc analysis of the sample population to ensure that it was adequately representative of the study population as a whole (Kumar 1996, Fink 2013).

The reliability of the survey was also assessed. Stability (that is, of the scores achieved on the same test on two different occasions) and internal consistency (that is, the extent to which a test or questionnaire is homogenous) were confirmed. Internal consistency was verified through the calculation of Cronbach’s alpha, which in this case reached 0.83 (Gray 2009, Kumar, 1996).

Note on complementarity of qualitative and quantitative studies (table 4.2)
The inclusion of both quantitative and qualitative studies allowed different aspects of the phenomena under investigation to be assessed. The quantitative study measured the frequency of specific, pre-designated attitudes and beliefs and an assessment of the major issues and concerns among a large sample population. This study was used to assist the refinement of the qualitative schedules by helping define the questions that were to be addressed therein.

The qualitative study allowed a rich and deep analysis of many of the issues that had been raised, directly or indirectly, in the quantitative analysis. The qualitative data made possible detailed exploration of personal attitudes, beliefs and ethical perspectives and the reasons underlying them. Analysis of the quantitative data suggested a number of key tensions that appeared to underly many of the concerns of the participants. These were explored in further depth and detail through the qualitative interviews. It is noted that this complementarity between qualitative and quantitative methodologies can be deployed in multiple ways, and that it is also possible for hypotheses suggested by the qualitative phase of this study to be tested in future, possibly larger and more comprehensive, quantitative surveys.

The different methodological strategies inherent in the quantitative and qualitative approaches enabled these complex and varied outcomes. Key features of these strategies as applied in this project are summarised as follows:
Table 4.2: Procedures in quantitative and qualitative data analysis (based on: Creswell and Plano Clark, 2007)

<table>
<thead>
<tr>
<th>Quantitative procedures</th>
<th>Qualitative procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preparation of data:</strong></td>
<td></td>
</tr>
<tr>
<td>Coding by assigning numeric values, recording or computing</td>
<td>Organising documents, transcribing.</td>
</tr>
<tr>
<td>new variables.</td>
<td></td>
</tr>
<tr>
<td><strong>Exploration of data:</strong></td>
<td></td>
</tr>
<tr>
<td>Visual inspection, descriptive analysis; checking for trends;</td>
<td>Reading and rereading, writing memos, developing codebooks.</td>
</tr>
<tr>
<td>hypothesis testing.</td>
<td></td>
</tr>
<tr>
<td><strong>Data analysis:</strong></td>
<td></td>
</tr>
<tr>
<td>Choosing appropriate quantitative presentation, applying</td>
<td>Coding, assigning labels, grouping codes into themes and</td>
</tr>
<tr>
<td>statistical tests, reporting inferential tests, effect sizes,</td>
<td>categories, comparing themes, developing taxonomies.</td>
</tr>
<tr>
<td>confidence intervals etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Presentation of data:</strong></td>
<td></td>
</tr>
<tr>
<td>Statements, tables, figures and graphs.</td>
<td>Verbal discussion, visual models, figures and tables.</td>
</tr>
<tr>
<td><strong>Data validation:</strong></td>
<td></td>
</tr>
<tr>
<td>External standards, reliability, validity.</td>
<td>Researcher, participant and reviewer standards, validation</td>
</tr>
<tr>
<td></td>
<td>strategies (member checking, triangulation, peer review).</td>
</tr>
</tbody>
</table>

4.4 Ethical issues

The empirical studies were approved by the Monash University Human Research Ethics Committee and by the relevant authorities at Jordanian hospitals and the Ministry of Health. Monash University Human Research Ethics Committee approval for the empirical studies within this project (1603) was obtained on 12th April 2017, valid for five years.

The study was designated “low risk”, meaning that the risk of harms was considered to be low or negligible. Essentially, these risks referred to the possibility of some inconvenience and anxiety associated with questions that might be regarded as personal or intrusive.
The possibility was also considered that some participants could indicate their dissatisfaction with some aspects of the Jordanian health system or of issues that arise within their hospitals. To protect participants against the possibility of adverse consequences from the expression of such opinions the strategies to ensure confidentiality described above were developed and rigorously observed.

The consent process was also managed in accordance with the principles established within the ethics committee system in Australia (as stated in the National Statement regarding research involving human participants, 2017) as well as the principles observed in Jordan. The former emphasised the agreement of the individual health professionals to participate, which was verified by their signing the prescribed consent form (Appendix 8). The latter allowed the possibility of a wider discussion within the hospital or other community identified by the doctors who wished to take into account the views of their colleagues or families. The consent form indicated that participants were permitted to withdraw from the study at any time, although none asked to do so.

The hospital managements required confirmation that no patient data or information would be discussed in a manner that enabled individuals to be identified. Such confirmation was provided and participants were reminded of this obligation prior to undertaking the survey or semi-structured interviews.
Section 3
Chapter 5
Philosophical issues in ethics and Islam

5.1 Introduction

The aim of this chapter is to describe the way in which Islamic culture approaches ethics and bioethical challenges in Islam and Arab countries. The chapter also seeks to explain the differences between Western and Islamic thought in relation to clinical ethics. It concludes by illustrating these ideas with two specific examples: those of consent and confidentiality.

The chapter explains some basic ideas of Islam in relation both to religion and society. As previously indicated, its author starts from a personal position that is committed to the Islamic religion, with the stated intentions of enhancing the mutual understanding between the Arab world and the West, and of improving the ability of doctors working in an Islamic culture, such as that of Jordan, to deliver ethically informed and appropriate services.

It is a premise of the argument and analysis to follow that Islam, which covers a third of the global population, offers a comprehensive way of thinking and acting, caring, and responding to social, cultural and spiritual needs. It does this by drawing on three primary resources: the Qur'an, Sunnah (Prophet Mohammad’s principles, behaviours and creed) and Ijtihad (a dynamic source discussing issues not mentioned in the Qur’an and Sunnah). The flexibility of Islam that emerges from this structure will be heavily stressed, along with its implications for how Islam responds to the new challenges relating to international standards and the pressure of cultural change.

Key values of Islam, such as such as “honour”, “integrity”, “freedom”, “responsibility”, “justice”, “trust” and “openness” to the cultures of others will be discussed, along with an explanation of how Islam responds to novel social and technical issues arising in the modern context. The aim here is to show how Islam operates as a dynamic body of thought rooted in an ancient culture that is seeking
to come to terms with the demands of the communities in flux and evolving global forces.

This chapter discusses how Islam is similar to and different from some ethical approaches in the West. I pay particular attention to the extent to which Islam can absorb or accommodate the norms of the West, especially in relation to clinical issues like abortion, organ donation and transplantation, consent, confidentiality and certain sensitive issues. I am hopeful that in doing this I am able to contribute to the understanding by people in other cultures of the ways in which Islamic people think and, in particular, how religious men or jurists in Islam work with physicians to help solve ethical problems.

5.2 Islam and ethics in medicine

The Islamic religion was established in 610 CE and has become a worldwide religion with 1.3 billion adherents distributed around the world. Of these, 40% are from India, Pakistan, Afghanistan, Indonesia, Malaysia, China, and the Philippines; 30% are from Africa and the Middle East; 3% are from Europe; and 1% are Native Americans (Rady et al. 2009). The world’s population of Muslims will reach 2.5 billion by 2020 (Serour et al. 1995).

The ethical views of Islam are closely linked to those of Jews and Christians. This is because all believe in the same God. For Islam, the primary ethical authorities are the Qur’an and Sunnah (Hadith: the traditions and sayings of the Prophet Muhammed). If any issues that arise cannot be clearly resolved by reference to these texts Muslim scholars refer to the third source, Ijtihad, which presents opinions and analyses of ethics and values following a particular methodology and principles (Rady et al., 2009). This provides an extensive resource that records reflections on and conversations about ethics and other matters stretching back more than a thousand years. Where uncertainty remains, the ancient principles and precepts are adapted and reinterpreted to the extent needed to establish continuity between the existing law and contemporary requirements.
This process of interpretation and reinterpretation is especially important in health care, in which new issues continue to arise, because of new technologies, new patterns of disease and changing social attitudes (Hedayat, 2007). For this reason, Islam is not a rigid religion (Serour et al., 1995), but is highly flexible in relation to the many situations surrounding Muslim communities.

In the past five decades many new issues have been considered in Islamic writings on ethics. These have included the definition of death, animal rights, stem cell research and neural tissue transplantation, as well as cross-cultural clinical ethics and alternative medicine (Al-Umran et al., 2006).

Clinical ethics in Islam is embodied in the adab al-tabib (Physician Ethics) which refers to codes of ethics, and states that “the virtuous physician can improve body and soul” (Padela et al., 2011a). Medical ethics has been developed by physicians, Islamic law experts, religious men and historians who have participated in vigorous reflections on clinical ethics.

Islamic ethics seeks to provide both patients and health professionals with guidelines on what type of therapies and treatment can be applied, as well as offering a method for negotiating clinical and cultural values in both local and global settings. Islam covers all aspects of life: spiritual, material, educational, economic, individual and political (Serour, 1993).

5.3 Law and guidance of ethics in Islam

There is increasing pressure within Islam for responses to bioethical dilemmas. The outcomes sought must be consistent with both Islamic and civil law but also responsive to community needs (Zahedi and Larijani, 2008).

The relationship between religious law and the civil law can be complex (Gatrad and Sheikh, 2001). For example, in the civil law the age of consent for a child is around sixteen years. However, in the Islamic texts, the age of majority and full autonomy occur when the child is physically mature, which is represented by the first nocturnal emission for males and menstruation for females. These
discrepancies have sometimes created uncertainty or tensions. For example, some American Muslim physicians have expressed confusion about end of life and decision-making (Padela and Mohiuddin, 2015), arguing that Islam guidelines are often disregarded.

Whereas in many secular Western countries the main power guiding ethical decision making is the strength of law, for Muslim communities it is considered that the power resides primarily with God’s law (Allah’s guidance).

The majority of health professionals and patients in Islamic countries are Muslims who are very careful not to offend religious principles in the way they provide or receive health care services, even if their decisions may affect their health negatively.

Doctors who have graduated from Western countries—who comprise a large number of physicians in Jordan—also follow the principles of Islam.

5.4 Worship and ethics in Islam

Health and spiritual ethics in Islam are discussed by Al Aqeel (2007), who highlights the fact that Islamic ethics may be derived from both religion and “culture”, or ihsan. This latter refers to ancient, deeply entrenched values of respect and compassion, which can be readily applied in medical or bioethical settings, including in relation to both mental and spiritual issues. It is compulsory for physicians to do the best according to the demands of their faith (Padela et al., 2008). Islamic rulings respect human dignity and the eternity of life, the immortal soul after death and different principles such as humanity and kindness (Zahedi and Larijani, 2008). There is no “gap” between Islam and ethical principles. Muslims believe that pain has the purpose of learning and self-purification which may delete the sins of human behaviours.

There is a strict relationship between the clinical ethics principles of Islam and the situation of Muslims in worship (Zahedi and Larijani, 2008). For example, fasting during holy Ramadan is compulsory, but it may harm pregnant and ill
people. Because the public interest requires that Muslims remain healthy and comfortable, pregnant and sick people are therefore permitted not to fast during Ramadan.

Islam requires Muslims to be empathetic and compassionate with others. Muslims are told “to worship Allah as if you could see him, but if you cannot see him, then learn that he does see you” (Al-Bukhari and Al-Muslim). This is the philosophy of Islam to treat others appropriately in order to produce communities where empathy and mercy are fairly distributed for happiness and peace.

The duty of doctors is to protect their patients’ health and dignity, believing in the eternity of life and that the soul is for God (Allah SWT). If patients feel pain, this is of importance for them and health care professionals because Muslims believe that if they are feeling pain, more rewards will be gained accordingly. This may have major consequences for care, because patients may accept medical treatments that cause great discomfort without complaint. Their spiritual senses may support Muslim patients to endure suffering with patience and strength because they believe that all medical complications and painful interventions or procedures will be added to their balance sheet at the end of their lives as rewards (Hasanat).

There is a strong relationship between religious men and physicians asking about religious issues on clinical consultations through Fatawa. For example, there is a special department in Jordan called “Daerat al iftaa al amm” which is responsible for issuing opinions on Islam and al-Shari`ah relating to different issues in multiple approaches either in daily life or at the end of life.

5.5 Principles of ethics in Islam

As explained above, in Islamic countries, scientists and scholars depend on rules derived from the Holy Qur’an and the opinions of religious men (fatwa) in shaping ethical guidelines and codes. Multiple participants in addition to physicians may contribute to clinical ethical decision-making, including
philosophers, legal experts, sociologists, and others from different specializations (Zahedi and Larijani, 2008).

In the West, the concept of autonomy is often taken to be paramount. In Islam there are several interpretations of autonomy (Hedayat, 2007). In one view, autonomy is limited by an obligation to care for one’s body, which is not regarded as one’s own but as belonging to God. For example, Hedayat (2007) emphasises that Muslims should be responsible in their daily activities and treat their bodies when they are ill; otherwise the sin is on them. Moreover, even though a Muslim can make multiple choices in his life, at the end he or she will be held responsible for all the decisions, because there is a final accounting on the Day of Judgement. In this sense, even in the context of “free choice” obligations and guidelines are always in force (Hedayat, 2007).

In addition to the religious colouring of autonomy, which is always present, the concept of “freedom” is very different between Islam and the West. This is because Islam is a community-based religion and personhood is only understood as a form of engagement and connection with others. Accordingly, no one is ever isolated from others and so cannot be understood as acting alone or in isolation. In such a context, autonomy is not freedom from others or the ability to act outside or contrary to the needs of a group, but exactly the opposite: it is the capacity to act in harmony with the group, to fulfil the mutual values and needs of the community in which one is embedded.

Generally speaking, there are some universal guiding principles of ethics in Islam which, at least on the face of it, appear to be very similar to those that are accepted in the West. These include the imperative to maintain life and protect individual freedom (as described above), and intellect, integrity, property and honour (Gatrad and Sheikh, 2001). It is argued by some (Westra et al., 2009) that both the Qur’an and the Sunnah place the protection of integrity and honour as highly as life.
The concept of “honour” is an ancient one with particular value in Islam which has its roots in tribal relationships. There is no exact equivalent of it in Western thought, although it has some links with the concept of personal “identity”. However, here too, the idea is not a purely individualistic one, because the honour of a person refers not merely to his or her personal sense of value or worth but to the conditions of integrity of the entire family or community of which he is a part.

For these reasons, although there are close links between the aims of medicine in Islamic and Western countries, there are also differences. In the West, the aim of medicine is not to prolong life but to maximize benefits and minimize harms. It is recognised that lifesaving treatment and procedures such as cardiopulmonary resuscitation, mechanical ventilation and nasogastric feeding may delay death but at the same time may hurt patients. In Islam, the view is somewhat different. Medicine aims not to abolish pain altogether or to prevent death at all costs but to achieve reasonable control of pain and to avoid a prolonged death (Zahedi et al., 2007). There is a balance here also. However, it is not the balance itself that is important but the fact that the underlying values, obligations, connections and responsibilities are honoured and protected in the process.

According to Padela and Mohiuddin (2015) relatively little has been written regarding the end of life in Islamic ethics. They argue that clinicians struggle to achieve a balance between their ethical responsibilities and their patients’ concerns and values to reach rational decisions, just as do doctors in the West. Others argue similarly that even if it is readily available it is not always necessary to employ life support in order to prolong life—for example, in the cases of many elderly patients suffering from chronic illnesses (Hassan and Ali, 2018). However, not everyone agrees with this point of view, because in traditional Islam every minute of life is precious and it is always of value to prolong it, even for a short time.

In addition to principles such as autonomy and mutual responsibility, Islamic ethics considers both the microethical dimensions of individual relationships and
interactions and the macro-ethical questions relating to large-scale impacts of
decisions and actions on whole communities (Serour et al, 1995).

5.6 Ethics teaching and curricula
In the clinical curricula in Arab countries, it is noticeable that very abstract issues
are often included. This is especially the case in Middle Eastern countries
(Görgülü and Dinç, 2007). These issues include theories of ethics, principles of
ethics, informed consent, autonomy, life and death and palliative care (Arawi and
Charafeddine , 2018). It is often argued that clinical ethics consultations provide
opportunities for consultants, health professionals and families to share decision-
making and the outcomes of such consultations differ little between Islamic
cultures and Western societies (Zahedi and Larijani, 2008).

Nonetheless, because there are no typical or universally accepted ethical codes in
Islam (Al Aqeel, 2007) there is no public consensus regarding physical, genetic,
social, psychological issues or complex questions relating to consent,
confidentiality, privacy and other sometimes controversial issues. As a result, the
resolution of dilemmas and controversies tends to be dependent on local contexts,
including personal, clinical, family and cultural variables (Zahedi et al., 2007).

It has been argued that there is a need for a more systematic approach in Islamic
societies to both the teaching of ethics and the development of publicly agreed
guidelines and codes (Arawi and Charafeddine , 2018). In accordance with the
precepts of Islamic culture it is widely agreed that the participation of scholars
from both medical and non-medical fields is needed to shape such ethical
guidelines and codes, and to ensure the incorporation of Qur’anic principles and
injunctions (Al Aqeel, 2007). Health care professionals of Islamic faith believe
that the responsibility for taking care of patients has been given to them by God
(Allah SWT) as individuals and as members of their communities. They see this
ethical commitment as a vital part of their belief system.

There is a need in Islamic countries for better and increased educational resources
to allow medical professionals to respond to the diversity of patients from
different cultures and religions (Padela et al., 2008). This is particularly the case because of the increased need for recognition of this issue in comparison with the conditions existing in Islam in earlier times (Guessous, 2017).

5.7 **Ethical challenges in Islam**

There are many ethical challenges facing health-care professionals in Islamic communities. These include disagreements between patients and health care providers about treatment decisions, waiting lists, health care resources for the aged and mentally ill, the shortage of family physicians as well as medical errors and medical technology (Zahedi et al., 2007). Other challenges include: withholding and withdrawing life-sustaining treatment, achieving consent, conducting clinical research and decision making, non-resuscitation, brain death, and end-of-life issues (Chamsi-Pasha and Albar, 2017c).

While, as argued above, there are major overlaps between Islam and the ethical principles widely applied in Western countries, there are also differences. These relate to philosophical assumptions, the role of religion, the understanding of the relationship between individuals and their communities, and the processes for addressing ethical dilemmas (Zahedi et al., 2007). It is fundamental to Islam that it acts as a balance between people and their communities, between personal interests, those of the local community and international norms (Hedayat, 2007). For the development of Islam-specific codes, therefore, international guidelines, including those relating to “human rights”, should be interrogated to ensure they are compatible with Islamic law.

Muslims believe that real healing and treatment is from God (Allah SWT), and the doctor acts only according to the will of Allah SWT (Westra et al, 2009). As the Qur’an states: “If Allah touches you with affliction, none can remove it but Him.” (6:17). They believe that the soul belongs to God (Zahedi et al., 2007) and it cannot be taken by human beings. The Qur’an Kareem says that "anyone who has killed a fellow human except in lieu of murder or mischief on earth, it would be as he slew the whole mankind" (Holy Qur’an 5:32). The Qur’an also states: “It is
not given to any soul to die, save by the leave of God, at an appointed time” (Holy Qur’an 3:145).

Some ethical issues in Islam

End of life issues in Islam should be considered within Islamic philosophy and anthropology (Ilkilic, 2015). In other words, decision-making at the end of life should consider the real meaning of life and death and not only the quality of life.

Euthanasia which is defined generally as the deliberate killing of a person for his/her benefit, raises moral and religious questions such as: Is it ever justified for another person to end the life of a terminally ill patient who is in severe pain or enduring other suffering? (Aramesh and Shadi, 2007, P.35).

While end of life decision-making in non-Islamic countries is culturally framed by law and public policy (Zahedi et al, 2007), belief systems in the West often lead to the conclusion that although there is no obligation to postpone death some technologies may be used to attempt to do so. Euthanasia can be effected at the request of the terminally ill or purportedly in their interests by medical practitioners. However, euthanasia remains a controversial issue because of its proponents’ claim that it is an “act of mercy”, despite its morally troublesome effect of ending a human life. (Ebrahim, 2007).

Monotheistic religions frequently view euthanasia as crimes, just like murders. They believe that human life is a gift from God, which no human being should dispose of. Islam is not just a religion in the contemporary understanding, but rather a way of life that encompasses all aspects of life and secures guidance and light for all mankind. Bioethical decision making is carried out within a framework of values derived from three sources of sacred law (Yousuf and Fauzi, 2012).

One of the most important factors that determines society's attitude towards death is religion. As there are various sects and tariqas (manner, creeds) in Islam that cause significant differences, it is important to understand the Islamic approach to death (Nikookar and Sooteh, 2014).
The argument is not merely academic; thousands die every year for want of organ transplants in the Islamic world, in part because of resistance to defining brain death as death (Brockopp, 2008). Despite this, Islamic law permits the withdrawal of useless treatment of whatever kind from mortally ill patients, leaving death to take its natural course (Chamsi-Pasha and Albar, 2017a).

Nonetheless, Islamic jurisprudence, based on interpretation of the holy Qura’n, does not in general recognize a person’s right to die voluntarily. According to Islamic teachings, life is a divine trust and cannot be terminated by any form of active or passive voluntary intervention (Aramesh and Shadi, 2007). In Islam, doctors are not permitted to assist patients to die and patients are not also permitted to request a voluntary death, because in both cases this would be considered suicide (Zahedi et al, 2007). Moreover, doctors cannot withdraw life-sustaining treatment unless they are certain about the unavoidability of death (Zahedi et al, 2007):

The Prophet said, "Avoid the seven great destructive sins." They (the people!) asked, "O Allah's Apostle! What are they?" He said, "To join partners in worship with Allah; to practice sorcery; to kill the life which Allah has forbidden except for a just cause (according to Islamic law); to eat up usury (Riba), to eat up the property of an orphan; to give one's back to the enemy and fleeing from the battle-field at the time of fighting and to accuse chaste women who never even think of anything touching chastity and are good believers." (Sahih al-Bukhari 6857).

The silence in the Qur’an regarding suicide due to intolerable pain and a firm opposition to suicide in the hadith literature led to a strong opinion among Muslims that neither repentance nor the suffering of the person can remove the sin of suicide or mercy ‘killing’ (al-qatl al-rahim), even if these acts are committed with the purpose of relieving suffering and pain (Isgandarova, 2015). At the same time, in the Judaic and Christian traditions suicide is strongly forbidden, as a result of which from these perspectives if may be considered that physicians who assist patients to kill themselves commit a serious crime (Zahedi et al, 2007). In
particular, those of the Catholic faith believe that life is for God and they are only stewards, not owners, emphasizing that illness, pain, and death have positive meanings (Zahedi et al, 2007).

Today, criticisms of physicians' attitudes are common. Sometimes these criticisms are unfair (Nikookar and Sooteh, 2014). However, people who commit suicide are ‘labeled’ for losing faith in the afterlife without a chance to repent for their act (Isgandarova, 2015).

Brain death is also a contentious issue in Islam. Over recent years, in many countries, including both Western and non-Western, it has become accepted that death is caused by cessation of functions of the brain (heart beating) or the circulation (non-heart beating) (Rady et al., 2009). The Uniform Determination of Death Act (UDDA) in the USA states that a person can be considered dead when either the heart and lungs or the brain and brain-stem stop functioning permanently (Zahedi et al, 2007).

It can be clarified that the Quran does define death as biologic disintegration and clearly distinguishes it from the dying process, so brain death belongs scientifically within the spectrum of neurologic disorders of consciousness and should not be confused with cardiac death. Further, religious and legal discord about brain death has grown in jurisdictions worldwide (Rady and Verheijde, 2016).

Brain death has been acknowledged as representing “true death” by many Muslim scholars and medical organizations, including the Islamic Fiqh Academies of the Organization of the Islamic Conference and the Muslim World League, the Islamic Medical Association of North America, and other faith-based medical organizations as well as legal rulings by multiple Islamic nations. However, consensus in the Muslim world is not unanimous, and a sizable minority accepts death by cardiopulmonary criteria only (Miller et al, 2014).

These issues remain controversial in Islam as well as some other religions,
especially as they apply to the donation of organs for transplantation (Rady et al., 2009). It can be asserted that brain death is not absolute death according to Islamic sources, for in the patients diagnosed with brain death the soul still has not abandoned the body. Therefore, these patients suffer in every operation performed on them (Bedir and Aksoy, 2011).

Many Islamic councils exercise influence over Muslim clinicians and patients who encounter the challenges of brain death at the bedside, clarifying gaps in their assessments and helping overcome clinically ambiguity (Padela et al., 2013).

The nature of communication may be very important. For example, among Islamic thinkers, cancer may be seen as a reminder of the fragility and sacredness of life, as a result of which patients with this condition themselves acquire a degree of holiness, as a result of which they require more specific attention to informed consent, truth telling, confidentiality, and ethical decision-making (Zahedi et al., 2007). Patients with cancer need special arrangements such as end of life counselling and spiritual matters and resolving some life conflicts and financial affairs (Zahedi et al., 2007). Telling cancer patients and their families about the process of dying requires highly-developed communication skills and explanations. Moreover, there are some common features of death in physical, cultural and religious terms, such as pain management, avoiding a prolonged dying process, preparation for death, a sense of control, spirituality and emotions, and appropriate communication involving patients, their families and physicians. Special training and communication may be needed for doctors and clinicians to be able cope with such difficult situations.

Abortion and reproductive issues are also important in Islamic ethics. A key authority from the Qur’an to which Islamic scholars refer in relation to reproductive issues (Gatrad and Sheikh, 2001) is as follows:

and certainly did we create man from an extract of clay. Then we placed him as a sperm-drop in a firm lodging. Then we made the sperm-drop into a clinging clot, and we made the clot into a lump (of flesh), and we made
(from) the lump, bones, and we covered the bones with flesh; then we
developed him into another creation. So blessed is Allah, the best of
creators (Qur’an Kareem, 23:12-14).

Although a majority of Muslims worldwide agree with the stance taken at the
population conference, and most would state that Islam forbids abortion, the Muslim
theological position on abortion does not approximate the Roman Catholic
condemnation of the practice. A full prohibition of abortion represents neither the
sophisticated Muslim jurisprudence literature on abortion nor current practices of
some Muslim women (Bowen, 1997). Nonetheless, Islam has a strict position against
medically-assisted conception because childbirth is seen as fundamentally involving
family commitments and not only as a biological function (Serour et al. 1995).

In accordance with this perspective, in terms of reproduction, the choice would be not
only that of the patient but also of her partner, family and society (Serour et al, 1995).
A key question that is raised here is that of the nature of autonomy because
reproductive interventions not only affect multiple individuals but also reflect on the
underlying belief system (Hedayat, 2007). The embryo’s life is not only for the woman
herself but also for the father and the remainder of the community (Hedayat, 2007). Nonetheless, there are various settings in which abortion is considered to be ethically
acceptable, such as during chemotherapy (Daar and Al Khitamy, 2001), or where the
pregnancy is dangerous for the mother’s health (Gatrad and Sheikh, 2001). In these
cases, according to Islamic scholars, the ova can be preserved and frozen for in vitro
fertilization in the future to be combined with her husbands’ sperm.

Religious fatāwa have been issued allowing abortions in certain circumstances. An
understanding of variations in Muslim beliefs and practices, and the interplay between
politics, religion, history and reproductive rights, is key to understanding abortion in
different Muslim societies (Hessini, 2007).

There is a consensus that “ensoulment” occurs at four months, when the spirit causes
the emergence of potentiality for rational thought. This stage marks a significant
change in the status of the fetus, and abortion after this stage is prohibited except in
extreme circumstances when the mother's life is threatened (Hussain, 2005).
Some scholars authors urge Muslim law makers to also consider abortion post ensoulment if it is certain that the malformed fetus will die soon after birth or will be severely malformed and physically and mentally incapacitated to avoid substantial hardship that may continue for years for mothers and family members. (Al-Matary and Ali, 2014).

Islam's guidelines for jurisprudence and the prioritization of preventing harm over gaining a benefit are important in its position on abortion. In Islam, abortion is not permitted except in limited circumstances where its certain benefit to the mother outweighs the harm of ending the fetus's life or potential life (Alamri, 2011).

Organ donation is broadly favoured in Islam (Rady et al., 2009). The shortage of donations of organs for transplantation has been accompanied by encouragement by religious men, physicians, and jurists to increase donation rates within their communities (Chaim and Duguet, 2018). Cultural, social and ethical issues are all taken into consideration. Here, there is a lack of religious authority, with no reference to organ donation in Qur’an and Sunnah. Transplantation of organs in Islam was discussed in 1981 as the “Islamic code of ethics” dealing with modern technologies such as transplantation and reproductive biomedical issues. It was agreed that because life is sacred and saving, organ donation may be regarded as a duty (Daar and Al Khitamy, 2001), although others have recommended flexibility free from ultimate theological opinions (Paris et al., 2018; Daar and Al Khitamy (2001); Padela and Duivenbode (2018).

A review of the positions of the major faith groups about organ donation shows that the large majority of faiths take a positive stance toward it. Factors such as emotional responses, cultural values, and spiritual issues may be even more compelling for family members than religious beliefs. (Gillman, 1999). Religious scholars through the help of transplant physicians and surgeons can also be of immense help in this regard (Ilyas et al, 2009).

Clinicians may not have an understanding of the cultural and religious perspectives of Muslim families of critically ill patients who may be approached about brain death and
organ donation (Arbour et al. 2012). Among Muslim scholars and researchers, there are those who agree that there is legal support for its permissibility while others see it as illegal. Organ/tissues transplantation is considered a medical intervention that touches on the fundamental rights of the donor or the recipient (Bakari et al. 2012).

In a country with low literacy rate mass education at all levels can only increase the awareness about bioethical issues to formulate a "considered opinion" in enforcing the laws related to organ transplantation (Ilyas et al, 2009).

Muslim jurists have allowed different forms of bone graft (autograft, allograft and xenograft) for seriously broken bones. Ibn Sina in 1037 discussed this subject in Al-Kanoon 1000 years ago. In 1959, the Muftis of Egypt and Tunisia allowed, under specific conditions, corneal transplants from dead persons. Thereafter, many fatwas on organ transplantation have been issued from different parts of the Muslim world. In Amman, Jordan, the International Islamic Jurist Council recognized brain-death as a recognized sign of death in Islam in October 1986. This paved the way for organ transplantation from brain-dead persons, which started immediately in Saudi Arabia. In 1990 and 2003, the International Islamic Fiqh Academy (IIFA) and the Islamic Fiqh Academy (IFA) issued important fatwas on organ transplantation. By the end of 2008, more than 3600 organs had been transplanted from brain-dead persons in Saudi Arabia (Albar, 2012).

In vitro fertilisation. The Prophet Muhammad provided the foundation for a medical tradition that related to human beings in their totality; the spiritual, the psychological, and the physical were considered within the context of the social milieu. The Prophet described marriage as being half of religion, so in Islam children are considered a great and blessed gift of Allah. Despite the high prevalence of male infertility, infertility is usually considered the woman’s problem. Thus, the role of male infertility is vastly under-appreciated in Middle Eastern societies. Medical intervention is in keeping with the Islamic tradition; there are no religious objections in Islamic codes of ethics to an infertile couple pursuing medical treatment for infertility (Abu-Rabia, 2013).

Seeking a cure for infertility is not only permissible, but also encouraged in Islam. In Islamic law, all assisted reproductive technologies are allowed, provided that the
source of the sperm, ovum, and uterus is a legally married couple during the span of their marriage. No third party should intrude upon the marital functions of sex and procreation (Al-Bar and Chamsi-Pasha, 2015).

Examination of both the legal framework and the surrounding rhetoric highlights how the tensions between Islam and secularism unfold in this particular field, and traces how the rise of neo-conservatism and the expansion of the role of religious organizations and discourses have led to the promotion and development of assisted reproduction, but only within strictly enforced conjugal confines (Gürtin, 2016).

The understanding of how religion requires interpretation in order to respond to contemporary challenges and emphasize the interrelationship between various local and global considerations at the nexus of medicine, commerce, law, and family-making in shaping assisted reproduction practice (Gürtin et al., 2015).

As early as 1980, authoritative fatwas issued from Egypt’s famed Al-Azhar University suggested that IVF and similar technologies are permissible as long as they do not involve any form of third-party donation of sperm, eggs, embryos, or uteruses (Inhorn, 2006).

Gender is also a key issue in Islamic clinical ethics. This will be discussed in further detail below, where the link with the concept of honour will be explained. It is difficult for female doctors to touch males during physical assessment, or even to shake hands with male patients and colleagues (Padela et al., 2008). Similarly, male medical students are often rejected by female patients due to their religion and culture forbidding them from being exposed to them, particularly in gynaecological and obstetric examinations and when attending medical consultations or taking previous histories (McLean et al., 2010).

This sensitivity within Islamic medicine (Padela 2007) to gender issues may be contrasted with the physician’s obligation to provide health care and healing for sensitive areas of patients’ bodies such as the genitalia. Dilemmas also arise when female patients refuse to use bed pans and prefer to use the toilet instead for cleanliness reasons before prayers (Padela, 2007). Some physicians, patients or
religious authorities may consider that male physicians should not be allowed to assess the bodies of female Muslims by doing rectal examinations. Islam and physical examination is also discussed by McLean et al. (2010), who state that in Middle Eastern countries male doctors should be accompanied by female nurses during physical examinations of female patients. They also state that female Muslims should be clothed over the whole body from head to toe according to the Islamic religion and Arabian norms and cultures.

As male circumcision is included in some religions such as Islam, Judaism and for some Christians in Egypt, the religious demands are close to the culture and traditions in Islamic countries. Alahmad (2017) points out that the law of Islam serves not only Arab countries but all Islamic countries sharing the same social setting and religion.

The examples just quoted indicate that there are many common ethical dilemmas between Muslim and Western countries in health care. However, it should be clear that there are some clear views that prevail in Islam that may not be universally shared in the West. The key principles for Muslims are that all human life is sacred and it is not permitted for clinicians or non-clinicians to terminate it; that human souls belong to Allah SWT who is the only one who can decide to terminate the life of a patient; and that Muslims have patience regarding the death of their children because they believe they will be settled in Paradise as birds and angels. Also, nothing is mentioned in the Qur’an and Sunnah about organ donation and transplantation, and to date no specific codes and guidelines exist that could be easily adopted in relation to these matters. Muslims accept modern trends and technologies, even where religious authorities and precedents are lacking.

5.8 Decision-making processes in Islam

For the most part, decisions in Islam are made in the context of conversations and dialogues that take into account all aspects of life, including social, cultural, mental, financial, psychological and ethical, and the pre-existing body of cultural, religious and spiritual wisdom.

In fact, the processes according to which decisions are taken is a key determinant of ethical validity. As previously described, Islam is a community-based religion and
ethical judgments must reflect the embeddedness of individuals in the lives and interests of others. In addition, all aspects of physical and spiritual life are understood to be encompassed by the values and precepts of religious faith. The specific details of the faith, however, are themselves highly complex, reflecting a fluid balance between the three main textual sources of the Qur’an, the Sunnah and the Ijtihad, which provide a comprehensive record of the wisdom of the ages. The actual application of these cultural, ethical and theological resources is put into effect through careful deliberation involving multiple social participants, which include religious scholars, professionals and community members.

This process provides the mechanism by which Islam strikes a balance between the contending issues and forces that influence decision-making in everyday life and ensures a degree of both continuity and flexibility in relation to ethical judgments. The flexibility is not absolute, because strong limits are established in relation to issues such as the sacredness of human life. Nonetheless, it does provide a mechanism by which Islamic practices can be adjusted in relation to novel treatments, technologies and social and political attitudes.

Because the nature of process is so fundamental to ethical decision-making in Islam it is useful to set out in details some of the steps required if an ethical decision is to be considered as valid within the culture (the following is adapted from Padela et al. (2011a):

1. The first step is to assess the facts, including the attitudes of people from different perspectives, including beliefs of people from other cultures.

2. The main issues to be decided then need to be defined and clarified. This step is undertaken under the guidance of religious scholars and those with other relevant knowledge.

3. A decision is then made to distinguish between halal and haram, that is permissibility according to Islam. Additional questions are then examined, relating to the particular contextual issues of the case at hand, including the personal views and preferences of the patient and his or her family.
4. The relevance of community, cultural issues and traditions is then examined.

5. Some initial discussions are undertaken involving expert scholars who propose provisional solutions.

6. Practical issues and possible responses are then compared with theoretical aspects in conversation with participants from different backgrounds and expertise.

7. An initial proposal is established, which includes an opinion about the relevant values and outstanding, unresolved issues.

8. A reconciliation process is pursued in which differences are negotiated among the various parties.

The above steps outline the process that defines the formation of a valid ethical decision-making process in an Islamic context. The decisions involve the participation of experts and scholars who come from different approaches, including knowledge of the Islamic religion in particular. Doctors do not often make decisions without religious consultations. Participation from the patient’s community and hospital management is often also included. The process involves detailed and extensive dialogue. The outcome is accepted by all parties as having validity and ethical force on the basis that the process that generated it is widely accepted as just and fair.

5.9 Muslim doctors and the international community

The World Health Organisation and other international organisations such as the World Medical Organisation have created guidelines for ethical conduct in various clinical settings (Zahedi and Larijani, 2008). Islam and Muslims have often been under-represented in the processes by which these guidelines have been developed (Padela et al., 2008), as well as in the global medical literature regarding clinical ethics in general. It has been argued that this reflects a view
among many Muslim physicians that Islamic values and beliefs are sufficiently articulated within their culture and provide adequate guidance for their practical decision-making.

Is there a conflict between Islamic understandings of clinical ethics and those of the West? As we have argued, the three major world faiths have many similarities regarding the practice of clinical ethics, although there are differences on some important issues (Clarfield et al., 2003).

In Islam, ethical decision-making in the clinical context must consider the patient’s background, religion and culture, the physician’s opinion, the law of the country and the participation of the family, in addition to Islamic moral theology and law (Padela, 2017). Communication processes must be refined to meet the demands of the various participants, following the steps outlined above (Westra et al., 2009). Where scientific issues or facts are concerned there is generally little controversy (Zahedi and Larijani, 2008).

For the most part, this means that the outcomes regarding specific ethical questions will be similar in Islamic countries and Western ones (Padela et al., 2008). Muslims consider that they are created with full freedom, autonomy and the right to self-determination and are committed to protecting these values and just and fair outcomes in all contexts, including the most controversial ones, such as genetic research, organ transplantation and end of life care (Gatrad and Sheikh, 2001).

There are, however, significant areas of difference, as described above. These mainly relate to the firm commitment of Islam to the concept of the sacredness of life and respect for gender differences. This leads to specific conclusions about assisted dying, abortion, assisted reproduction, and the management of women’s issues in which Islamic ethics may depart from views commonly accepted in Western countries. There are also differences that emerge in relation to the fundamental concepts of autonomy, consent, confidentiality and privacy, as will be discussed in the following chapter.
5.10 Summary of the argument so far

Ethics in Islam is not seen as part of a civil law but as something that comes from God through His messengers. Islam is a comprehensive religion which considers people as a whole. The main power guiding human beings in Western countries is the strength of secular law while in Muslim communities it is God’s law. However, Islam is dynamic in dealing with Muslim affairs to obtain solutions to secure satisfying situations for Muslims. For example, Islam allows flexibility for health care professionals, enabling a balance between international standards and their patients’ needs.

There is harmony between Islam and ethics. Islam requires Muslims to have empathy with and compassion for others. This is called ihsan: “to worship Allah SWT as if you could see him, but if you cannot see him, then learn that he does see you” (Al-Bukhari and Al-Muslim).

Muslims believe that if they feel pain, more rewards will be gained, and this may enable the medical procedures and treatments to be implemented without many complaints. Islam is a religion of mercy and compassion. Ethical considerations are a vital part of worship because the ignorance of health is considered to be a sin, which means that the responsibilities of clinical ethics are social and religious. Islamic instructions require Muslims to develop Muslim awareness by adopting openness to the cultures of others and clinical curricula discussing all behavioural and technical issues in medicine.

The termination of life of patients is totally rejected in Islam, even if technological methods or international developed guidelines are applied. Muslims have different thinking in relation to pain and health complications and this may help clinicians to prepare their families in critical care and palliative situations. Regarding organ donation and transplantation, nothing is mentioned in the Qur’an or Sunnah and there are no specific codes and guidelines in Islamic clinical culture. Physical examinations of females and wearing the hijab require caution and most Islamic countries have special areas for female patients with female resident doctors.

In the remainder of this chapter consent and confidentiality are discussed in detail
in order to compare the ways in which these concepts are viewed in Islam with how they are understood from Western perspectives.

5.11 Consent

Consent is an essential aspect of all harmonious systems of relationships, according to which individuals agree to accept the distribution of functions and duties among them in their personal and public activities. This section will examine some similarities and differences between Islam and the West in the concepts of consent they apply in health care settings.

5.11.1 Consent in the West

Consent in the West is understood primarily as a mechanism for ensuring respect for a patient’s autonomy and personal dignity (Ramahi and Silverman, 2009). It is often approached in a formal manner. When a “consent” agreement is reached among people, whether it is personal or public, the parties involved often prefer to have it documented in writing or in some other manner. This is to clarify exactly which details are agreed by all parties.

There are various “definitions” of consent, but a representative one is:

An authorization initiated by a patient for an intended data requester via an agreement between them (Jin et al., 2016).

A more comprehensive formulation is:

…in regard to a patient’s treatment [consent] is a legal, and ethical, issue of autonomy. At the heart of informed consent is respecting a person’s autonomy to make personal choices based on the appropriate appraisal of information about the actual or potential circumstances of a situation (Rich, 2013).

“Consent” may also be understood to refer to a written document from a health professional to confirm that full details have been provided, including details about the possibility of negative outcomes, before proceeding with a clinical
intervention (Del Pozo and Fins, 2008). Moreover, while consent may originate as a process to achieve agreement on a shared course of action in health care it can also be used to identify fault and enforce duty (Schuck, 1994).

It is accepted that any consent process must be transacted by using accurate and well written language in both written and oral communication, in order to ensure honesty and understanding. Written language standards are often stipulated to meet the needs of people with low levels of literacy (Paasche-Orlow et al., 2003).

The World Medical Association (WMA) Declaration of Lisbon on the rights of the patient states further:

> Information should be given in a way appropriate to the patient’s culture and in such a way that the patient can understand… The patient has the right not to be informed on his/her explicit request, unless required for the protection of another person’s life (Hammami et al., 2007).

For doctors who strongly believe in consent and shared decision-making, it is easy to understand the complicated dynamics of clinical care and patient satisfaction (Whitney et al, 2004). From this perspective, a properly conducted consent process enables patients to make appropriate decisions and also reinforces doctors’ relationships with their patients and families, which may support good medical care (Appelbaum and Grisso, 1988).

Consent is associated with the concepts of “patient-centred care”, “patient empowerment” and “evidence-based patient choice” (Whitney et al., 2004). From these perspectives the aim of gaining consent is to give patients information about the process of health care and the medical intervention (Whitney et al., 2004) to enable them to make their own decisions, hopefully gaining their agreement to proceed. An additional purpose is to create better understanding of the proposed treatment, taking into account patients’ personal values and religious beliefs (Whitney et al., 2004).

As indicated, Western consent processes place particular emphasis on consent forms.
It is widely acknowledged that, despite the rhetoric, the majority of these are designed to protect the physicians rather than the patients and are sometimes difficult to read by patients due to the nature of the stressful environment and the quantity of information provided (Cassileth et al., 1980). It is therefore required that an element of consent involves an assessment by doctors of patients' capacity before engaging them in relation to their decisions and preferences (Appelbaum and Grisso, 1998). An outcome of this is that very young patients, and those who are unconscious, mentally ill or merely confused are considered unable to be included in consent processes, are not provided with consent forms and can be treated independently of their stated wishes within the paternalistic style (O'Neil, 2003).

It is also required that sufficient information is included in consent forms to enable patients and families to make appropriate decisions. Therefore, “transparency” and “adequacy” of information are necessary for decisions (Truog, 2008). At the same time, consent forms should give patients sufficient information to enable them to refuse or withhold consent (O'Neil, 2003).

Consent is a relatively recent concept that is the result of a process of historical development. In the 1950s the concept of consent was examined critically by scholars in ethics and law, legislators, physicians, philosophers and sociologists (O'Neil, 2003). Around this time, the norms of health care were changed to reject the pre-existing view that “doctors know best”. This meant that patients were required to be fully informed of the benefits and risks of treatment and the nature of the health care being offered to them in order to enable them to make their own decisions (Appelbaum and Grisso, 1988). It was also recognised that different factors played significant roles in obtaining consent, such as education, medical status and the nature of health care services (Cassileth et al., 1980). In other words, it was now recognised that legal, ethical and clinical issues were all involved in the nature, use and interpretation of consent forms (Appelbaum and Grisso, 1988).

Vulnerable groups, such as those suffering poverty and illness, present special issues, because they may have insufficient ability to protect themselves (Ramahi and Silverman, 2009). Therefore particular care may be needed to
ensure that they are protected, or at least free of some effects relating to their political, personal, religious or financial circumstances. (Barnett, 1986). In these cases, the achievement of valid consent may require additional forms of social action.

A key aspect of consent is to ensure that patients and their families are neither deceived nor coerced (O’Neill, 2003). In specific settings particular arrangements may be needed to make sure this is the case: for example, in relation to the donation of organs the consent process should be separated from the clinical treatment of the donor or the grief reactions of those providing the consent (Truog, 2008).

In all these cases, consent is not just a moment of the clinical encounter. It refers to a formal, comprehensive system of law, culture and ethics, from which it cannot be separated (Barnett, 1986). Therefore, in the West, consent is a legal and ethical concept that is the outcome of multiple historical, legal and cultural influences (Hammami et al, 2007).

5.11.2 Consent in Islam and the Arab world

Islam provides guidance for Muslims in all aspects of their lives (Binghalib, 2011). Moral perspectives within it seek to ensure the ideal life for humankind. *Allah SWT* says in his holy *Qur’an*: "And indeed, you are of a great moral character" (*Qur’an* 68:4). Islam is the main religion in Arab and Middle Eastern countries and it influences people’s decisions traditions and customs (Alahmad et al, 2015). Twenty two Arab countries are closely aligned with Islam in culture and language, with 90% of their populations being Muslim (Dardas and Simmons, 2015). Civil law in Arab countries seeks to achieve harmony with Islamic law (Alahmad et al., 2015). Although Muslims come from different countries and cultures, they share a single common set of beliefs (Binghalib, 2011).

Islam has a particular focus on the concept of consent as a key feature of all daily life. *Allah SWT* says in the *Qur’an*: "Those who fulfil the covenant of *Allah* do not break the contract" (*Qur’an* 13:20). Consent to medical procedures is part of Islamic law because Islam ensures that Muslims are totally protected with respect
to their blood, property and honour (Del Pozo and Fins, 2008). Some Islamic countries consider that if medical procedures do not follow Islamic instructions and regulations there can be no confidence that consent has been achieved (Jafarey and Farooqui, 2005).

The diversity of religion, culture, beliefs, values and practices presents a complicated challenge for health care systems and heightens the need for consent processes (Nabolsi and Carson, 2011). It is recognised that it is the responsibility of physicians to involve patients in treatment decisions (Jafarey and Farooqui, 2005). Consent promotes better pain tolerance, protects patients from risks, builds trust and increases satisfaction (Hammami et al., 2007).

Despite this clear acceptance of the primacy of consent in Islamic culture there is a relatively limited literature about the nature, process and consequences of consent. Few Muslim scholars have conducted significant debates or made contributions to bioethics to represent the needs of Islamic bioethics in both international and Islamic countries (Sachedina, 2009). If the jurisprudence is not clear in Islamic countries, Muslim scholars prefer to follow fatwa, which are non-binding religious edicts to provide guidance (Hessini, 2007).

This lack of a formal literature has generated uncertainty and confusion. The injunction to follow Islamic legal processes has sometimes been interpreted to mean that consent forms are mandatory. As a result, some clinicians may inappropriately pressure fathers or mothers or husbands or wives to sign on behalf of their patients (Alahmad et al., 2015).

In addition, families often try not to tell their patients about the nature of their diseases in attempts to avoid scaring them. In these cases, doctors face conflicts between telling the truth by upholding patients’ rights to know or shielding their patients from bad news (Jafarey and Farooqui, 2005).

An additional complication is that health professionals are sometimes confused about the relative status of Islamic and Western norms. Many doctors undergo their formative education in Islamic countries, to the ethical and belief systems of
which they are therefore committed. They then undergo training in the West, where they are exposed to a different set of norms and values. The confusion is often reflected deep within the society, with differences being expressed at multiple levels, in interactions between doctors and patients, patients and families and health professionals and hospital administrators.

Despite these difficulties, a rigorous and satisfactory concept of consent, however, is readily available in Islamic thought and culture. This arises from the concept of the individual which it assumes as being embedded in society and inseparable from his or her links with community and other people. In Islam, individual persons are not understood to be isolated, self-governing agents who make their decisions independently of, and in opposition to, other people (Shah et al., 2008). Indeed, the individual is defined by his or her connections with others, understood as the basic mutual responsibility that defines what it is to be human (Jafarey and Farooqui, 2005).

Islam provides a comprehensive metaphysical and ontological context within which individuals emerge, exist and interact with each other. Their interactions are regulated and guided by their belief system and, especially, the complex array of texts, together with their historical interpretations. This elaborate set of resources provides a framework within which a large proportion of daily interactions and conversations take place. They control and regulate relationships between men and women, parents and children, ordinary community members and health professionals and their patients.

From this perspective, consent in Islamic societies has clear similarities to, and differences from, the way in which the concept is used in the West. On the one hand, as in the West, consent plays a key role in ensuring harmonious agreement in multiple settings so that people can work or act together or take difficult decisions in health care. On the other, the nature of the conversation is not that of one isolated individual with another in relation to a set of abstract, historically-conditioned norms or conditions. It is a dynamic engagement between communities, in a closely-textured, rigorously structured framework of rules, obligations and values.
This means that while consent in Islamic societies may have a similar fundamental significance to that in the West, it follows a quite different dynamic and leads to quite different consequences. The consent “process” often entails a complex conversation involving patients, doctors, family members, other community members and religious scholars. The outcome may be a form of consensus that represents a compromise, often guided by authority figures, that finds a way of taking into account the multiple interests that are represented and the requirements of Islamic law.

“Obtaining consent” in Islamic settings requires great experience and thought by doctors. They have to decide how to discuss the options with their patients and families. They may need to involve religious or other scholars. They have to balance the personal needs of the patient with the communal interests and the honour of the family. In the contemporary setting they also have to balance the community-based assumptions of their culture and the historical requirements of their faith with the Western conventions and systems of norms presented to them in their education and from the international community.

Consent in Islam is complex. There is no doubt that some regard it as too difficult or out of date. As a result, some hospital administrators, and some medical professionals, prefer to adopt ready packages or checklists (Jafarey and Farooqui, 2005). This often leads not to genuine consent but to an undermining of genuine processes of conversation and agreement.

Regardless of these difficulties and tensions, consent is an integral part of medical practice which is primarily ethical rather than legal or bureaucratic. The debates about it, and how it continues to evolve, will undoubtedly continue (Hammami et al., 2007).

5.12 Confidentiality

The ethical domains of health care settings (Hall et al., 2002) include “faithfulness”, which refers to caring and advocating for the patient’s interests; “competence” in both professional and personal skills; “honesty”, or telling the
truth; and “confidentiality”, or using sensitive information properly. The elements are brought together and unified in practical contexts by mutually shared, global trust.

Drawing on this schema, in this section some similarities and differences between the concepts of confidentiality in Islam and the West will be discussed.

5.12.1 Confidentiality in the West

The Western concept of confidentiality in health care settings refers to:

the legally protected right afforded to (and duty required of) specifically designated health care professionals not to disclose information discerned or communicated during consultation with a patient (Miller et al., 2003).

Patient understanding of confidentiality is based on the health providers’ explanations and the style of their communication, and depends not only on how information is handled but also on what patients believe and understand about how it is handled (Jenkins et al., 2005).

Although they are linked, there is a difference between confidentiality and “trust” in health care. Patients expect technical competence in their doctors, availability, and ease of access (Lings et al., 2003). Moreover, in health care there are some different mechanisms to support trust, including specifying health care services of good quality and standards and monitoring the provision of services as well as carrying the responsibility for the health of the population (Miller et al., 2003). Trust in a physician is enhanced if the latter is sensitive to patient concerns in terms of clinical information and adequacy, and adopts an appropriate communication style (Berrios et al., 2006).

If a patient does not trust the physician, it is difficult for the patient to express his/her real concerns and the doctor cannot provide an accurate diagnosis (Tavaokkoli et al., 2015). In this vein, trust between a physician and a patient is the key to patient satisfaction and continuity with the physician (Bonds et al.,
Also, there are different features of trust, including competence, compassion, privacy and confidentiality, reliability, dependability and communication (Bonds et al., 2004).

Confidentiality arises out of this context of trust to guarantee the safe limits within which the medical interaction can be conducted. The key idea is that what a patient says to a doctor, what is “confided”, is not communicated to other people without the consent of the patient. The function of confidentiality is to isolate the relationship from the remainder of society, to privilege it and protect it from the influences of family, community, civil society and maybe even religious and legal constraints.

Conceived from this individualistically-focused conception of personhood and relationships, the Western notion of confidentiality encounters some fundamental limits. Because individuals live in societies from which they cannot be so rigorously separated it is clear that confidentiality cannot be applied or upheld in an absolute manner.

It is recognised that breaches of confidentiality occur, both legitimately and inappropriately. These include accessing electronic registries, transporting patients’ information through the internet and email, accessing telemedicine records by both medical personnel and other hospital staff (Tavaokkoli et al., 2015). They may include decisions that are made to protect other individuals, or the patients themselves. Breaches may be required for legal reasons. Information may be shared without patients’ permission in the course of medical research.

Breaches of confidentiality may be ethically and legally required in some cases, such as reporting communicable diseases (Tavaokkoli et al., 2015), reporting births or deaths, testifying in court, disclosing a patient’s participation in committing a crime, revealing a secret for self-protection, and protecting others. Physicians sometimes need to consider the option of warning patients by providing information to the police or different bodies such as colleagues and authorities (Elger, 2009a).
More informally, physicians sometimes talk to family members and friends about cases of patients without sufficient precautions and the same may occur while talking in public places (Elger, 2009a). Patients may accept that their health professionals will discuss their cases with colleagues in the interest of their care (Lucassen and Parker, 2004).

Confidentiality is often regarded in the West as a basic concept of medical ethics (Noroozi et al., 2017). Indeed, it is referred to by some as “the cornerstone of medical ethics”, which is central to the idea of professionalism and must be placed centrally in all curricula (Elger, 2009b). However, it is not absolute or without limits (Tavaokkoli et al., 2015) because despite the emphasis on autonomy and freedom individuals can never be completely separated from their enmeshed relationships with others. For this reason, confidentiality in the West should be seen more as a philosophical and cultural aspiration that encounters its limits in the real world rather than as a fundamental, unbreakable ethical obligation.

5.12.2 Confidentiality in Islam and Arab world
Confidentiality is also a fundamental concept in Islamic thought. However, as may be seen to follow from the discussion of consent above, it departs from a starting point that is almost opposite to that of the Western one. Rather than starting from the assumption that individuals are separate from society and need to be protected from it—which is in essence the Western perspective—confidentiality in Islam starts from the embeddedness of all persons in society and seeks to establish a domain in which they can be recognised and acknowledged as individuals.

As in the West, the basic underlying value is that of trust. Trust is mentioned in the Qur’an as follows: “And they who are to their trusts and their promises attentive” (Qur’an 23:8). Also, Prophet Mohammad (PBUH) states that “if someone keeps his Muslim brother’s secret Allah (God) will keep his secrets in this world and in the afterlife” (Riyad as Salihin, The book of miscellany, Hadith 244). The Messenger of Allah (PBUH) said: “The Muslim is the one from whose
tongue and hand the people are safe, and the believer is the one people trust with their lives and wealth.” (Sunan al-Nasâ’î 4998).

Prophet Mohammad (PBUH) also said: “When the trust is lost, then wait for the Hour.” It was said, “O Messenger of Allah, how will it be lost?” The Prophet said, “When authority is given to those who do not deserve it, then wait for the Hour.” (Sahih Bukhari: 6131). The Messenger of Allah, peace and blessings be upon him, said, “The one is who is consulted is in a position of trust.” (Sunan At-Tirmidhi 2822). The Messenger of Allah (PBUH) said “The signs of a hypocrite are three even if he fasts and prays and claims to be a Muslim: when he speaks he lies, when he gives a promise he breaks it, and when he is trusted he is treacherous” (Sahih Bukhari 33, Sahih Muslim 59).

In other words, in Islam, trust is regarded as fundamental to relationships among people. It determines the nature of their interactions and shapes the style of their communication with each other. In clinical settings, this means that doctors must pay careful attention to the nature of their communication with their patients. Allah says: “And speak to him with gentle speech that perhaps he may be reminded or fear [Allah]” (Qur’an Kareem 20: 44), and “O you who have believed, fear Allah and speak words of appropriate justice” (Qur’an Kareem 33: 70). In general, it is accepted broadly that the requirement of trust mean that disclosure of others’ secrets is a sin and will attract punishment hereafter (Tavakoli et al., 2015).

However, as in the West, attempts to draw the boundaries between individuals and the communities in which they are embedded come up against limits. In the Islamic context these limits arise from the assumption that an individual person cannot be conceived and has no status independently of his or her community and the broader context of the faith. In Western terms, this would be described as “paternalism” but in Islam it refers to a value on an equal footing with individual freedom (Nair and Ibrahim, 2015).
There are many examples from Arab culture relevant to health care confidentiality that illustrate this tension. For example, female sexuality cannot easily be discussed in the Arab world for reasons fundamental to the entire ontological framework, as will be discussed below. This undoubtedly presents obstacles to female sexual health and research (Anis et al., 2011). Moreover, for Arab Muslims, seeking mental health services is considered to be a sensitive issue according to cultural and traditional beliefs (Pasic et al., 2010). Undoubtedly, very few people from the Arab world can access mental health services owing to societal stigma (Shah et al., 2008). Similarly, “shame” and “honour” are highly emphasized in the Arab community and a bad action by one family member affects not only the individual, but also the family unit as a whole (Shah et al., 2008)—not just in terms of unfavourable consequences but by threatening the entire structure that gives the lives of all involved stability and meaning. For these reasons too, traditional norms disapprove of homosexual relations, and drug or alcohol use (Hammad et al., 1999).

Gender roles also provide structure and form. In Islam, the man is considered the head of the family and leadership should be his responsibility in relation to financial provision for the family and other duties (Dhami and Sheikh, 2000). Some important distinctions should be made here. Gender roles are not identical to gender differences. While the latter are ontological and fundamental, the former are linked to local, “tribal” traditions and may allow for greater fluidity. For this reason, increasing women’s social interactions is not excluded in Islamic societies, and should be pursued to clarify and where appropriate change roles and rights, in the interests of improving gender equity (Alyaemni et al., 2013). In addition, there is no implication that the different ways in which men and women are regarded in Islam means that women are inferior in the eyes of their faith. On the contrary, whereas in Christianity the relationship between men and women is conceived in relation to the concept of sin, in Islam all people, men and women, are considered equal in their individual relationships with God.

In Islam, there are many limitations of confidentiality that are similar to those described above in relation to the Western concept. If patients threaten others’
lives, such as an epileptic patient working as a driver or someone with HIV engaging in sexual activity, then the physician’s duty is to inform the official departments (Chamsi-Pasha and Albar, 2016). Further, at the International Islamic *fiqh* Academy in 1993, jurists agreed that breaches of confidentiality are acceptable only if the harm of maintaining confidentiality overrides its benefits in order to prevent public damage (Chamsi-Pasha and Albar, 2016).

Therefore, confidentiality is a strong pillar of the physician-patient relationship, and there may be serious harm to the patients’ trust, and the ongoing viability of the relationships, if it is damaged (Asemani and Ebrahimi, 2014). In this approach, ethicists and practitioners within health care settings must deal with the complexity of interactions between culture, religion, local morality and legislation to match the lens of global bioethics (Serour, 2015).

As in the case of consent, despite the extensive resources available within the Islamic and Arab traditions, the principles underlying Islam’s approach to confidentiality in health care remain insufficiently understood by many clinicians (Mustafa, 2014). For this reason teaching the art of physician-patient relationships has not yet been developed in clinical schools (Chamsi-Pasha and Albar, 2016). That means challenges remain in relation to the understanding of the issues involved and the complexity of the demands thereby presented, which require an appreciation of the clinical circumstances, the patients’ religious and cultural beliefs, the wider community and social conditions and the religious requirements, all of which have to be negotiated through sensitive, finely tuned patient-provider communication (Hasnain et al., 2011).

### 5.13 Privacy

There are several concepts of privacy in both the Arab world and the West, derived from different sources, including legal, religious, social and traditional. This section will present an interpretation of similarities and differences between the ways in which privacy is commonly regarded in the two settings.
5.13.1 Privacy in the West

Privacy is difficult to define because different factors may be included in this concept, such as moral, legal, and social ones (Moore, 2014). It may be helpful to distinguish two main kinds of privacy: “psychological” privacy and “information” privacy (Moore, 2014). Psychological privacy compromises six dimensions, such as reserve, isolation, solitude, intimacy with friends and family, and anonymity. By contrast, information privacy refers to control of information, making sure that the collecting and dissemination of the information is dealt with properly (Moore, 2014). Health data normally comprise “categorical data” (e.g. diagnosis codes, procedure codes, drugs dispensed, laboratory tests ordered, and geographical information about the patient and the provider), as well as “numeric data” (e.g. age in years, length of stay in hospital, and time since last visit) (El Emam and Dankar, 2013, p.55).

Privacy in the clinical setting may be defined as follows:

[Privacy refers to] the patient’s rights and expectations that personal health information is shared only between professionals who need it to manage the patient… [It includes] the physical space, clothing and other measures taken to ensure that the private conversations remain so, and that patients’ dignity is preserved, and embarrassment minimised by providing appropriate clothing (Miller, 2003).

Although the focus of most ethical debates and regulatory frameworks is on the control of personal information, in practice, as in this definition, the idea extends further to encompass issues relating to personal privacy, especially in relation to the exposure of private body parts (Yue et al., 2016). In relation to all senses of privacy frequent breaches have been widely discussed. Medical personnel are known to discuss patients in public from time to time (Yue et al., 2016) and accounts of health professionals disregarding patient modesty are also well recorded (Tavaokkoli et al., 2015)
Privacy is considered by some to play an important role in patient–physician relationships and to contribute a range of clinical benefits, including facilitating correct diagnosis and treatment, and avoiding adverse drug interactions (Appari and Johnson, 2010), although other authors consider it less fundamental than confidentiality (Gostin 1997).

“Respect for privacy” in most cases assumes that patients should be able to share information freely with their physicians and other confidants in relation to sensitive issues of both a medical and a personal kind (El Emam and Dankar, 2013). This often requires high level communication skills on the parts of doctors, which are not always forthcoming (Street et al., 2003). In this context, the collection of health care information should reflect a balance between the societal interest in collecting and sharing data and individual interests in keeping personal information about them secret (Gostin, 1997).

Many institutions establish as a condition of admission their ability to access private information without the patient’s explicit authorization. It is also a common, although not universal, policy that patients should have access to their records (Annas, 2003). In some jurisdictions such access is established as a legal right.

In general, the access of health care professionals to private information about a patient is considered to be appropriately limited to the purposes of treatment (Beech, 2007). Often this principle is established and controlled by law. Legal frameworks may stipulate precisely how personal information may be collected and how it should be managed, organized, respected, stored properly and, in some cases, disclosed for important purposes considered to be in the public interest (Gostin 1997).

The restrictive nature of the concept of privacy has often been criticised, with some authors arguing for a shift in the focus of regulatory policies from ownership and control of the information itself to the sensitivity, nature, uses and public applications of information (Grande et al., 2015).
While the need for privacy has been widely assumed in the contemporary bioethics literature there has been relatively little analysis of its philosophical origins and the way in which it should be distinguished from confidentiality. In fact, the two concepts represent quite separate philosophical lineages and relate to different value frameworks. This is of importance because in Islamic thought the concepts of privacy and confidentiality are also separate and signify different pathways of cultural evolution, although in a manner that is different from that which exists in the West (Komesaroff, 2005).

As discussed above, philosophically, the concept of confidentiality relates to relationships of trust between individuals. This is the case in both the West and in Islam. The legal structures around confidentiality identify and protect particular categories of relationship society considers to be of value. Ethically, the limits to confidentiality refer to the boundaries between the personal lives of individuals and the more public spaces they inhabit. This too is common between Islam and the West, although—as has been emphasised—the ways in which the nature of the “individual” and his or her relationship to society differ radically.

In the West, the philosophical origins of privacy arise with the concept of the individual as an autonomous agent who not only stands fundamentally in opposition to society but whose ontological substance arises from his or her ability to own property. Privacy is a manifestation of the “possessive individualism” that provided the conditions for the emergence of capitalist society (Macpherson and Cunningham, 1962), whose philosophical roots can be traced back to Descartes, Locke and similar thinkers (Macpherson and Cunningham, 1962). In this sense, “privacy” strictly refers to the ownership of data or information relating to an individual person. Its individualistic focus is distinguished from the relationship-based focus of confidentiality. For this reason, the legal regulatory frameworks are closer to property laws than they are to those that seeks to guide the conduct of individuals engaging with each other.
In other words, privacy in the West provides an ethical and legal construction according to which the value-creating activity of an individual is linked to concepts of private property and socially current ideas such as possessive individualism. They stand alongside the older concepts and structures associated with confidentiality but represent and perpetuate a quite separate intellectual tradition (Moore, 2014 and Gostin, 1997).

5.13.2 Privacy in Islam and Arab world
As in Western thought, privacy in Islam is a basic concept. As in Western thought it is distinguished from confidentiality, which applies to some overlapping phenomena. However, the distinctions and the origins are quite different between Islam and the West. In some ways, this difference between the two bodies of thought most vividly characterises the underlying theoretical gap that separates them.

Privacy is discussed in the Qur’an. Allah SWT says:

O you who have believed, do not enter houses other than your own houses until you ascertain welcome and greet their inhabitants. That is best for you; perhaps you will be reminded (Qur’an 24:27).

In Islam the law protects and secures the right of each person to that which is rightly his (or hers), not merely in the sense of ownership of property but also in the sense of what defines his or her identify and set of values. Here, it is true that “information” should be protected unless the owner gives his permission to disclose (Lubis and Kartiwi, 2013). However, the loss of control of that information is not experienced as a violation of personal property but as an attack on a more fundamental concept of what constitutes, forms and sustains the individual.

Indeed, privacy relates primarily not to the domain of the individual but to that of the family or community group. What is put at risk by an infringement of privacy is not the legal right to own property (as in the West) but the values that constitute
the identity of the community or family. This is what is described as “honour” in Arabic societies.

Honour is a tribal rather than a purely Islamic concept. It arises from the multipolar domains of social relationships, authority and values that stand alongside the unitary focus of monotheism. Honour coexists with the values and authority relationships of Islam to allow diverse community structures to come into existence and flourish. It contributes to the establishment of those elements of personal and cultural identity that go beyond the over-arching features of Islamic thought and cultural practice. It is personal, but not identified with private property, as in the West.

Privacy in Islam refers to the recognition of the realm of honour in Islamic societies. As such, its origins are completely separate from those of confidentiality. Accordingly, it does not refer to “trust” but to personal identity. What is more, it refers not merely to a theoretical idea or a postulated value but to an ontological status. Accordingly, if there is a breakdown of privacy this may have implications of much more profound significance than a breach in formal legal provisions may suggest (as in the West). Rather, such a lapse can challenge the basic philosophical and ethical framework within which individual selfhood is defined.

In Arab cultures, therefore, privacy plays a powerful role that overlaps with Islamic thought but also extends beyond it. In this sense it occupies a position of balance between religious and cultural ideas. It provides a link between the domain of the family and the public spaces of religion, politics and civil society (Memarian and Sadoughi, 2011). It also helps regulate personal relationships between outsiders and neighbours, between male and female and between family members and relatives (Othman et al., 2015).

This expanded concept of privacy beyond the domain of information or data has yet further implications. Specifically, its application to meanings attached to bodies and bodily experiences is also taken seriously. For example, many Muslim women resist prenatal genetic screening tests that are standard in Western
countries because they see them as threatening their cultural and religious values (Matin and LeBaron, 2004) by intruding into their bodily integrity. Muslim patients who enter the clinical area also experience feelings of vulnerability related to the possibility of physical intrusion (Kopec and Han, 2008).

The protection of privacy (in this “Arab sense”) can present challenges in clinical settings. This sometimes reflects a lack of sensitivity of health care professionals, who may make it difficult for women to express their concerns (Matin and LeBaron, 2004). There may also be practical obstacles to ensuring the conditions for adequate respect for privacy. The most important elements for securing privacy for women in health care include: seclusion of women; segregation between men and women; the existence of spaces to segregate private lives from public intercourse; the wearing of the hijab; and the architectural features needed to permit these elements to be realised (Razali and Talibb, 2013). The “intimate parts” (awrah) of both women and men have special significance and need to be considered in health care contexts. For men, this refers to the area from the navel to the knee and for women to the entire body except the face and hands (Othman et al., 2015).

Issues relating to respect for privacy may arise in more subtle aspects of the interaction between health care professionals and Muslim patients. For example, eye contact with female patients should be avoided if they are being examined by male doctors. Also, male doctors may have to communicate with the spouses of female patients. Health care professionals of the same sex are preferred for physician examinations; otherwise a third party chaperone should be present to provide comfort to the patient (Attum and Shamoon, 2018).

5.14 Comparison of the concepts of consent, confidentiality and privacy between the West and the Arab world

In the West, the concepts of consent, confidentiality and privacy all proceed from the basic conception of the human person as an autonomous agent, not only separated from other persons but inherently in opposition to them. Consent is understood as a mechanism to guarantee freedom by endowing individual patients with decision-making power. Confidentiality refers to the privileging of particular
relationships that are therefore isolated or protected from interactions external to them. Privacy relates to the basic conditions of possessive individualism, according to which a person’s identity arises in relation to his or her ability to own property, in this case, property in their bodies and the information associated with them.

As clear as these concepts may appear, they are not without complexities, controversies and challenges. By its nature consent raises the question of the level of individual capacity to provide the agreement or authorisation that is sought, thereby excluding large numbers of people. In addition, its one-sided nature inherently presents the risk of imposing the very relationship of power it sets out to avoid. Confidentiality is limited by the fact that it is in practice impossible to quarantine relationships from others in society, as a result of which the boundaries of these relationships always have to be negotiated. Privacy is complicated by the very assumption that gives rise to it, because health care inherently involves the entry of an individual into the public space and the sharing of information about bodies and bodily experiences.

In the Arab world all three concepts depart from a quite different conception of the person, as someone embedded in a community, acquiring identity from membership of a family and value from the wider context of culture and religion. Religion comprises not just the principles of faith but the record of the interpretations according to which intricate problems of ethics and human relationships have been analysed and resolved over the ages. It therefore relates to the wholeness of life in all aspects.

In this setting consent in Islam is understood as a much extended conversation, which, explicitly or implicitly, includes the patient, the health professionals, the community, religious scholars and others whose contributions might be relevant. Consent is not the simple agreement of an individual to a medical treatment but a mapping of a problem against the entire social and religious landscape. Confidentiality refers to the component of trust in a relationship and is less linked to the exclusivity that is central to the Western concept. Privacy reflects the
mechanisms for establishing a sense of identity or belonging arising from tribal forms of social organisation and being understood as constituting honour.

In Islam, as in the West, these concepts present difficulties and uncertainties. Consent depends on high level communication skills and an ability to cross disciplinary boundaries. Confidentiality encounters the same limits between the private and public spaces that arise in the West. In addition, the structures of gender relationships set out the complexity of these boundaries. Privacy requires elaborate physical conditions and rituals which may be experienced as inconvenient or old fashioned in the modern world.

Additional complications arise in Arab countries owing to failing education systems, confusion about the values of Islam in relation to those propagated by international codes of ethics, and differences generated by internal tensions.

The religion of Islam provides an entire system of beliefs and meanings about life, relationships and ethics. It allows no real space for individualistic considerations or for the ultimate autonomy valued in the West.

5.15 Summary of chapter
Islam draws on the Qur’an and Sunnah as primary resources in addition to Ijtihad, which presents the opinions and analyses of some morals and values. Medical ethics was developed from these sources by physicians, Islamic law experts, religious men and historians. There is a strict relationship between the principles of ethics and those of Islam and worship. In Islamic countries, scientists and scholars follow rules derived from the Holy Qur’an, Sunnah and the opinions of religious men (fatwa) in shaping ethical guidelines and codes. Islam has its own set of principles in terms of jurisprudence, the purposes of Islamic law and Islamic legal maxims which can be applied in novel contexts.

Major ethical challenges facing health care relate to disagreements between patients and health care professionals about treatment decisions. Other challenges include withholding and withdrawing life-sustaining treatment, consent, privacy,
confidentiality, organ donation and transplantation. Despite its rich history and extensive resources, much more training on how to cope with ethical issues is needed in Islamic countries.

Regarding confidentiality, privacy and consent, differences arise between the emphasis in Islam on the community and Western assumptions of individualism. These also lead to major differences between the ways in which freedom, autonomy, paternalism, gender differences and religious considerations are understood.
Section 4
Chapter 6
The struggle for clinical ethics in Jordanian hospitals

ABSTRACT

Background. The Arab and Islamic world is in cultural, political and ethical flux. Pressures of globalisation contend with ancient ideas and concepts that permeate cultural frameworks. Health professionals are among the many groups battling to accommodate the rapidly changing conditions. In many predominantly Muslim countries intense debates are underway among clinicians about the impact of the forces of change on their practices.

Objective. To explore the nature and content of ethical decision making in Jordanian hospitals.

Participants and setting. Doctors working in four Jordanian hospitals (public, academic, Islamic and private) in a variety of medical specialities.

Methods. We conducted a study of the experiences of clinicians in the Hashemite Kingdom of Jordan, a Middle Eastern nation state where the overwhelming majority of the population is Muslim. The study included both a quantitative survey, covering a wide range of issues, and qualitative, free-text written responses.

Results. The sample contained 508 doctors and doctors-in-training, of whom 63% were male and 80% were younger than 40 years of age. Our results demonstrated high levels of disquiet related to the overall organisation and administration of the health care system, the specific content of ethical decision-making, and the impact of changing social, cultural and religious factors. Concerns included overcrowding, widespread corruption and hierarchical, non-democratic,

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management practices, the changing roles of traditional and modern ways of understanding approaches to ethics, especially in relation to consent, organ donation, confidentiality, privacy, abortion, and the role of women. The role of religion and religious authorities, the relative importance of the family, community or tribal obligations were also areas of contention.

**Conclusions.** The study exposes profound divisions and widely differing perspectives among Jordanian doctors and an abiding sense of uncertainty and instability within the profession. Many doctors express ambivalence in relation to both modern trends and traditional precepts. Three main axes of ethical contention were demonstrated, relating to the tensions between: “conservative” and “pragmatic” styles of decision-making; “traditional” approaches and internationalised standards of ethics; and the role of Islam and pressures to disengage ethical decision-making from religious authority.

We speculate that these issues and divisions, and the deep sense of disquiet, revealed by our data, reflect large-scale forces to which Jordanian society is exposed, and to a substantial degree may provide a way to understand the ethical predicament of many other countries in the contemporary Arab world.
6.1 Introduction and background
For Muslims around the world, the path of religion involves an attempt to fulfil the word of God (Allah SWT) to ensure that human affairs are conducted in a peaceful, ethically guided manner. Despite the emphasis on “peace”, which is the etymological origin of the word “Islam”, in recent times, tragically, the religion has been discredited by a tiny minority of violent extremists who brutally kill both Muslims and non-Muslims for personal and political motives. The causes of this distortion are complex but reflect in part the multiple, rapidly changing pressures that are presently sweeping the Muslim world.

There is a clear need for those both inside and outside Islamic faith communities to understand the nature of these pressures in order to contribute to a peaceful resolution to current conflicts, consistent with the basic precepts of all the major religions. The current project seeks to contribute, however modestly, to this task.

Among the many areas in which the contending forces are being negotiated is that of health care where, like everyone else, health professionals are battling to accommodate rapidly changing social, cultural and economic conditions. In many predominantly Muslim countries intense debates are underway among clinicians about the impact of the forces of change on their practices, in some cases generating significant personal stress and uncertainty. An analysis of these struggles can provide a lens to illuminate the internal tensions being experienced more broadly within Arabic and other Islamic societies. The fact that in the clinical domain the tensions are negotiated largely through mutually respectful ethical discourse may offer a model of broad applicability.

This study seeks to contribute to the understanding of the tensions within Islamic societies by investigating the experiences of clinicians in the Hashemite Kingdom of Jordan, a Middle Eastern nation state where the overwhelming majority of the population is Muslim. Its focus is on the nature and content of ethical decision making in Jordanian hospitals and the concerns, tensions and challenges clinicians encounter in the course of their work. We employ a broad understanding of “clinical ethics” as referring to the field of values and value-related decision-
making within a health care setting, in order to accommodate the great variety of approaches to, and perspectives on, ethics, spiritual perspectives, codes of conduct, and attitudes towards personal and interpersonal responsibility.

Some brief background comments on Jordan and Islamic ethics may help orient Western readers. Situated between Israel, Palestine, Syria, Iraq and Saudi Arabia, Jordan has a population of about 10 million (Department of Statistics DOS, 2017 and 2018). A former British colony with continuing close cultural and political links to both the East and the West, its government is a constitutional monarchy in which the King has wide legislative and executive powers. Although the population is overwhelmingly Muslim, the country prides itself on its tolerance of diverse cultural, religious and political perspectives (Hashemite Royal Court). Jordan has a highly developed health system, in which a majority of senior doctors as decision makers and managers have studied in a Western country. It has 104 hospitals and about 22,000 doctors, giving a ratio of 22.2 doctors/10,000 people (MoH, 2015). Jordanian clinicians seek to balance the needs of individual patients, the demands of their cultural tradition, the views of Islamic jurists (Ulama fiqh), and international standards of science and ethics. In this manner, they epitomise the challenges and dilemmas faced in many settings across the Arab world (Siddiqui, 1997).

In Islamic culture, reflections on ethics have a long tradition and multiple sources, with contributions from a great many esteemed philosophical and theological commentators. Many of the great Arab philosophers were also physicians, and were deeply affected by, and contributed to, Western approaches to ethics. The first formal statement of clinical ethics was written by Ishaq ibn ’Ali al-Ruhawi (died 931 CE), in the adab al-tabib (Conduct of a Physician), which departed from the premise that “the virtuous physician can improve body and soul” (Padela et al., 2011a). Great Islamic thinkers on ethics have also included Al Tazi (Razi d 925), Al-Majusi (d 994), Ibn Sina (also known as Avicenna, d 1037 CE), al-Ghazali (d 1111), and Ibn Rush’d (also known as Averroes, d 1198) (Abul Qasem, 1975).
In law and ethics, Islam draws on three main resources (Gatrad and Sheikh, 2001): (i) the Qur'an Kareem, the Muslims’ holy book, which is regarded by believers as the direct word of Allah SWT; (ii) the Sunnah, understood to represent the words and deeds of the Prophet Mohammad(PBUH); and (iii) Ijtihad, an interpretative body of dynamic law that provides responses to challenges and concerns arising in daily life. From these are derived principles and rules (Sachedina, 2009) that provide guidance about what is necessary (wajib), prohibited (haram), permitted (mubah), recommended (mustahabb) and reprehensible (makruh). Together, the various components constitute the fiqh, which provides "insight" or guidance with a focus primarily on processes and duties rather than on presupposed outcomes or consequences (Brockopp and Eich, 2008).

The formulation just described is that accepted by the overwhelming majority of the Jordanian population, about 95% of whom are Sunni Muslims. It is acknowledged that other intellectual traditions of Islam—such as those of Shi‘ism, Ahmadism and Sufism—also occur, albeit in very small numbers, as also do Christian, Druze and other religious groups [US Dept of State, 2017]. Despite this decisive preponderance of the Sunni approach to Islam, and therefore broad agreement about the basic conceptual structure of the faith, considerable tensions have developed about how to respond to a range of challenges the country is widely perceived to face. Some of these gained vivid expression elsewhere in the region during the so-called “Arab Spring”. They include, among other issues, the impact of globalisation in both the economic and cultural domains and internal pressures for social and political change [Brynen et al., 2012; Ogbonnaya, 2013; El Hassane, 2012].

The present study, which is part of a larger investigation into the sources of contemporary Islamic clinical ethics, seeks to elucidate responses to contemporary concerns and challenges in the context of the rich and complex history of Islamic thought.
6.2 Methods

A quantitative survey, complemented by qualitative, free-text written responses, was undertaken to assess the awareness of health care professionals in Jordan, and their attitudes, beliefs and concerns about, a range of issues relating to ethical issues, described below, arising in their professional lives. The study population comprised doctors working in four major hospitals in the capital city, Amman, including a large public hospital, a large and highly esteemed academic hospital, an Islamic hospital, and a private hospital with a strong professional reputation in the Arabian health care market. Doctors were invited to participate through brochures, emails and face to face contact. All participants gave full written consent.

The questionnaire, which was provided in both Arabic and English, was developed on the basis of an analysis of the literature and extensive consultation with experts knowledgeable in the field, in both Jordan and Australia. It included a demographic section and thirty specific statements with associated questions, as well as an invitation to provide open, free-text reflections on any of the matters raised.

The questions were grouped under four headings: The first, *How doctors think about ethical issues in clinical settings in Jordanian hospitals*, made specific reference to doctors’ awareness and understanding of, and attitudes towards, the theory and practice of clinical ethics. The second, *Ethical issues clinicians encounter in their practices*, posed detailed questions about consent, communication, justice, harm, trust, confidentiality and privacy. The third, *The role of religion in clinical decision making*, covered the resources of Islam, abortion, organ transplantation, wearing *hijab*, examination of female patients, and concepts of death. The fourth, *The practical and theoretical resources needed to enhance ethical decision making*, drew attention especially to the roles of different institutions and commissions in Jordanian society, global authorities, ethics committee and codes, protocols and guidelines. An additional section, *Challenges facing doctors with respect to ethical decision making*, took the form
of an invitation to participants to respond freely with a broad reflection on the major issues facing ethics and clinical practice in their country.

The questionnaires were introduced personally by the first author to each of the participants and responses were transcribed and translated into English. The quantitative data were compiled and analysed descriptively in terms of numbers and percentages, with reference as far as possible to variations among defined subgroups. Descriptive statistics were presented and hypothesis testing was not undertaken; however the data were subjected to logistic analysis to clarify the effects on doctors’ attitudes of specific demographic variables, kind of hospital, area of specialisation, religion and nationality.

The qualitative data were analysed using rigorous qualitative analysis techniques to develop broad analytical categories of concepts and ideas, test the categories recursively against the primary data, and then provide an explanation of why the categories occurred. The analysis was conducted by hand, reading and re-reading, developing codes and themes, and discussing transcripts between the investigators.

The study was approved by the Monash University Human Research Ethics Committee and by the relevant authorities at each of the participating institutions.

6.3 Results
6.3.1 Demographic characteristics of participants (Table 6.1)
The sample consisted of 508 people, of whom 63% were male and 80% were younger than 40 years of age, drawn from a total population of 1,710 doctors or doctors in training in the four hospitals, representing a response rate of 30%. The vast majority (86%) were involved in clinical practice and identified as of Islamic faith (94%). 28% had post-graduate degrees and 11% were of non-Jordanian nationality. Just under one quarter (22%) of the sample were students.

The medical specialities represented included internal medicine (19%), surgery (11%), paediatrics (2%), dentistry (13%), gynaecology (4%), emergency medicine (5%), dermatology (4%) and radiology (6%).
Table 6.1: Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Categories</th>
<th>Number (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N=508)</td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-29 years</td>
<td>247 (48.6)</td>
<td></td>
</tr>
<tr>
<td>30-39 years</td>
<td>158 (31.1)</td>
<td></td>
</tr>
<tr>
<td>40-49 years</td>
<td>56 (11.0)</td>
<td></td>
</tr>
<tr>
<td>50-59 years</td>
<td>27 (5.3)</td>
<td></td>
</tr>
<tr>
<td>60 years and more</td>
<td>20 (3.9)</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>322 (63.4)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>186 (36.6)</td>
<td></td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>243 (47.8)</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>255 (50.2)</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>10 (2.0)</td>
<td></td>
</tr>
<tr>
<td><strong>Type of hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islamic hospital</td>
<td>48 (9.4)</td>
<td></td>
</tr>
<tr>
<td>Academic hospital</td>
<td>195 (38.4)</td>
<td></td>
</tr>
<tr>
<td>Private hospital</td>
<td>33 (6.5)</td>
<td></td>
</tr>
<tr>
<td>Public hospital</td>
<td>232 (45.7)</td>
<td></td>
</tr>
<tr>
<td><strong>Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Student</td>
<td>114 (22.4)</td>
<td></td>
</tr>
<tr>
<td>Training Dr</td>
<td>36 (7.1)</td>
<td></td>
</tr>
<tr>
<td>Resident doctor or GP</td>
<td>236 (46.5)</td>
<td></td>
</tr>
<tr>
<td>Specialist or Consultant</td>
<td>122 (24.0)</td>
<td></td>
</tr>
<tr>
<td><strong>Main practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>438 (86.2)</td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>31 (6.1)</td>
<td></td>
</tr>
<tr>
<td>Teaching</td>
<td>27 (5.3)</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>12 (2.4)</td>
<td></td>
</tr>
<tr>
<td><strong>Academic qualification</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>114 (22.4)</td>
<td></td>
</tr>
<tr>
<td>Bachelor</td>
<td>253 (49.8)</td>
<td></td>
</tr>
<tr>
<td>Master</td>
<td>72 (14.2)</td>
<td></td>
</tr>
<tr>
<td>Doctorate</td>
<td>69 (13.6)</td>
<td></td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islam</td>
<td>482 (94.9)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>26 (5.1)</td>
<td></td>
</tr>
<tr>
<td><strong>Nationality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jordanian</td>
<td>443 (87.2)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>65 (12.8)</td>
<td></td>
</tr>
</tbody>
</table>

6.3.2 How doctors think about clinical ethics in Jordanian hospitals (Table 6.2)

More than half of respondents (55%) rated clinical ethics at their hospital as “fair” or “poor”, and about one third (34%) rated their own knowledge of ethics similarly. Fewer than two thirds (65%) considered that doctors “always serve their patients interests”.

120
### Table 6.2: How doctors think about ethical issues in clinical settings

<table>
<thead>
<tr>
<th>Item</th>
<th>Answer</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, how would you describe clinical ethics at your hospital?</td>
<td>Good</td>
<td>226 (44.50)</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>231 (45.5)</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>51 (10.0)</td>
</tr>
<tr>
<td>How would you rate your awareness of clinical ethics?</td>
<td>Good</td>
<td>333 (65.6)</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>158 (31.1)</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>17 (3.3)</td>
</tr>
<tr>
<td>How you evaluate the ethical decision making at your hospital?</td>
<td>Rational</td>
<td>59 (11.6)</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>279 (54.9)</td>
</tr>
<tr>
<td></td>
<td>Intuitive</td>
<td>170 (33.5)</td>
</tr>
<tr>
<td>What is the basis for ethical decision-making at your hospital?</td>
<td>Scientific</td>
<td>200 (39.4)</td>
</tr>
<tr>
<td></td>
<td>Religious</td>
<td>120 (23.6)</td>
</tr>
<tr>
<td></td>
<td>Social and cultural</td>
<td>188 (37.0)</td>
</tr>
<tr>
<td>How you define clinical ethics?</td>
<td>Distinguishing right and wrong</td>
<td>75 (14.8)</td>
</tr>
<tr>
<td></td>
<td>Legal vs. illegal</td>
<td>233 (45.9)</td>
</tr>
<tr>
<td></td>
<td>Justice vs. injustice</td>
<td>200 (39.4)</td>
</tr>
<tr>
<td>Doctors always serve their patients’ interests rather than other interests</td>
<td>Agree</td>
<td>333 (65.6)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>147 (28.9)</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>28 (5.5)</td>
</tr>
</tbody>
</table>

Respondents were questioned about the philosophical basis of their thinking in two ways. When asked about the broad disciplinary field generally applied in relation to ethical decision-making at their hospitals, they were split between “scientific” (39%), “religious” (24%) and “traditional” (37%) considerations. Similarly, when asked about the conceptual basis, answers were divided between philosophical (15%), theological (39%) and legal (46%) concepts. Only a few (12%) considered ethics to be characterised by rational, responsible intervention, with the majority (88%) stating instead that decisions were based on intuition and inherently uncertain.

Multiple regression analysis showed that responses to the question about knowledge of clinical ethics varied according to hospital of origin and religious affiliation but not in relation to other demographic variables, including age, sex, level of seniority or area of specialisation (Table 6.6).

#### 6.3.3 Ethical issues encountered by clinicians in hospital practice (Table 6.3)
When asked about the quality of “informed consent” (aged masoolayah) procedures, only 43% of respondents “agreed” that these were satisfactory. Nearly 80% expressed a recognition of the need for full discussion and “open communication” with patients before an ethical decision was taken. However, fewer than one third (30%) agreed that “the concept of justice” (adalah) was being adequately implemented at their hospital.

Table 6.3: Ethical issues encountered by clinicians

<table>
<thead>
<tr>
<th>Item</th>
<th>Answer</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed consent at my hospital satisfies the requirements of ethics.</td>
<td>Disagree</td>
<td>36 (7.1)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>256 (50.4)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>216 (42.5)</td>
</tr>
<tr>
<td>I prefer to have full discussion and open communication with my patients before taking ethical decisions</td>
<td>Disagree</td>
<td>14 (2.8)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>99 (19.5)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>395 (77.8)</td>
</tr>
<tr>
<td>I believe that the concept of justice is being demonstrated at my hospital</td>
<td>Disagree</td>
<td>115 (22.6)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>238 (46.9)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>155 (30.5)</td>
</tr>
<tr>
<td>I believe that doctors are causing harm against their patients in clinical settings.</td>
<td>Disagree</td>
<td>419 (82.5)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>48 (9.4)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>41 (8.1)</td>
</tr>
<tr>
<td>I believe that doctors are causing harm against patients in non-clinical settings.</td>
<td>Disagree</td>
<td>415 (81.7)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>44 (8.7)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>49 (9.6)</td>
</tr>
<tr>
<td>Patients trust their doctors in this hospital</td>
<td>Disagree</td>
<td>31 (6.1)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>196 (38.6)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>281 (55.3)</td>
</tr>
<tr>
<td>In this hospital, doctors respect the confidentiality of their patients with respect to securing data, keeping secrets and maintaining trusted communication</td>
<td>Disagree</td>
<td>41 (8.1)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>149 (29.3)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>318 (62.6)</td>
</tr>
<tr>
<td>Doctors respect their patients’ privacy in terms of physical environments and territoriality</td>
<td>Disagree</td>
<td>27 (5.3)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>177 (34.8)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>304 (59.8)</td>
</tr>
</tbody>
</table>

When asked whether they felt that patients trusted their doctors, 44% either “disagreed” or were “neutral”. Fewer than two thirds (63%) considered that confidentiality was adequately protected and a similar proportion (60%) that privacy was respected in hospital practice. Just under 20% of participants felt that doctors were actively causing harm in the course of their practice.

Multiple regression analysis showed that the identification of ethical issues was uniform across demographic variables, hospital and religion (Table 6.6).
6.3.4 The role of religion in clinical decision making (Table 6.4)

Just over half (54%) of doctors stated that they believed that clinical ethics should follow Islamic principles (mabade) and more than two thirds (67%) felt that the Qur’an, Sunnah and Ijtihad provide an appropriate basis for ethical decision making in hospital practice. 40% indicated their preference for consulting religious scholars prior to taking ethical decisions.

Table 6.4: The role of religion in clinical decision making

<table>
<thead>
<tr>
<th>Item</th>
<th>Answer</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical ethics should be related to Islamic considerations</td>
<td>Disagree</td>
<td>74 (14.6)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>158 (31.1)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>276 (54.3)</td>
</tr>
<tr>
<td>Qur’an, Sunnah and Ijtihad are suitable for ethical decision making</td>
<td>Disagree</td>
<td>34 (6.7)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>134 (26.4)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>340 (66.9)</td>
</tr>
<tr>
<td>I prefer to consult the religious men before taking some ethical</td>
<td>Disagree</td>
<td>99 (19.5)</td>
</tr>
<tr>
<td>decisions</td>
<td>Neutral</td>
<td>205 (40.4)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>204 (40.2)</td>
</tr>
<tr>
<td>I believe that abortion is being conducted according to Islamic</td>
<td>Disagree</td>
<td>43 (8.5)</td>
</tr>
<tr>
<td>regulations</td>
<td>Neutral</td>
<td>174 (34.3)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>291 (57.3)</td>
</tr>
<tr>
<td>I believe that organ transplantation is being conducted according to</td>
<td>Disagree</td>
<td>31 (6.1)</td>
</tr>
<tr>
<td>Islamic regulations</td>
<td>Neutral</td>
<td>173 (34.1)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>304 (59.8)</td>
</tr>
<tr>
<td>I believe that women should wear the hijab in this hospital.</td>
<td>Disagree</td>
<td>83 (16.3)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>199 (39.2)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>226 (44.5)</td>
</tr>
<tr>
<td>There are visible considerations while male doctors examining female</td>
<td>Disagree</td>
<td>30 (5.9)</td>
</tr>
<tr>
<td>patients to match the Islamic demands and regulations</td>
<td>Neutral</td>
<td>193 (38.0)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>285 (56.1)</td>
</tr>
<tr>
<td>Islamic requirements regarding death are being followed</td>
<td>Disagree</td>
<td>12 (2.4)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>168 (33.1)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>328 (64.6)</td>
</tr>
<tr>
<td>Informed consent is being practised according to Islamic requirements</td>
<td>Disagree</td>
<td>37 (7.3)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>197 (38.8)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>274 (53.9)</td>
</tr>
</tbody>
</table>

More than half considered that abortion (ijihadh) and organ transplantation (zeraet al adaa’) were being conducted appropriately in accordance with Islamic principles (57% and 60% respectively). A minority (45%) considered that female patients should be compelled to wear the hijab when attending a hospital. Just over half (56%) considered that male doctors should be restricted in their ability...
to examine female patients, in accordance with Islamic customs. Nearly two thirds (65%) felt that Islamic customs (idad lelmawt) were being adequately observed in relation to death, but a smaller number (54%) were satisfied that consent processes conformed adequately to Islamic requirements.

6.3.5 Resources needed to enhance ethical decision making in Jordanian hospitals (Table 6.5)

For most participants, formal training in ethics has been limited, with 70% having only encountered “weak” or “limited” teaching. Nonetheless, most (57%) felt that international standards of ethics were largely observed in Jordan. A substantially greater number of respondents felt that ethics should be guided by “scientific” rather than by “social and traditional” considerations (74% vs. 20%). A strong majority (78%) also supported the concept of diversity among ethical perspectives.

There was limited confidence in the effectiveness of hospital ethics committees, with only 18% considering them to be “effective”. Similarly, a minority (41%) agree that current protocols and guidelines provide useful assistance for ethical decision making.

<table>
<thead>
<tr>
<th>Item</th>
<th>Answer</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have studied clinical ethics at university.</td>
<td>Weak</td>
<td>91 (17.9)</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>265 (52.2)</td>
</tr>
<tr>
<td></td>
<td>Clear &amp; complete</td>
<td>152 (29.9)</td>
</tr>
<tr>
<td>International standards of clinical ethics are followed in my hospital</td>
<td>Disagree</td>
<td>34 (6.7)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>184 (36.2)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>290 (57.1)</td>
</tr>
<tr>
<td>Clinical ethics should be guided by scientific and intellectual considerations.</td>
<td>Disagree</td>
<td>11 (2.2)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>123 (24.2)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>374 (73.6)</td>
</tr>
<tr>
<td>Clinical ethics should be guided by social norms and traditions.</td>
<td>Disagree</td>
<td>229 (45.1)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>176 (34.6)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>103 (20.3)</td>
</tr>
<tr>
<td>Clinical ethics should be open to a diverse range of perspectives among scholars and clinical and non-clinical bodies</td>
<td>Disagree</td>
<td>26 (5.1)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>86 (16.9)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>396 (78.0)</td>
</tr>
<tr>
<td>Ethics committees at the hospital are effective.</td>
<td>Non effective</td>
<td>120 (23.6)</td>
</tr>
<tr>
<td></td>
<td>Neutral</td>
<td>297 (58.5)</td>
</tr>
</tbody>
</table>
Multiple regression analysis showed that attitudes to the role of religion varied was uniform across demographic variables (Table 6.6).

Table 6.6: Logistic analysis

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Thoughts &amp; opinions</th>
<th>Clinical Issues</th>
<th>Religious considerations</th>
<th>Practical &amp; theoretical resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Sex</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Marital S</td>
<td>NS</td>
<td>NS</td>
<td>P&lt;0.01</td>
<td>NS</td>
</tr>
<tr>
<td>Experience</td>
<td>NS</td>
<td>P&lt;0.01</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Hospital</td>
<td>P&lt;0.01</td>
<td>NS</td>
<td>NS</td>
<td>P=0.01</td>
</tr>
<tr>
<td>Specialisation</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Position</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Mission</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Qualification</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>University</td>
<td>NS</td>
<td>NS</td>
<td>P&lt;0.01</td>
<td>NS</td>
</tr>
<tr>
<td>Religion</td>
<td>P=0.01</td>
<td>NS</td>
<td>P&lt;0.01</td>
<td>NS</td>
</tr>
<tr>
<td>Nationality</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>P=0.01</td>
</tr>
</tbody>
</table>

6.3.6 Challenges facing doctors with respect to ethical decision making (Table 6.7)

When invited to offer a free comment about the challenges facing ethical decision-making in Jordanian hospitals, 82% of participants contributed. Their responses (415 in all) were grouped into three main themes: organisational problems within the system; issues relating to the content of ethical decision-making; and social and religious factors.

Consistent with the manner in which the question was phrased, the overwhelming majority of responses (72%) were of a critical character. The minority of predominantly positive comments expressed the view that the system was “fair”
and “clear”, standards were high, that “mutual respect” was demonstrated, and that practice was generally consistent with the requirements of Islamic law.

Some representative extracts from the data are presented in the Box. In relation to organisational problems (22% of comments), participants referred to: persistent overcrowding; lack of resources; poor doctors’ pay and lack of monetary incentives; lack of protocols and specialised committees; and insufficient time to see patients. On the subject of issues relating to the content of ethical decision-making (27%) participants mentioned: corruption, favouritism (*mahsoobeyah*); nepotism (*wasetah*); lack of awareness by doctors and patients of ethical problems; a tendency of doctors to pursue their own interests; discrimination against certain patients; lack of respect for patients’ rights; unjust distribution of resources; and inadequate provision to ensure patient privacy.

In relation to social and religious factors (40% of comments), participants: drew attention to a perceived dearth of common rules; stated concerns about a lack of patient education; supported respect for diverse approaches; expressed the view that Islam should apply to all aspects of life; stated that there is inadequate awareness of religious issues and *al-Sharī`ah* law (*thaqafah*) among both patients and doctors; expressed concern that there is confusion between customs, religion and law; observed that the tribal nature of communities often intrudes into clinical decision-making; and drew attention to difficulties associated with multiple, mixed customs.

The attitudes and beliefs expressed by individual participants with respect to each of the three themes were differentiated in relation to three common sources of tension among key values, to which we refer as tensions between (i) conservatism and pragmatism, (ii) religion and secularism, and (iii) tradition and modernity. Here “conservatism” takes the form of a rigid understanding, and “pragmatism” to an openness to flexible and fluid interpretations of established texts and authorities; “religion” and “secularism” refer to contending views about the proper role of considerations regarding the Islamic faith in ethical decision-making; and “tradition” and “modernity” to opposing relationships to currents of
thought arising from within and outside Jordanian society (see Table 6.8 for further explanation). Within each of the thematic areas all six of these values in tension were represented.

### Table 6.7: Representative quotations

<table>
<thead>
<tr>
<th>Administrative and organizational issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The huge number of patients affects the quality of ethical decisions.</td>
</tr>
<tr>
<td>• In the paediatrics department, no procedure can be performed without the consent of the father and there is huge ignorance of the mother’s role.</td>
</tr>
<tr>
<td>• Obstacles arise from the absence of comprehensive and clear strategies that health and medical foundations can rely on.</td>
</tr>
<tr>
<td>• Some doctors are good and they have excellent manners, but the medical and administrative management is weak in its commitment to medical ethics. There is a commonplace religious cover for the behaviour of medical ethics.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religious beliefs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The absence of women doctors may cause pressure on male doctors to deal with female patients and vice versa.</td>
</tr>
<tr>
<td>• The comprehensive protocols of good morals in all medical institutions include the perfect values of Islam.</td>
</tr>
<tr>
<td>• Its origin must be Islamic Sharīʿah, because it is comprehensive for all aspects of life.</td>
</tr>
<tr>
<td>• The basis of medical ethics is honesty with God and with respect for Arabic and Islamic ethics.</td>
</tr>
<tr>
<td>• We need more awareness and moral understanding of religion.</td>
</tr>
<tr>
<td>• Medical ethics is related to each person separately regardless of the different in religions and beliefs.</td>
</tr>
<tr>
<td>• Most of the medical staff has no extensive background or understanding of medical ethics. Unfortunately, religion is not the source of ethics and social habits could be biggest obstacles.</td>
</tr>
<tr>
<td>• Patients, especially women, are examined in the presence of a nurse if the examiner is a male. The relationship between the patient and the doctor is completely a family and not a religious relationship.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Norms and traditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• There is a lack of effectiveness and control and there are signs of favouritism and nepotism in appointments.</td>
</tr>
<tr>
<td>• My opinion is that the medical ethics in the hospital I work in depends on the society’s traditions and customs and on the doctor’s own ethics, but there is no certain reference or base.</td>
</tr>
<tr>
<td>• Ethics often depends on the social aspect, on customs and traditions, and this is sometimes unacceptable as it may cause harm to the patient and his or her medical condition.</td>
</tr>
<tr>
<td>• In emergency rooms, there is no privacy for the patient. Patients and their relatives stay in the clinic during the examination.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Curriculum</th>
</tr>
</thead>
</table>

127
• Ethical crises are related to lack of education in terms of medical ethics, in addition to the volume of work.
• The environment of education has a big role in ethics and there is a lack of religious and spiritual content.

**Ethical argument**

• The morals of citizens have declined in general in previous years and this has been reflected in doctors, as the ethics of professions are within the social controls and customs and traditions of Islamic and tribal origins (from the tribe) there is no activation of the laws in many things.
• The confusion of the religious concept with the laws, where they are opposed to make the doctor sometimes committed to the task of religious and sometimes the law causing him to be confused.
• The ethical and medical decisions in the hospital are logical and scientific, while the bases are the patient's culture rather than the culture of hospital.
• Ethics should be based on legal matters completely away from religious matters.

### 6.4 Discussion

This mixed qualitative and quantitative study has examined the multiple ethical issues causing concern among medical professionals in Jordanian hospitals. It has highlighted particular areas of disquiet related to the overall organisation and administration of the health care system, the specific content of ethical decision-making, and the impact of changing social, cultural and religious factors. Administrative factors relate to anxiety about overcrowding, inadequate resources, insufficient support, widespread corruption and hierarchical, non-democratic, management practices. Ethical issues include the changing roles of traditional and modern ways of understanding approaches to ethics, consent, organ donation, confidentiality, privacy, abortion, and the role of women. Social factors encompass the role of religion and religious authorities, the relative importance of the family, community or tribal obligations, and the impact of global culture and standards of practice.

Our findings highlight profound divisions and widely differing perspectives among Jordanian doctors and an abiding sense of uncertainty and instability within the profession. Clinicians express widespread dissatisfaction with the existing system and modes of practice but little unanimity about how to address the problems. Doctors are aware of international trends in relation to ethical philosophies and principles but are divided about their applicability to Jordanian society. Many express ambivalence in relation to traditional precepts, such as the
treatment of women, and the role of community and family members in decision-making.

These results are broadly consistent with the findings of the limited pre-existing studies that have been conducted in relation to attitudes to clinical ethics and health care in Islamic countries [Sabbour 2012 et al; Franco et al., 2004; Daw and Elkhammas, 2008]. As discussed below, they are also consistent with the wider array of tensions exposed in many countries across the region during the Arab Spring.

A distinctive feature of our study is the attention it draws to the intense ferment that is currently sweeping Arab countries and the uncertainty generated by it. We have found that among doctors in Jordan there are three main areas of ethical contention, around which differing opinions are formed, which emerged from our data as three “axes” of ethical tension. We refer to these three axes as: “conservatism-pragmatism”, “tradition-modernity” and “religion-secularism” (Table 6.8)

<table>
<thead>
<tr>
<th>Tension</th>
<th>Key features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservatism vs. pragmatism</td>
<td></td>
</tr>
<tr>
<td>• Conservatism</td>
<td>Insistence on fixed standards and conclusions</td>
</tr>
<tr>
<td>• Pragmatism</td>
<td>Flexible approach to decision making</td>
</tr>
<tr>
<td>Tradition vs. modernity</td>
<td></td>
</tr>
<tr>
<td>• Tradition</td>
<td>Strong emphasis on historical cultural attitudes and practices</td>
</tr>
<tr>
<td>• Modernity</td>
<td>Openness to Western approaches</td>
</tr>
<tr>
<td>Religion vs. secularism</td>
<td></td>
</tr>
<tr>
<td>• Religion</td>
<td>Stress on central role of Islamic principles</td>
</tr>
<tr>
<td>• Secularism</td>
<td>Exclusion of religious considerations from ethical decision making</td>
</tr>
</tbody>
</table>

The first area of contention relates to the choice between “conservative” and “pragmatic” styles of decision-making. The former demands obedience to literal, high level principles, while the latter applies a flexible approach to ethical decision making in relation to local circumstances, principles and methodologies. This tension reflects an abiding, deep-seated cleavage within Arab and Islamic culture which appears to have emerged in the present day with renewed force.
Typically, participants who adopted a conservative approach sought to apply fixed, pre-existing principles, while those who were more pragmatic rejected fixed values and responded to clinical exigency.

The second area of contention relates to the tension between “traditional” approaches to clinical decision-making and “modern”, or internationalised, standards of ethics and ethical codes. The former place value on established attitudes, practices and relationships, which could derive from Arab, Islamic or tribal origins. The latter tend to refer primarily to ideas, concepts and guidelines imported into Jordan in the form of globalised cultural attitudes, economic practices and formal philosophical texts, and reflect the impact of foreign medical education. While many doctors express support for the formulations obviously linked to Western approaches to bioethics, many others remain cautious or suspicious. Thus participants adopting a traditional approach would favour attitudes embedded in familiar practices within their communities, while those supporting a modern approach would typically appeal to texts, codes and guidelines supported by Western bioethics centres, the United Nations or related organisations.

The third area of tension relates to the role of Islam and to social pressures to disengage ethical decision-making from religious authority. While this too has been a longstanding theme in Arab societies it has acquired intense urgency in the wake of the Arab Spring and its violent aftermath. Here, the opposing approaches are often quite stark: those supporting a religious approach require explicit reference to Islamic texts or religious authorities in the course of ethical decision-making, while those favouring a secular perspective explicit disavow the latter’s appropriateness or relevance.

Our qualitative and quantitative data have demonstrated the full range of possibilities mapped out by these three axes of ethical value. Medical practitioners in Jordan occupy all positions in relation to the three thematic problems of modernity, pragmatism and secularism. In addition, it may be—although this needs to be formally tested—that different positions are adopted in relation to
different thematic questions. Further, the domains of difference and the intensity of the concerns appear to be largely uniform among medical professionals of different ages, specialities and levels of seniority, with minor exceptions relating to hospital location or religious affiliation.

The lack of ethical consensus magnifies the disquiet regarding topics of concern around the world, while at the same time raising new and specific issues. The organisational pressures to which Jordanian hospitals are exposed in large part reflect changes in the world economy and the need to respond to contemporary market demands. However, rather than being seen as a purely technical matter, the resultant scarcity of resources is interpreted as symptomatic of an underlying ethical malaise, which is expressed in terms of disquiet about corruption, personal greed, nepotism and organisational deficiencies within the Jordanian health system.

The exact origins of the sources of the tensions described by our participants are uncertain. However, they are likely to embrace multiple local and global factors. The local factors may include the facts that: many Jordanian doctors are trained in the West and are therefore exposed to Western ideas about ethics, religion, culture and society, which may conflict with the more traditional views with which they grew up; hospital administrators, religious authorities and community members do not have such experience; there is very limited discussion about, and training in, ethics in the educational programs by which health professionals are trained in Jordan; there are limited opportunities for public debate about the impact of novel technologies and ethical issues in the clinical setting; and the Jordanian economy has been stressed as a result of multiple regional and international forces, including the influx of refugees from conflicts in neighbouring countries (Achilli, 2015). The global factors include the impact of the globalised economy and its accompanying culture, including that of the internet and social media, which has supported the proliferation of a radical questioning of traditional values and beliefs, especially among young people in the region. The development of new critical attitudes, which cover human rights, the role of women, and political and social organisation, have been attributed as important drivers of the social ferment that led to major political changes in
Tunisia, Egypt, Libya and some other countries [Brynen et al., 2012 and Eldin 2011]. We speculate that the phenomena we have documented among health care professionals in Jordan are shared in at least some of these other countries.

Similarly, ethical issues familiar to bioethicists around the world, such as consent, organ donation, abortion and end of life care, are understood in the Jordanian context as evoking a sense of cultural crisis, and have become linked to a broader sense of instability and change. Although Western formulations about ethics, including its characteristic focus on individual subjectivity and agency, are commonly employed, the fundamental status of the family, the community and the culture is often given equal weight.

We speculate that these issues and divisions, and the deep sense of disquiet, revealed by our data, reflect the large-scale forces to which Jordanian society is exposed, and to a substantial degree thus may provide a way to understand the ethical predicament of many other countries in the contemporary Arab world. We believe the concerns of Jordanian physicians epitomise the impact of the pressures created by the globalization of economy and culture, and the critical questioning of traditional beliefs, attitudes and practices to which they have given rise. The richness of the ethical discourse, the maturity of the debates, and the courteous and respectful manner in which the discussions have been able to take place in Jordan, however, provide an optimistic alternative to the violence of the conflicts being pursued in geographically close locations.

Despite the consistency in our findings across demographic variables our study has certain limitations. The sample population was drawn from four major hospitals in the capital city of Jordan and may not be fully representative of medical practice elsewhere in the country. In particular, there was only limited representation of practitioners from poorer areas, ethnic minorities (such as the Jordanian Bedouin population) and refugee communities. In addition, both the Arab and Islamic worlds are extremely diverse and, despite the wide applicability of many of the themes that have emerged from our data, it cannot be assumed that our findings apply to other Islamic countries, including both other Arab countries.
within the Islamic world and non-Arab countries with large Muslim populations, such as in Iran, Indonesia, Southern Asia and Africa.

It is also important to acknowledge that many scholars contend that the ethical standards applied in Western countries are not greatly different from those in the Islamic world. Thus Daar and Al Khitamy (2001) highlighted that the three monotheistic religions, Islam, Judaism and Christianity, essentially, with only minor differences, share the same morality. Al Aqeel (2007) concluded that Islamic ethics places a strong emphasis on concepts widely applied in the West, such as “respect” and “compassion”, and Sachedina (2009) argued that Islamic law (al-Sharī`ah) is consistent with Western principles of ethics in the guidance it provides about obligations, duties and prohibitions. Similarly, the concept of fiqh, which refers to "insight" or guidance, with a focus primarily on processes and duties rather than on presupposed outcomes or consequences (Brockopp and Eich, 2008), is consistent with some contemporary Western approaches to ethics (Schroder et al., 2014), as is the hermeneutic process implicit within Ijtihad in the analysis of the archive of opinions about morality and value (Rady et al, 2009).

The Arab and Islamic world is in flux: a flux of ideas, cultures, political forces and ethics. There are pressures of globalisation, including the permeation of ideas from outside Islam, as well as the persistence of ancient ideas and concepts that continue to permeate the cultural frameworks. It is not surprising that this ferment is manifested in many areas of life, including in the health care sector.

Our study has shown that health professionals in Jordan are perturbed by the current circumstances in their country and are uncertain and divided about key issues. Examined through the lens of clinical ethics, three main thematic areas of substantive concern are apparent, referring to organisational structures, the actual content of ethical decision-making, and religious and social issues. In relation to each of these, a constant array of ethical tensions is manifested, relating to conservative versus pragmatic styles of practice or dispositions of mind, varying emphases on the roles of tradition and modernity, and disagreements about the contemporary role of religious and secular perspectives.
We surmise that unease related to both the thematic content and the ethical tensions identified in this study applies more generally to Islamic societies and may contribute a window of understanding in other settings. The fact that health professionals in Jordan seek to address their uncertainties and differences through respectful debate and open discussion about ethics provides encouragement and optimism about the resolution of wider tensions.
Chapter 7

Clinical ethics from the Islamic perspective: a qualitative study exploring the views of Jordanian doctors

ABSTRACT

Background. Like other Arab countries, Jordan has to find ways of responding to the rapid processes of change that are affecting many aspects of social life. The need to do this is particularly urgent in health care, where social and technical change is often manifested in tensions about ethical decision-making in the clinic.

Objective. To explore the attitudes, beliefs and concerns relating to ethical decision-making among health professionals in Jordanian hospitals.

Design. A qualitative study involving face to face interviews with medical personnel in four hospitals in Amman, the capital of Jordan. Data were analysed thematically in relation to a pre-existing set of ethical categories.

Participants and setting. Interviews were conducted with 38 doctors covering most medical specialities. Fourteen participants were working in a public hospital and 8 in each of an academic hospital, an Islamic hospital and a private hospital.

Results. Five major themes emerged from the interviews: ethical awareness; ethical issues; the impact of religion on ethical decision-making; practical and theoretical resources for ethical decision-making; and challenges. Participants stated that they often relied on personal experiences when making ethical decisions, rather than on traditional processes of Islamic decision-making, such as community and religious discussions, although the latter do occur. It was widely believed that the traditional Islamic texts provide only limited guidance in

relation to key contemporary ethical issues, such as organ donation, withholding and withdrawing of life-sustaining treatment and abortion. Ambivalence was expressed about commonly-applied processes of consent, with participants claiming that these conformed neither to those of Islam nor to those of the West. The participants expressed a commitment to the role of jurists in resolving conflicts in health care settings and believed that Jordanian patients prefer Islamic hospitals to secular ones, owing to a perceived belief that these hospitals were superior in their treatment of religious obligations, attitudes to gender segregation and respect for privacy. While uncertainty was expressed about some aspects of Western approaches to ethics, participants strongly supported adoption of a range of Western bioethical principles, including cultural and ethical diversity, along with adherence with Islamic religious norms. A range of serious ethical challenges facing the Jordanian health system were identified, covering social, legal, managerial and technical issues.

**Conclusions.** Ethical decision-making in Jordan is complex, having to accommodate the needs of patients, the opinions of doctors and their families, the views of religious authorities, managerial considerations, and both local norms and international standards. Health professionals struggle with three sets of tensions that emerge out of the struggle between traditional, community-embedded forms of social organisation and the demands generated by globalisation and the influence of Western culture: the tensions between tradition and modernity, conservatism and pragmatism, and religion and secularism. Doctors in Jordan prefer approaches to ethical decision making that realise a balance between the extremes, although the exact nature of where that balance should lie remains uncertain.
7.1 Introduction

Islam is a monotheistic religion with a strong emphasis on ethics. The Islamic legacy long predates academic teaching in ethics in the West (Padela et al., 2011a). However, unlike the West, Islam does not provide a comprehensive theory of medical ethics or a specific agenda covering all clinical issues (Zahedi and Larijani, 2008). In health care settings, it is therefore necessary for Muslim physicians to rely on the well-defined broader processes of ethical consideration to generate possible solutions (Khadduri, 2017). From the Islamic perspective, “health care settings” include a wide community comprising patients, health professionals, family and community members, scholars in religion and law, and maybe others (Clarfield et al. 2003).

Jordan is a Middle Eastern nation state which is a former British colony with continuing close cultural and political links to both the East and the West (The Royal Hashemite Court). The overwhelming majority of the 10.3 million population is Muslim (Department of Statistics DOS, 2017 and 2018). The life expectancy is 73 years for males and 76 years for females (WHO, 2016). From a health perspective, Jordan is ranked as the most advanced in the Arab region (WHO, Amman Jordan, 2015).

Despite its strengths, the health care system in Jordan faces many challenges, including increasing population and health care costs and lack of governmental planning for health services (Al-Oun and Smadi, 2011). Opposing ideologies are vigorously represented, including Arab nationalism, Islamic conservatism, pro-Western modernism, and tribalism (Munson, 2003). Nonetheless, Jordanian people often rely heavily for advice and guidance on religious authorities in relation to medical procedures and interventions (Department of iftaa Jordan, 2018).

This study aims to explore the problems presented by the lack of a clear understanding of how Islamic ethical thought applies to the health care domain in Jordan and by the lack of an organisational and educational infrastructure to support the practice of clinical ethics in Arab countries, and in Jordan in particular.
It seeks to do so by exploring the attitudes, beliefs and concerns about ethical decision-making of health professionals in Jordanian hospitals.

7.2 Methods

7.2.1 Setting and design

The present study is part of a larger research project to explore the nature and content of ethical decision-making in Jordanian hospitals. The study involves semi-structured, face-to-face interviews with clinical doctors from hospitals in Jordan. A report on a quantitative survey we have conducted of this population has previously been published (Obeidat and Komesaroff, 2019).

The study team comprises a researcher with a background as a health professional in Jordan who is undertaking study for a PhD in Australia (AO) and who is assisted by a supervisor from Australia (PK) and a methodological advisor from an Eastern European background. The researcher has relied on his awareness of Jordanian hospitals, the culture of Islam, and the importance of religion to Jordanian people in the development and implementation of the project.

The larger study is framed in relation to five research questions: 1. What do doctors think about ethical issues in clinical settings in Jordanian hospitals? 2. What is the role of Islam in clinical decision-making in Jordanian hospitals? 3. What ethical issues do clinicians encounter in their practices in Jordanian hospitals? 4. What practical and theoretical resources are needed to enhance ethical decision making? 5. What obstacles and challenges face doctors with respect to ethical decision-making in Jordanian hospitals? To address these questions through a qualitative interview strategy and to develop an interview protocol a range of issues and topics for conversation were derived from the literature and from the personal experience of the student researcher in health care in Jordan.

This process generated a long list of questions and prompts, such as:

- How do you understand clinical ethics from your perspective as a doctor?
• What are the most important ethical issues you face in your clinical practice?
• What factors shape the ethical agenda in this hospital and what is the role of the surrounding community?
• Do you follow international guidelines or protocols from the Western community? If yes, please explain why.
• For Muslim patients how important are religious factors in ethical decision making?
• Who, if anyone, should be involved in ethical decisions apart from doctors, patients and their families?
• What roles do clinical institutions and professional bodies play in training in ethics.
• What are the most important ethical challenges and obstacles facing your hospital?

On this basis, a draft interview schedule was developed which was tested, as described below. The resulting protocol was used as the basis for one-hour semi-structured interviews with health professionals, including front-line managers (who are mostly doctors and decision-makers, specialists and general practitioners).

Because the study aimed to understand the perspectives and experiences of doctors in Jordanian hospitals in relation to clinical ethics using their own words it is regarded as phenomenological in character and a suitable methodology was chosen (Grbich, 2007).

7.2.2 Participants and recruitment
To achieve sample diversity, we purposefully recruited doctors from four hospitals in Amman reflecting the main classifications in the Jordanian healthcare system: a public hospital (“H1”), an academic hospital (“H2”), an Islamic hospital (“H3”), and a private hospital (“H4”). The participants were chosen to ensure a range of age and gender, areas of clinical specialisation, research experience and knowledge of Islamic law (Edmonds and Kennedy 2016). The specialisations
included: Internal Medicine, General Surgery, Ophthalmology, Endocrinology, Gynaecology, Paediatrics, Family Medicine, Dental Surgery, Urology, Dermatology, Cardiology, Anaesthesia, Rehabilitation Medicine, Emergency Medicine, and Nuclear Medicine; in addition, heads of clinical departments were General Practitioners by training.

Doctors were invited to participate by letters from Monash University and the academic supervisor (PK). Letters from the Jordanian Ministry of Health and the management of the hospitals were also sent to potential participants encouraging them to participate.

The study was approved by the Monash University Human Research Ethics Committee. Following this, full details of the project were sent to the Jordanian Ministry of Health and the boards of management of the Jordanian hospitals which provided approval to conduct the study there.

7.2.3 Pilot study and validity

In order to ensure the validity of the study, a pilot study was conducted. This involved seeking comments from experienced researchers from Australia or Jordan who were asked to assess the quality of the study in relation to content and the extent to which it reflected concepts and theories raised in the literature. Opinions were also sought from doctors working in Jordanian hospitals (n=48) and fellow PhD students at Monash University (n=5) regarding readability, understandability and language. This process was particularly aided by support from a senior cardiologist at a private hospital in Jordan who made himself available for detailed discussions with the researcher.

The interview schedule was assessed for content and construct validity. Content validity was assessed by the pilot interviews to ensure that the questions accurately represented the characteristics or attitudes they were intended to measure. Construct validity was ensured by the inclusion of reference to an adequate range of ethical concepts and theories. The pilot testing contributed to
the refinement of the interview questions in relation both to their wording and content.

7.3 Data collection and analysis

The interviews were conducted in the Arabic language and recorded electronically. The recordings were transcribed verbatim and checked by the researcher. The latter then translated the transcripts into English, with assistance from native English speakers. Where uncertainty arose regarding nuances of meaning the researcher consulted dictionaries and the literature or sought specific help from linguistic experts; examples of such cases involved several words in common Arabic usage that have meanings closely related to “ethics” and “morality”.

Analysis was then undertaken using techniques appropriate to a phenomenological study. The researcher preferred to use hand coding and analysis in order to remain close to his data, physically and intellectually. Following Caven (2010), Grbich (2007) and Bazeley (2013), the data were analysed using a thematic approach to generate codes, categories and themes. The transcripts were read several times and a strategy was developed to classify the meanings, concepts and interpretations, using social and technical glossaries.

The researcher also drew on his own experience to extract the ideas most useful for developing theories and conclusions. The contents of individual interviews were classified according to themes, and relevant words and sentences were labelled to assist with the development of concepts. The stories of the interviews were then developed in a manner that encompassed significant issues concerning clinical ethics in Jordanian hospitals, with special reference to varying social and religious perspectives. Themes and subthemes were identified from the codes.

To summarise this approach in more detail, in accordance with Creswell’s (2007) outline of the phenomenological approach, six steps were followed:

1. Collection of a wide array of descriptions of personal experiences of clinical ethics in Jordanian and Arab culture;
2. Development of a list of significant statements describing individuals’ experiences using their own words;
3. Classification of these statements into themes in relation to recurring ideas;
4. Description of “what” participants experienced, how they coped with dilemmas and challenges and the resources on which they drew, using verbatim examples;
5. Description of “how” the experiences happened: that is, how participants used the ethical resources, thought about ethical issues, employed religious, social or international norms, and responded to obstacles and challenges;
6. Finally, a presentation of the “essence” of the experiences, encompassing participants’ thoughts and actions and the contexts within which these occurred.

7.4 Results

Thirty eight participants were recruited from four Jordanian hospitals. Details of the participants are shown in Table 7.1. The participants mostly occupied senior positions as managers, team supervisors, consultants, academics and chairs of ethics committees. Some were experts in Islamic affairs and bioethics.

Fourteen participants (37%) were working in H1 (the public hospital), and 8 (21%) in each of H2 (academic), H3 (Islamic) and H4 (private) hospitals. Twenty eight (74%) were male and 10 (26%) were female. More than half (63%) were aged more than 51 years.
### Table 7.1: Participant characteristics

<table>
<thead>
<tr>
<th>Hospitals (n=4) / participants ( n=38)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>H1 (n=14, 37%)</td>
<td>H2 (n=8, 21%) H3 (n=8, 21%) H4 (n=8, 21%)</td>
</tr>
</tbody>
</table>

#### Gender

<table>
<thead>
<tr>
<th>M (n=28, 74%)</th>
<th>F (n=10, 26%)</th>
</tr>
</thead>
</table>

#### Age

<table>
<thead>
<tr>
<th>24-35 (n=7, 18%)</th>
<th>36-50 (n=7, 18%)</th>
<th>51 and more (n=24, 63%)</th>
</tr>
</thead>
</table>

#### Specialisation

<table>
<thead>
<tr>
<th>Internist (n=7, 18%)</th>
<th>Dental surgeon (n=3, 8%)</th>
<th>Family medicine (n=2, 5%)</th>
<th>Emergency specialist (n=2, 5%)</th>
<th>Anaesthetist (n=2, 5%)</th>
<th>GP (n=4, 11%)</th>
<th>Endocrinologist (n=2, 5%)</th>
<th>General surgeon (n=3, 8%)</th>
<th>Paediatrician (n=3, 8%)</th>
<th>Cardiologist (n=1, 3%)</th>
<th>Dermatologist (n=2, 5%)</th>
<th>Urologist (n=1, 3%)</th>
<th>Gynaecologist (n=2, 5%)</th>
<th>Ophthalmologist (n=2, 5%)</th>
<th>Rehabilitation medicine (n=1, 3%)</th>
<th>Nuclear medicine (n=1, 3%)</th>
</tr>
</thead>
</table>

### 7.4.1 Taxonomy of themes and subthemes

Multiple “significant statements” were extracted from the texts. These statements were clustered into 25 subthemes which were grouped into five major themes: 1. “Ethical awareness”; 2. “Ethical issues”; 3. “Impact of religion”; 4. “Practical and theoretical resources”; and 5. “Challenges facing clinical ethics in Jordanian hospitals”.

As shown in Table 7.2, Theme 1 included five subthemes, Theme 2 had eleven subthemes, Theme 3 had two subthemes, Theme 4 had seven subthemes and Theme 5 had no subthemes.
Table 7.2: Taxonomy of themes and subthemes

<table>
<thead>
<tr>
<th>Categories</th>
<th>themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ethical awareness</td>
<td>Social responsibility; Meaning of ethics; Decision tools; Daily activities; and Levels of satisfaction</td>
</tr>
<tr>
<td>2. Ethical issues</td>
<td>Privacy and women; Confidentiality; Harm; Organ transplantation; Withholding and withdrawing treatment; Abortion; Consent; Justice; Communication; Death preparation; and Time limit</td>
</tr>
<tr>
<td>3. Impact of religion</td>
<td>Role of jurists on the impact of religion; and Why Islamic hospitals are favoured</td>
</tr>
<tr>
<td>4. Practical and theoretical resources</td>
<td>Curriculum; International ethics; Ministry of Health; Diversity; Ethics committees; Medical associations; and Training</td>
</tr>
<tr>
<td>5. Challenges</td>
<td></td>
</tr>
</tbody>
</table>

7.4.2 Theme 1: Ethical awareness

This theme describes the ways in which the participants understood some basic elements of ethics in health care, including concepts of ethics, responsibilities towards patients and families, and religious requirements in relation to ethical decision making. A description of the seven subthemes follows. Additional quotations relating to this theme are presented in Table 7.3.

7.4.2.1 Meaning of ethics

Participants focused on religious concerns as a major priority and on concepts such as dignity and tolerance, wisdom and accountability. Many participants responded to questions about the meanings of ethics and religious faith by referring to the command of God (Allah SWT):

Fear of God comes first and last [Paediatrician (H3)].

7.4.2.2 Social responsibility

Participants stated that through their work they sought to enhance the meaning of soul (ruh), to act charitably in every part of their work and to demonstrate integrity
and social service. They often referred to the importance of the values of responsibility and respect.

One participant said that responsibility meant for them demonstrating signs of integrity and social service:

I believe that we as Muslims live in a society governed by Islamic values, and if we apply ethics we will not have any troubles [Cardiologist (H4)].

7.4.2.3 Daily activities
Participants stated that they should “feel with their patients” in their daily concerns and fulfil their technical and religious responsibilities. The traditional title (hakim) was their main aim. They felt that their managerial positions brought them closer to their patients’ needs. They placed great emphasis on active communication and relationships with patients and families.

One participant said that their first priority was to fulfil their traditional title (hakim), which means giving wisdom and making rational interventions:

He must establish special scales for the environment, culture and sciences. He is called “wise”, because he has sufficient wisdom in scientific, social and psychological terms [Endocrinologist (H3)].

7.4.2.4 Decision tools
Descriptions of decision making often focused on the need to maintain technical standards. Many participants felt that greater diversity of doctors’ backgrounds was needed. They believed that differences in education and culture between doctors and their patients created differences in their ways of thinking. Limited time was an obstacle to effective decision making.

One participant focused on technical standards, considering social, religious and ethical considerations to be of secondary importance:
Firstly is the scientific element, secondly the official element, thirdly might relate to the religious commitment. [Internist (H1)].

7.4.2.5 Level of satisfaction on ethics
Some participants focused strongly on gaining certificates and titles for the sake of social prestige and other benefits. A major concern of doctors in Islamic hospitals was to decrease patients’ financial concerns. They also indicated a strong focus on satisfying the requirements of management and international accreditation.

One participant said that huge numbers of patients and pressures of management as well as personal concerns affected their clinical mission negatively:

We have to relieve the burden on the doctor so that he can focus on his work [GP (H4)].

Table 7.3: Illustrative quotations relating to Theme 1

<table>
<thead>
<tr>
<th>Meaning of ethics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethics are comprehensive and complete, and religion organizes the work of our profession (H1 Emergency, M 36-50 yrs).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ethical approach involves knowing the patient's case and providing complete support to the patient and his family, and involvement in voluntary and charity work (H2, GP, M, 25-35yrs).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Daily activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The honourable Hadith says “If anyone fulfils his brother’s needs, Allah will fulfil his needs; if one relieves a Muslim of his troubles, Allah will relieve his troubles on the Day of Resurrection” (H4, Cardiologist, M, &gt;51yrs).</td>
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</table>

<table>
<thead>
<tr>
<th>Decision tools</th>
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</thead>
<tbody>
<tr>
<td>Actually, there is nothing written as a reference, but it is the doctor’s knowledge, information, experience, personality and his culture, and you have to have the complete vision when doing a medical procedures not just follow a routine (H1, General surgeon, M, &gt;51).</td>
</tr>
</tbody>
</table>
7.4.3 Theme 2: Ethical issues

This theme describes the ways in which participants understood some of the most important issues in Islamic health care in Jordan, reflecting their struggles between traditional values and those encountered from the West. Among the many issues raised by the participants were: privacy and women; confidentiality; the nature of the doctor-patient relationship; organ donation and transplantation; end of life care; and the ways in which the Islamic viewpoint colours the understanding of the questions thereby raised. This theme also describes the nature of communication between doctors and patients in a Muslim society. A description of the eleven subthemes follows. Additional quotations relating to this theme are presented in Table 7.4.

7.4.3.1 Privacy and considerations relating to women

Participants said that there was not enough space or access to suitable environments for patient examinations and discussion. They felt that there was no contradiction between religious and societal norms in relation to respect for women. Participants stated that families could influence the privacy provided to patients. They agreed that additional precautions needed to be taken to match religious and community norms, especially for female patients. Participants stated that relatives considered that it was their right to discuss patients’ conditions with doctors, whether male or female. They felt that managers often interfered with medical decisions, especially in public hospitals.

One participant stated patient that data were often discussed among clinicians without strict controls:
There are some cases where the patient’s privacy is breached when information is circulated among the doctors and the medical staff, nurses and pharmacists [Family medicine (H2)].

7.4.3.2 Confidentiality
Participants stated that doctors often discuss their cases freely in public settings and that there are strong pressures to breach confidentiality, especially regarding female patients. There are no clear instructions or guidelines about how doctors should speak to relatives.

One participant mentioned that “as a tribal community”, Jordanian people always inquire of doctors and clinicians about their relatives’ situations:

One of the problems we face as doctors is that the relatives of the patient keep asking about the patient's health [General surgeon (H3)].

7.4.3.3 Harm
It was regarded as traditional for Muslim physicians to be considered philosophers and wise men and to have a comprehensive understanding about their patients’ concerns. In spite of this it was often stated that patients often complain about financial and social issues; often little respect was shown to medical specialists; and ignorance about the role and functioning of professional institutions was widespread. Many participants felt that unnecessary procedures are frequently undertaken that waste time and money, harm patients and deplete families’ resources.

One participant said that ignorance was the most important ethical issue between patients and their doctors and causes patients harm:

The most harmful practice is to ignore patients and their families and to fail to communicate with them about diagnosis and treatment. [Internist (H3)].
7.4.3.4 Organ donation and transplantation

Complicated issues arise regarding the diagnosis of brain death and cardiac death. Participants agreed that these issues needed to be considered simultaneously from clinical, legal and religious perspectives. However, delays often occurred because of the lack of clear religious guidelines about donation and transplantation. Religious opinions essentially merely repeated that everything is subject to rewards from Allah SWT in the hereafter. Some stated that legislation and technical standards should reflect national agreed standards and should not be able to be changed by doctors or patients while others felt that processes and procedures should be developed that allowed responsiveness to local circumstances.

One participant stated that if no Jordanian guidelines for organ donation or other subjects existed we should draw on the experience of foreign countries:

There was no governmental foundation to organize organ transplantation, but when I arrived here it was still written and not executed. I started collecting documents from all around the world, for example USA, Europe, Turkey, Middle East, including about combating human trafficking [General surgeon (H1)].

7.4.3.5 Withdrawing and withholding treatment

Participants felt that patients’ families had insufficient awareness of the religious, legal and clinical reasons for withdrawing or withholding treatment. There was felt to be no clear view in Jordan relating to such decisions. Participants believed that diverse opinions should be respected in relation to this issue. Generally, they felt that doctors should not kill their patients, even when serious medical conditions existed. In addition to satisfying their religious beliefs they were determined to meet clinical and technical demands.

One participant stated that brain death was equivalent to other forms of physical death but that discussions were needed between doctors and religious men to clarify how to recognise when it occurred:
This subject is very similar to the movement of slaughtered animals which wriggle in pain and will eventually die. The disagreement among the doctors may help define the concept of brain death, in conjunction with the jurists [Endocrinologist (H3)].

7.4.3.6 Abortion
Participants believed that the law of Islam (al-Sharī`ah) should be involved in decisions about abortion. In Islam abortion was prohibited but there was no civil legislation. Mostly, abortion was considered in relation to religious and technical issues, although financial reasons may also be important. There is no strict control on abortion in Jordan.

One participant felt that we should consider technical considerations relating to the mother’s health as of first importance:

I’ve met all of medical specialties and categories of doctors and I found that the abortion decision must be a technical medical decision related to the amount of harm to the health of the mother [Rehabilitation doctor (H1)].

7.4.3.7 Consent
Obtaining consent was described as a process for explaining the steps of treatment rather than a mechanism for ensuring patient protection. The power of doctors was revealed in this idea of consent, which was intended more to protect doctors rather than patients. Male authority was acknowledged to be strong in tribal communities in the Arab world and Jordan.

One participant said that the international community was more systematic, and had strong rules that helped maintain patients’ rights and autonomy:

I am a graduate of Germany, where the consent form includes the patient’s rights and duties, contains four pages, while ours is only a signature from the patient that he accepts to do the surgery. So the consent form which is used in Europe should be followed [Urologist (H4)].
7.4.3.8 Justice

Participants felt that discrimination often occurred through consideration of patients’ class and insurance levels when deciding on the care they would receive. Several stated that more attention needed to be paid to the needs of poor people and minorities. Also, discrimination was said to occur often on the basis of friendship and personal relationships. Some participants stated that in Islam there should be no discrimination in relation to religion, social attitudes or culture, a concept that needed to be taught to medical students.

One participant said that as a tribal community, Jordanians focus on interpersonal relationships:

…Everything ultimately depends on personal relationships and family
[Internist (H2)].

7.4.3.9 Communication

The case loads carried by doctors allowed them to spend only limited time with their patients. One participant said that soothing talk to patients was important to gain the patient’s trust:

I have thirty years’ experience and I can assure you that talking to the patient or his companion especially in emergency cases can gain the patient's trust. Smooth talk between doctors and patients is important for good medical decision-making. [Internist (H2)].

7.4.3.10 Preparation for death

Many participants felt that religious preparations were needed before facing Allah SWT. Also, it was important to share emotions during the dying process and to make all possible attempts to assist patients.

One participant said that Muslims became more religious during sickness:
Religion has a great spiritual relationship to those who get close to death, especially with regard to time and death and patience, which drive them to donate their organs [Endocrinologist (H3)].

7.4.3.11 Limited time
Many participants complained about pressure of work and management demands to see large numbers of patients. One participant said that doctors knew that wasting time caused harm:

I will control the timing and will stop referring the patients to other specialties to avoid crowding [Internist (H1)].

Table 7.4: Illustrative quotations related to Theme 2

<table>
<thead>
<tr>
<th>Privacy and women</th>
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<tbody>
<tr>
<td>I try to maintain the privacy of female cases, especially the young girls so they can get married in the future (H1, Internist, M, 51 &amp; more*).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Confidentiality</th>
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<tbody>
<tr>
<td>Confidentiality is rarely observed... due to overcrowding in governmental hospitals (H1, Ophthalmologist, M, 51 &amp; more).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Harm</th>
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</thead>
<tbody>
<tr>
<td>You have to try to avoid any kind of harm - either medical, social or financial (H3, Endocrinologist, M, 51 &amp; more).</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Donation &amp; organ transplantation</th>
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</thead>
<tbody>
<tr>
<td>In Jordan we have an organ transplantation centre, where they have a consultant in al-Sharī`ah law who participates in all the decisions (H3, Anaesthetist, M, 36-50).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Withholding &amp; withdrawing treatment</th>
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<tbody>
<tr>
<td>A fatwa was issued in 1986 about removing devices from brain death patients by consensus between the family and the doctor, but not for the purposes of organ donation. The devices will not be stopped when patients or relatives oppose (H1, General surgeon, M, 51 &amp; more).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abortion</th>
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<tbody>
<tr>
<td>Abortion might be optional and this is prohibited, except in cases where a fetus has a cerebral deformity and it is impossible for him to live (H4, Family medicine, 36-50).</td>
</tr>
</tbody>
</table>
7.4.4 Theme 3: Religious issues

This theme describes the views of participants about the role of jurists and religious men in assisting the work of doctors, reflecting both a commitment to the role of Islamic law and misgivings about its relevance to clinical decision making. It also explores why doctors believe many patients favour Islamic hospitals. A description of the two subthemes follows. Additional quotations relating to this theme are presented in Table 7.5.

7.4.4.1 The impact of religion

Most participants felt that their patients needed to be sure that all their medical and surgical procedures were conducted according to al-Sharī‘ah and the commands of Allah SWT. Therefore, they felt there needed to be cooperation between doctors and religious departments, but not a rigid process. They stated that religious considerations did not only refer to Islam but that all religions should be considered and respected in ethical decisions. It was felt necessary for medical
procedures to be guided by religious opinion but that religious departments should not have the capacity to diagnose brain death. Generally, it was felt that both science and religion should contribute to balanced opinions.

One participant said that the core of Islam was to reveal the validity of any action, that is, whether it is permitted or prohibited:

Before proceeding, doctors and patients need to make sure that an intervention is halal, “permitted”, and not haram, “prohibited” [Dental surgeon (H2)].

7.4.4.2 Why Islamic hospitals are preferred

Islamic hospitals in Jordan include doctors and religious men (imams) working side by side. Participants believed that segregation of genders is necessary for their work and that this also helps reduce patients’ financial concerns. They claimed that in these hospitals there is no discrimination on the basis of religion, social attitudes and culture.

One participant said that when hospitals are named “Islamic” they have to follow every single aspect of Islam to their patients:

At the same time when we make mistakes, many of the patients blame us and say, "You are an Islamic hospital, so how do you make mistakes?" [Endocrinologist (H3)].

<table>
<thead>
<tr>
<th>Table 7.5: Illustrative quotations related to Theme 3</th>
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<tbody>
<tr>
<td><strong>The impact of religion</strong></td>
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<tr>
<td>The problem is with the gynaecologists to separate the opinions of the science and religion. In general, all should agree on the fear of Allah SWT (H1, Emergency, M, 36-50).</td>
</tr>
<tr>
<td><strong>Why Islamic hospitals</strong></td>
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</table>

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Ethical motivation is the most important factor because of gender segregation, as well as the scientific status of doctors who are working in the (Islamic) Hospital (H3, General surgeon, M, 36-50).

7.4.5 Theme 4: Ethics resources
This theme describes issues participants raised in relation to the teaching of ethics, relationships between Islamic and Western ethics in clinical decision making, the importance of, and difficulties associated with, the promotion of cultural diversity, the role of medical associations in providing resources for the development of clinical ethics in Jordanian hospitals, and other issues. It reflects dissatisfaction about the perceived insufficiency of resources applied to social and ethical aspects of clinical practice. A description of the seven subthemes follows. Additional quotations relating to this theme are presented in Table 7.6.

7.4.5.1 Universities and medical curricula
Participants stated that there was a gap between learning ethics through theory and practice. Theory was not sufficient to develop skills because actual practice in clinical ethics was also needed. Hospital managers in Jordan were said to focus almost exclusively on technical issues while doctors were concerned with technical, social and ethical considerations. Some participants felt that doctors had to discover how to act from their personal experiences by trial and error because weaknesses in curricula did not provide them with relevant knowledge.

In one example, it was claimed that Jordanian universities provided their students with some skills about how to cope with their patients, but that the courses were overall inadequate:

The courses are not enough, maybe because the technical issues must be taught much more, and generally medicine students are not ethically educated [Family medicine (H2)].

7.4.5.2 International (Western) ethics
Many participants strongly supported the strict accountability associated with Western standards. At the same time they expressed loyalty to their Islamic and
Arab traditions, stating that religion and the norms associated with are also needed. There was agreement that international ethical standards were acceptable where there was no conflict with Islam. However, they acknowledged that even in other cases international standards were often useful to help make practical decisions.

One participant stated that similar issues were encountered all over the world and that every country had to respond to the demands of religion and culture:

I don’t think religion is incompatible with global ethics standards. The Prophet Mohammad – peace be upon him – said: “I was only sent to uphold and complement ethical values”. It might sometimes be difficult to apply this because of social and religious differences [Rehabilitation doctor (H1)].

7.4.5.3 Ministry of Health
Participants said that from the point of view of Government departments and hospitals technical issues in health care were always considered as the first and main priority. One participant said that there was no interest in clinical ethics in Jordanian hospitals and no clear criteria for dealing with specific ethical issues:

Unfortunately, the Ministry of Health exercises no influence or control with regard to medical ethics [Urologist (H4)].

7.4.5.4 Diversity
Participants believed that scholars with different experiences should be involved in clinical ethics. For example, it was useful for the Faculty of Medicine to include people from non-medical backgrounds in clinical ethics. Also, they believed that Muslims and Christians should be responsible for their own communities.

Some participants stated that Islam requires non-Muslims to share their knowledge and insights with the Muslim community, and that this would help foster a modern developed community. One stated that religion was necessary but should be considered as of equal importance to technical work:
I prefer the doctor to be a jurist as well as a doctor [Internist (H3)].

7.4.5.5 Ethics committees
Participants stated that in their hospitals there were no committees that specialised in ethical issues, even though the influence of market economics and business was obvious.

One participant said that they may forget that their mission was social, religious, and managerial as well as technical:

> Ethics committees are effective and accurate in the field of research, but they do not contribute to medical and technical decisions or help avoid errors [General surgeon (H1)].

7.4.5.6 Medical associations and syndicates
Participants said that Jordanian doctors’ associations paid more attention to political issues than to clinical ones. They focused on matters such as medical errors, social problems and professional rights.

One participant stated that the focus on technical and financial issues meant there was insufficient awareness of ethical and social issues:

> Unfortunately, there is not enough awareness in the medical unions regarding medical ethics [Urologist (H4)].

7.4.5.7 Training
Many participants felt that better coordination was needed between the academic and clinical sectors. They believed that there was inadequate recognition of the importance of this. Also, they felt that education and training tended to focus on improving technical outcomes at the expense of ethical ones.

One participant stated that ethical judgement should be one of their vital duties:
Yes, it happens during practical training in the hospitals. Adhering to social and ethical norms is part of the evaluation process [Dental surgeon (H2)].

### Table 7.6: Illustrative quotations related to Theme 4

<table>
<thead>
<tr>
<th>Curriculum</th>
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<tbody>
<tr>
<td>Unfortunately, their role is very limited; it's just a kind of individual cooperation but not policies (H1, Ophthalmologist, M, 51 &amp; more).</td>
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<tr>
<th>International and Western bioethics</th>
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<tbody>
<tr>
<td>International ethics is valid globally, but we are in a Muslim country in which we have our traditions and habits, where our families, sons and relatives have a role in the patients’ decisions (H3, General surgeon, M, 36-50).</td>
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</table>

<table>
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<tr>
<th>Ministry of Health</th>
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<tbody>
<tr>
<td>Unfortunately, we do not have a reference or guideline so we have to rely on personal judgments which come through experience (H4, Urologist, M, 51 &amp; more).</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Diversity</th>
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<tbody>
<tr>
<td>It is good to include people with different skills even if the work will be more difficult when non-doctor specialists are involved (H1, Internist, M, 51 &amp; more).</td>
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<thead>
<tr>
<th>Ethics committees</th>
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<tbody>
<tr>
<td>Marketing of medical services should be controlled and we need the committee to help with this (H4, Dermatologist, M, 36-50).</td>
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<tr>
<th>Medical associations and syndicates</th>
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<tbody>
<tr>
<td>The work of the syndicates is weak due to their political positions that affect their role (H1, Pediatrician, M, 51 and more).</td>
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<tr>
<th>Training courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no cooperation between universities and hospitals to promote medical ethics (H1, Gynaecologist, M, 51 &amp; more).</td>
</tr>
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</table>

### 7.4.6 Theme 5: Obstacles and difficulties

This theme describes the most important challenges facing the development of clinical ethics in health care in Jordan, as seen by the participants, mainly in the clinical, social, managerial, legal and tribal domains. It illustrates the disquiet many doctors feel about the rapid changes occurring in their country and the uncertainty surrounding relationships between the Islamic world and the West. Additional quotations relating to this theme are presented in Table 7.7.
Many participants agreed that the medical curricula in relation to ethics are inadequate. These curricula lack a formal, written agenda and have even deteriorated in recent years as a result of increasing work pressures and administrative deficiencies. Some participants stated that they felt many doctors now focused primarily on money and business rather than on providing good care. For them, financial issues had become a major problem in health care in Jordan because there were not controls on costs or charges. They felt that this lack of control had greatly exacerbated ethical problems.

Many participants felt that there was inadequate coordination and frequent tensions between legal and religious decisions. Although the views of religious scholars were respected their recommendations often differed from the attitudes doctors had developed during their training in the West.

Privacy and confidentiality were not sufficiently respected and were often breached. Consent was often understood more as a device to protect doctors than to serve and respect patients’ interests. Some participants felt that relationships between doctors and their patients were becoming weaker and more uncertain. Some doctors stated that they relied on personal intuitions in relation to ethical decision-making rather than applying any systematic approach or appealing to education or public dialogue.

One participant said that misunderstandings often occurred about the role of health care and the demands of the community:

> The culture of the society now differs widely from the culture of official institutions [Internist (H1)].

**Table 7.7: Illustrative quotations related to Theme 5**

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<thead>
<tr>
<th>Quotation</th>
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<tbody>
<tr>
<td>There is little trust between parents and doctors because of what they hear from multiple sources (H3, Paediatrician, F, 36-50).</td>
</tr>
<tr>
<td>The culture of the society differs from the culture of the official institutions. There is a big gap between personal relationships and the ways doctors behave (H1, Internist, M, 51&amp;more).</td>
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</tbody>
</table>
There are many things that we are not allowed to do, whether technically, ethically or religiously, especially if the patient is deformed (H4, Gynaecologist, M, 51 and more).

7.5 Discussion

This study of the attitudes, beliefs and concerns relating to ethical decision-making among health professionals in Jordanian hospitals has drawn attention to a wide range of contentious issues about the operation of the health care system in that country. Doctors’ concerns relate both to patient management and to the wider cultural and institutional environments.

A recurring issue is the relationship between ethical standards applicable in Jordan and those operating in the West, where many Jordanian doctors have been trained. Our data suggest that while the views of the latter about medical ethics overlap with those prevailing in the West and there are many common features between the two approaches there are also significant differences. In particular, Jordanian health practitioners maintain a strong allegiance to the principles and practices of Islamic thought and the ethical framework associated with it, which they recognise are not always consistent with Western (or so-called “international”) standards. This has generated a degree of uncertainty and disquiet which in turn has provoked an ongoing social debate around some key, widely recognised tensions.

More specifically, the participants in our study identified contending forces they consider to be operating in the Jordanian health care environment. These apply in all five categories of topics on which our data were focused. In the domain of ethical awareness, the commitment to patients, acceptance of diversity and the central role of the religious tradition and its concept of hakim (wisdom) were viewed positively, while what was regarded as an oppressive and authoritarian institutional environment, a focus on technical issues to the exclusion of social and ethical ones, and a chronic shortage of resources, were seen as negatives.

Among the specific ethical issues discussed there was ambivalence about how to address questions that have only arisen in the modern setting, such as those
relating to organ donation and transplantation. Many doctors expressed concern and uncertainty about the status of communally-based Arab and Islamic views on consent, confidentiality, autonomy and other issues, in relation to the more individualistic perspectives promoted by Western bioethics. Nonetheless, there was broad agreement among our participants on the importance of including “religious considerations” within the field of ethical deliberation, although views on the actual roles religious figures should play in clinical decision-making varied.

In the discussions about ethical resources the differences were even more marked, with some participants arguing that there were no fundamental conflicts between Western international standards and guidelines and Islamic approaches, and others arguing for a clear separation of the two. There was, however, broad agreement about the need to continue to promote openness to new ideas, and tolerance of competing perspectives, to improve the ethics committee system, and to enhance the leadership role of professional associations and the Ministry of Health. It was universally accepted that training in ethics in Jordan was at present very rudimentary and that a revision of medical school curricula and postgraduate education in ethics was urgently required.

These discussions gave rise to the identification of a wide range of challenges which needed to be addressed if a more informed and mature approach to ethical decision-making were to be possible in the operation of the health care system in Jordan. These challenges included finding a way to shift the focus on economic, technical and managerial aspects of care towards an appreciation of social and ethical issues, to overcome the rigidity often associated with persisting tribal attitudes and belief systems, and to rectify a widely prevalent lack of engagement of patients and families in discussions about the nature and direction of health care.

Some, but not all, of our findings are novel. The deep commitment to Islamic values and the Islamic religion in Jordan is well recognised (Zahedi and Larijani, 2008; Padela et al., 2008), along with the fundamental role of paternalistic, communally based attitudes to decision-making (Nair and Ibrahim, 2015). The
coexistence of these traditional values with an openness to Western attitudes and standards and a tolerance of diverse views has also been recognised (Zahedi and Larijani, 2008). There have been multiple attempts to establish consistent approaches to the connection between clinical ethics and Islam (Gatrad and Sheikh, 2001), although these have at best so far been only partially successful (FIMA, Yearbooks, 2005-2017).

On the other hand, many of our findings have not been widely discussed previously. The deep anxiety among health professionals about what they see as an excessive emphasis on managerial and technical values, in many cases to the exclusion of ethical ones, has not previously been reported. Concerns about an authoritarian culture, which some see as anachronistic, and widespread corruption, nepotism and favouritism, while familiar topics of conversation in hospitals, have not previously been discussed publicly. The lack of consistent ethical standards—about confidentiality, communication with patients, billing practices etc.—which reflect a deficient infrastructure and lack of guidance from government and civil society organisations, is also novel. The enduring role of tribal values, the need to develop and extend the number and roles of ethics committees, and the struggle to establish a process of reconciliation between Islamic thought and culture and Western ethical thinking is also a striking finding. Recognition of the widespread acknowledgment of the deficiency in educational resources for doctors in the domain of ethics and the need for enhancement of capacity among students and graduate health professionals is a major outcome of this study.

Overall, our study has drawn attention to a wider complexity in the relationship between the Islamic world and the West, as seen through the eyes of health care practitioners in Jordan. Jordanian doctors recognise the need for change and acknowledge and respect the developments that have occurred in ethical thought and practice in the West. However, they are determined to preserve key aspects of their traditional culture, which includes both religious and non-religious components. The essential challenge they face is to find ways of accommodating the new perspectives about how to negotiate ethical processes and the dynamics of relationships in the health care context, and the recognition of the central
importance of communication, equity and human rights, without giving up the key religious values and core commitments of their pre-existing culture. This challenge manifests itself as a need for an open dialogue across theoretical and ethical worldviews, which is played out in public conversations around three sets of tension, or axes of contention, which we have previously characterised as “tradition vs. modernity”, “conservatism vs. pragmatism” and “religion vs. secularism” (Obeidat and Komesaroff, 2019; Chuka, 2012; Fins, 1998; Koenig, 2013).

Islam and the West are in a dynamic dialogue which will inevitably lead to change on both sides (Clarfield et al., 2003; Zahedi & Larijani, 2008). An enhanced understanding of the structure of this dialogue, as manifested in our interviews with Jordanian doctors, may assist in facilitating further productive communication. The understanding may also help explain the active processes of ferment within Arab societies over the last ten years (Coutts et al., 2013).

In addition to strengths, this study has some significant limitations. The strengths include its access to medical practitioners in multiple disciplines working in different settings in Jordan, which make it the first comprehensive study of doctors’ views of the strengths and weaknesses of an Arab health care system from an ethical point of view. The limitations relate primarily to the nature of the sample and its focus on a single city in Jordan, and medicine as practised in hospitals only. The study population consisted of health professionals only and did not include community members, patients or their families. Jordan has vast rural areas, and ethnic minorities—such as Bedouins, Druze, Armenians, Circassians and others—whose views were not systematically included in our data. The fact that the interviews were conducted by a single researcher, who was male, may also have limited the outcomes, especially with respect to the interviews involving or relating to women. The lack of pre-existing resources, written protocols and guidelines in clinical ethics has meant that much of the study has been exploratory rather than definitive. Also, the Islamic world is extremely wide and diverse, extending well beyond the Middle East, and the extent to which the conclusions derived herein can be generalised to other counties is uncertain.
In conclusion, this study has drawn attention to a vigorous and dynamic process of questioning among health care professionals in Jordan. It has identified strengths and weakness, and accomplishments and challenges, in the health care system and has given expression to both optimism and pessimism. This perspective has provided a lens that has allowed deep tensions and uncertainties in Jordanian society to be become visible, along with the active manner in which doctors are responding to the challenges confronting them. It has also highlighted key areas in which urgent reform is needed, which may assist both in addressing outstanding problems and facilitating further constructive accommodations across the international divide. Among the main challenges is the need for the development and implementation of curriculum change in order to enhance the development of capacity for ethical decision-making among the emerging generation of health care providers in the country.

Ethical decision making in Jordan and the Arab world is in a difficult state but there are many reasons for hope. The struggle to adapt a rich and ancient body of thought to contemporary conditions and demands has to continue. Hopefully, it will be possible to find a way to practise clinical ethics in Jordan in a fashion that both respects these traditions and responds effectively to the demands of the modern world.

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Competing interests: None.

Consent: Informed consent was obtained prior to the commencement of each interview. Participants consented to audio recording and understood that they could withdraw at any time.
**Ethical approval:** Ethics approval was obtained from the Monash University Human Research Ethics Committee. Local committees in Jordanian hospitals supported the study and were helpful in encouraging doctors to participate.
Section 5
Chapter 8
Conclusion

8.1 Introduction
This chapter summarises the findings of the thesis and presents an overview of some of the key arguments about clinical ethics from a Jordanian Islamic perspective. It describes: key features of the Islamic approach to ethics; some topics relating to Western approaches to ethics from an Islamic viewpoint; overlaps and divergences between the two approaches; and the findings from the quantitative and qualitative studies. It concludes by discussing the implications for, and challenges facing, the practice of clinical ethics in Jordan.

Approaches to ethics from Western and Islamic perspectives both overlap with each other and diverge in important ways, at the levels both of theory and practice. In addition, each of the two bodies of thought contain mechanisms for interacting with contrary viewpoints and for accommodating elements of those viewpoints into their own bodies of thought.

8.2 Western ethics
Key characteristics of Western ethical theories that are relevant for the purposes of this thesis are: (i) its focus on individual agency and rights; (ii) its emphasis on rules, guidelines and principles; and (iii) the reliance on the concept of professionalism.2

As discussed in Chapter 5, contemporary Western bioethics is built around an assumption that individual moral subjects are independent agents who function separately from, and frequently in opposition to, other individuals. This is a familiar concept that has been widely discussed and is a major point of divergence with Islamic ethics.

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2 As discussed, it is not suggested that this formulation should be understood as a comprehensive characterisation of Western ethics.
Western bioethics focuses on human rights. This is individually focused and is dependent on a concept of autonomy as separating individuals from others rather than bringing them together in a communal or cooperative framework. The concept of human rights is based on the assumption that an individual is under threat from others and should be protected by a legislative framework, often supported by an enforcement or punishment system.

The ideas of human rights is closely linked to the individualistic assumption of Western ethics. It is accepted as “self-evident” in this body of thought that people are born equal and have an equal, unqualified entitlement to certain benefits, referred to as “rights”. This assumption lies at the heart of much discourse about clinical ethics and ethical decision making by health professionals. In Western settings, human rights are conceived as philosophical claims that are linked to legal entitlements. While there is an obvious gap between the theory of “universal human rights” and the reality of poverty, injustice and lack of freedom in both developed and developing countries, the concept has a powerful aspirational value and helps shape actual ethical decision making (Laman et al., 2013).

While Islamic thought is generally in agreement with the goals implicit in statements outlining purported human rights, it does impose some limitations. These relate to the requirements of Islam itself, which include some restrictions on behaviour and relationships. As previously discussed, a key example of this are the claims relating to the differences between men and women, which are seen as ontological and generative of ethical judgments, rather than the result of an ethical judgment themselves. In other words, in Islam while human rights are universal they are not unqualified or unconditional and cannot be decided purely within the social, legal and political domains without reference to the religious one.

Consistent with the philosophical structures underlying human rights, Western clinical ethics are often presented in the form of codes of ethics—that is, as quasi-legal statements that in this case are produced by professional bodies or institutions to provide guidance to health practitioners, as well as patients and their families. Here too, the codes are of a secular nature and are presented as
conveying authority based on (usually unstated) philosophical assumptions which in many cases are concerned primarily with the problem of individual “autonomy” and freedom. As discussed below, the codification of ethics in the West follows the model of the codification of legal structures more generally, which stands in contrast to the concept of law and legal process that is central to the Islamic perspective.

Ethical guidelines typically provide guidance about specific topics, often drawing from high level principles and derived by argument and discussion among participating groups. They may set out broad concepts, such as the principles doctors should follow in their decisions or the need for “patient-centred” medicine; or they may focus on particular issues, such as end of life decisions, organ donation and transplantation, and the processes of consent in the clinic or in research.

Guidelines can offer great assistance to clinicians because they provide ready access to the outcomes of detailed, sometimes prolonged, conversations that have taken place within a clearly defined setting—for example, within a particular institution or professional society. Guidelines have been criticised for lacking sufficient detail to allow their application in actual clinical cases, being insufficiently responsive to local circumstances, ignoring the levels of discretion required for individual decision making, and other reasons. (Komesaroff, 2008 and Foster, 2001).

Nonetheless, they are often important and helpful and have become one of the powerful means by which the results of complex conversations are made available to diverse populations. The development of guidelines has not commonly been practised in Arab settings. Nonetheless, it is a conclusion of this study that, especially where the issues discussed are new ones, they may provide useful tools for facilitating significant resources for addressing novel ethical challenges.

Also important for the practice of ethics in the West is the underlying concept of medicine as a “profession”, in which practitioners come together with a common
ethical purpose to share their expertise with patients and the community. (Moore, 2014 and Zieske and Abbott, 2011)

A profession is a sociological framework that includes individuals who “profess” a shared range of competencies which are offered to the public under certain controlled conditions (Martimianakis et al., 2009). The profession forms a community of practitioners within which standards of behaviour are established, cultivated and enforced. Where appropriate, these standards cover ethical decision making which may be articulated in the form of codes of ethics or guidelines. Professions play other roles too, such as in education and in mediating relationships with external parties, including other professional groups and the government (Child and Fulk, 1982).

In the West, the medical profession has a complex history and many critics (Komesaroff, 2008; Illich, 1977). It plays an important role in education, in setting technical and ethical standards, and in negotiating with and advocating to government on behalf of its members. Professions contribute to the development and maintenance of systems of shared values, sometimes linked to disciplinary processes. They provide a context within which discussions can occur about technical and ethical standards, as well as clarifying the boundaries between the practitioners of the profession and those who can provide health or support in other areas. Typically, their educational functions relate especially to postgraduate education and continuing professional development.

One of the key roles of a profession is to elucidate the ways in which doctors interact with other individuals or groups within the society. These groups include families and support organisations, religious groups, and public agencies which can have input into the decision-making process. In this way, professional organisations provide a context for the practice of clinical ethics. The definition of professional roles permits a clear distinction between the roles of clinicians and those of managers and administrators (Benatar, 1997; Candy; 2014; Komesaroff, 2008).
The features of Western ethics just described demonstrate some of the great strengths of this body of thought. They include the explicit acknowledgement and awareness of the importance of ethical considerations in the clinic, respect for individuals and individual differences, the establishment of a domain within which professional dialogues and education can occur, and the development of formal summaries or sets of guidelines that can provide readily accessible assistance for clinical decision-makers.

The recognition of the need for training in ethics and ethics-related skills is a particular strength of Western approaches to clinical training. This is not always achieved satisfactorily and may not take the form of explicit courses in ethics. However, it is usually the case that some instruction is included about communication skills, reflection on the processes of consent, and the concepts of confidentiality and privacy. Multiple other issues, such as end of life decisions, organ donation etc. are also commonly discussed. (Francer et al., 2014; Komesaroff 2008; Komesaroff 2014; and Lakhan et al., 2009).

8.3 Islamic ethics

Despite recognition of its great strengths, from an Islamic point of view the Western approach to ethics also has some key weaknesses. The first and most obvious is its basic assumption of the individual as the absolute and solitary focus of ethical decision-making. The second is the heavy emphasis on a particular style of reasoning that gives priority to principles, theories and consequences rather than to dynamic processes of negotiation and dialogue. A third is a natural assumption that technical issues take priority over social and ethical ones, leading to a fundamental divergence between the consideration of decisions from the patient’s perspective and from that of the wider society.

In all these respects, Western ethics deviates from Islamic ethics, as will be discussed below. In addition, Western and Islamic points of view diverge in relation to how they see the relationships between men and women. Western ethics sees the role of women as an ethical question that is linked to the cultural attitudes prevailing in the broader society. This represents a major divergence
from the Islamic perspective and has significant implications for the how the concepts of consent, confidentiality and privacy are understood from the contrasting viewpoints.

As discussed in chapter 5, Islam incorporates an elaborate structure for identifying and analysing ethical issues, mapping them to the religious tradition, and undertaking an interpretive process to come to a decision. The structure is made up of certain key texts and linked processes. The texts include the Qur’an, the Sunnah and the Ijtihad, which are brought together and realised within the context of the techniques and methods of Islamic jurisprudence, or Fiqh. This structure marks Islamic ethics apart from Western ethics by its embeddedness in process rather than a focus on principles, duties, personal qualities or consequences. It also provides a high degree of flexibility, together with an openness to change and adaptation, within a tightly defined domain of beliefs and values. The outcomes of the interpretative process aim at the creation of basic value distinctions, referred to as the difference between halal, what is permitted, and haram, what is not, and this may occasionally issue in formal proclamations or injunctions, called fatwa.

The role of women is fundamental in Islam—not primarily as an ethical issue, as in the West, but as an ontological one: that is, as a basic structure of being. The distinction between the roles of women and men, in the widest sense not only marks out basic territories that underlie all social and religious life but also actually creates a value related to the idea of difference itself. The distinction is therefore not subject to ethical decisions, to maintain or change it: it is one of the sources of ethical distinctions on which many other structures of social life depend.

From the Islamic point of view, the loss of clarity in relation to this issue in the West challenges fundamental conditions of ethics and society. Where women have no strict territoriality or an environment separate from male invasion, certain topics of conversation are prevented and certain actions become impossible. The question is not one of a difference in value or importance but rather of a basic distinction that allows ethical questions to be identified and decided and a perspective of contrary attitudes and dispositions to be maintained within daily
life. The implications of the Islamic perspective on the fundamental importance of gender differences are far-reaching, extending to the ways in which basic concepts—such as those of confidentiality, privacy and individual identity—are understood, as previously discussed.

In Islam, no inherent distinction is recognised between religious and social norms, as there is in Western thought (Van Aarde, 2018 and Ayatollahy, 2018). In European countries, the separation between church and state has been an important issue since late medieval times and has been increasingly inscribed in law since the Protestant Reformation in the early Sixteenth Century. There is a very extensive body of literature tracing the origins of this doctrine, which was heavily influenced by the thought of the great Christian reformist thinker Martin Luther (Ortlund, 2008). By contrast, Islamic thought and jurisprudence has always assumed the inseparable nature of religion and the state, with no distinction being recognised between the institutions of state power and those of religious authority. This has deeper philosophical and ethical significance because it signifies an assumed continuity between personal experience in everyday social life and the broader value system associated with the structures of the religion. It has been claimed that many of the injunctions of the Qur’an crystallise and preserve the traditions and norms of Arab people established during the jahelleyah (that is, the pre-Islamic era). For example, the obligation to respect parents was clearly recognised during jahelleyah and subsequently acquired the status of a compulsory value via the Qur’an (Ali et al., 2004).

For Muslims, Islam is not merely one set of philosophical assumptions among others. It is understood as the correct and ethically most highly valued pathway in terms of all aspects of life. It is considered to be fully comprehensive, covering all aspects of ethical value. The list of valued characteristics is very extensive, and is not subject to inherent limits. By way of example, it includes: freedom, integrity, trust, justice, loyalty, equality, privacy, confidentiality, charity, forgiveness, tolerance, honesty, kindness, fulfilment of promises, modesty, humility, patience, decent speech, sincerity, respect for elders and anger management. While this list clearly overlaps with accounts of virtues recognised within the Western tradition,
it is important to recognise that within Islam there is no formal process of codification to which the elements are subject and the values themselves are not inscribed in a system of principles or overriding statutes in relation to which they can be scrutinised. Rather, the force of an individual value, and its relevance to a particular situation, is established through the application of the processes of Islamic jurisprudence taking into account local contextual variables.

A consequence of the comprehensive and fundamental status of the Islamic belief system is that its adoption, and the processes for addressing and resolving community issues within it, are not seen as just one choice among others. Instead, the system is seen to constitute and make possible both community life and individual experiences within it. In other words, it is understood as a condition of possibility for both truth and ethics. This has two consequences. On the one hand, Muslims must adopt the basic precepts of Islam and follow the processes it sets out if they are to gain rewards and avoid sin in both the present life and the hereafter (Hedayat, 2007; and Tavakoli et al., 2015). On the other, the obligations associated with Islam are seen to penetrate the most distant and mundane aspects of everyday life. Unlike Christianity, which assumes a separation of morality and “profane” social existence (Brown, 2001), in Islam every human activity, no matter how small or incidental, is considered to be deeply imbued with religious experience (Ayatollahy, 2018).

The obligations associated with the Islamic belief system extend to all areas of life. This, of course, includes the field of health care, where Muslims are obligated to consider all the issues arising therein from the point of view of Islamic law. This applies to all the participants in the process, whether they engage as patients, health care professionals, family members, government or hospital administrators, or religious advisors. In any health setting, all those involved must consider their personal obligations, both to each other and to God, as set out in the doctrines and traditions elaborated in the accumulated texts and collective knowledge of their religion and culture.
8.4 Openness and flexibility of Islamic ethics

Islam therefore—understood as a broad complex of beliefs, cultural dispositions, traditional practices and ontological assumptions—sets out an elaborate, complex, fixed, and admittedly somewhat rigid, system for regulating ethical decision making. However, despite the rigidity there is also a great deal of flexibility.

*Ijtihad* is a dynamic law which arises from a multi-faceted, open process. In addition, Islam encompasses different approaches to the methodologies of jurisprudence to derive laws from the primary sources. These include the use of case law—that is, the application of previous decisions adopted as legal precedents—and the issuing of *fatawa*. The traditional view has been that the laws must be regarded as contextual and responsive to culture and historical change, just as the underlying principles on which they are based are universal and enduring. However, discussion of a more radical nature has also taken place about the need for a new *fiqh* suitable for the modern world (Al-Attas, 1978 and Al-Faruqi 1982).

Whatever the outcomes of these discussions, in the context of health care, important issues and problems must be able to be assessed and considered in broad and open terms in accordance with Islamic principles. The Islamic ethical construction also helps guide the balancing of patients’ needs and the demands of community norms, including civil law and tribal traditions.

The tools, and the flexibility of the interpretative process that is applied to it, provide a diverse range of ethical resources. These can be applied creatively to new and old problems. They can also be used to evaluate generously ideas and materials that derive from outside Islam, including ethical guidelines developed in the West to respond to the demands of new technologies and novel, globalised social relationships.

In Islam as in the West, doctors have their own beliefs and personal value preferences which can differ widely and may be hotly contested. They also recognise the need to exercise sensitivity in communicating their views and responding to those of others—including patients, families and other health professionals—when negotiating ethical decisions. This is especially the case
when other religions and cultures are involved. While Muslims may be strongly committed to their own belief systems they fully recognise and respect the fact that non-Muslims see the world differently and on occasions may reach different, even at times contradictory, ethical conclusions.

In relation to particular ethical views, in some cases, the interaction between Islamic and non-Islamic views is straightforward. Where there is no conflict with established Islamic doctrines, complete openness is usually possible. This often applies to issues and problems arising in new technological fields on which the traditional texts and proclamations are silent, such as genetic research, assisted reproduction, organ donation, and the use of computers and big data. Many, if not most, guidelines developed about novel ethical issues fall into this category and so can be employed as useful resources to assist decision making in Islamic countries. This inherent flexibility of Islam is an important resource that is readily available to doctors, other health professionals, management, ethics committees and others to share their experiences and develop common approaches to new challenges.

Furthermore, Islam has always been committed to the development of science and where scientific facts or evidence are involved a conflict is unlikely to arise. Indeed, it is assumed within the Islamic religion that there is a deep obligation to increase knowledge in order to allow its insights to be able to be applied for the benefit of patients (Padela et al., 2011a; Safi, 2006; Hoodbhoy, 1991; and Cassileth et al., 1980). This means that even in their ethical discussions, Muslim practitioners are strictly accountable to the principles of science and scientific evidence. These principles are the same in Islam and the West and therefore must underlie and guide all decisions that are made in relation both to technical clinical questions and ethical ones.

By its nature, therefore, and perhaps in contrast to views commonly held in the West, Islamic ethics maintains a deep-seated openness to philosophical perspectives of broad scope. The method of Islamic ethics and jurisprudence—which incorporate the three elements of an ontological starting point relating to
the nature of individual and community, a fundamental commitment to the differences and distinctions inherent in everyday experience, and the application of a deliberative process of reasoning conducted through language—offers a powerful, profound resource that can be adapted to highly variable cultural settings.

Because Islam does not distinguish between the public, private and religious domains, the structures and processes of ethical reasoning translate directly into civil law and ordinary, mundane daily practices. These include all aspects of health care, including clinical, ethical, legal, social, political and religious. Because of the flexibility built into Islamic approaches to ethics, doctors in Muslim countries are often able to accommodate tensions and discontinuities and to respond to new challenges. Notwithstanding this, these responses are not always easy, as the empirical studies described in Chapters 6 and 7 have so clearly shown. Arab society is beset with fundamental tensions with which health professionals have to grapple and which often cause both uncertainty and anxiety.

8.5 Findings of empirical studies

The two studies conducted in the course of this project have examined the concerns about ethics and ethical issues among medical professionals in Jordanian hospitals.

The studies have highlighted particular areas of disquiet relating to multiple aspects of the nature and operation of the health care system. These include relationships of doctors with patients, their families, hospital administrators and religious authorities, the organisational culture of the health system and its perceived deficiencies, specific ethical issues, including those that have arisen in response to new technologies or pressure from the West, and issues relating to the lack of education and support for practitioners at all levels of their careers.

Specific areas of concern encompassed administrative, ethical and social factors. The administrative factors relate to overcrowding, inadequate resources, insufficient support, widespread corruption and hierarchical, non-democratic, management practices. Ethical issues include the changing roles of traditional and
modern ways of understanding approaches to ethics, consent, organ donation, confidentiality, privacy, abortion, and the role of women. Social factors refer to the role of religion and religious authorities, the relative importance of the family, community or tribal obligations, and the impact of global culture and standards of practice.

Our studies found that Jordanian doctors do not clearly distinguish ethical issues as they arise. Because of the all-pervasiveness of religious concerns no distinction can be made between the spheres of ethics and religion, and much time is spent trying to establish that a proposed course of action is compatible with Islamic law.

Health professionals fully accept the broad meaning of “health” as encompassing all aspects of physical, social, cultural and psychological well being and they recognise the importance of extended family and the community based considerations. They pay careful attention to their behaviour and language when communicating with patients and families and are sensitive to the need to build trust and avoid any appearance of arrogance or superiority. On the other hand, it is also widely considered that patients and their families have limited knowledge about medical issues and that their contributions to decision are therefore limited. In the spirit of the paternalism that is well-established in both Jordanian society and Islam, doctors often assume that their judgements should be accepted without question.

At the same time, major concerns are expressed about government and hospital management practices, which are said to be characterised by corruption, favouritism, nepotism and other adverse practices. Doctors’ workloads are often excessive and hospitals are under-resourced. Management decisions are often bureaucratic and peremptory and doctors feel undervalued. These problems are reflected in the conduct of clinical practice. Many of our participants felt that, despite the requirements of Islamic law, major lapses occurred in relation to patient privacy and confidentiality. Confidentiality is frequently breached for administrative and social reasons, such as teaching and friendship. Patients may not be told about their diagnoses, which are instead
conveyed to relatives and families. Consent to medical treatment is rarely sought. It is common practice for practitioners to use consent forms merely for their own protection rather than as a mechanism to discuss the clinical or ethical issues openly with their patients.

Lack of training and guidance in relation to novel and complex ethical issues—such as abortion, organ donation and transplantation, brain death, withholding and withdrawal of treatment and consent—uncertainty and conflicts are common among practitioners. Often the conflicts extend to include patients and their families, hospital management, and religious and legal authorities. On occasions, individual parties act alone in attempts to resolve problems, thereby increasing or intensifying conflicts. Together, these factors lead to a lack of trust between doctors and their patients and patients’ families which on occasions manifests itself in violence. Perhaps because of these uncertainties, and because of the underlying confidence Jordanian people have in their religion and religious authorities, patients often express their preference for Islamic hospitals over the more secular public ones.

Many Jordanian health professionals were trained in the West and have some familiarity with Western approaches to ethics and clinical practice. They are aware of international ethical guidelines and may refer to them informally when they feel they need assistance in confronting ethical issues they have not previously encountered. This is considered useful for matching standards between Jordan and the West. However, in the absence of more formal mechanisms for considering ethical issues, including the absence of effective ethics committees, the proliferation of guidelines based on an opposing set of cultural and ethical premises also can create confusion, uncertainty and anxiety.

Together, these findings highlight profound divisions and widely differing perspectives among Jordanian doctors and an abiding sense of uncertainty and instability within the profession. Clinicians experience widespread dissatisfaction with the existing system and modes of practice and little unanimity about how to address the problems. Doctors are aware of international trends in relation to
ethical philosophies and principles but are divided about their applicability to Jordanian society. Despite their insight and often diverse experience, many express ambivalence in relation to traditional precepts, such as the treatment of women, and the role of community and family members in decision-making.

8.6 The tensions confronting health professionals in Jordan

The divisions and uncertainties experienced by Jordanian health professionals can be summarised under the headings of three key sets of tensions. As discussed, these are tensions between “tradition and modernity”, “conservatism and pragmatism” and “religion and secularism”. The tensions have arisen in response both to internal challenges within Jordanian society itself and to external global economic, political and cultural forces. As well as describing the predicament of contemporary Jordanian society, health care and ethics, these tensions draw attention to fundamental structural features within Islamic ethical thought and its associated worldview. An understanding of the tensions provides a schema for addressing some of the key challenges facing health care in Jordan and Jordanian society more generally.

The tension between tradition and modernity relates to contending concepts of reason between Islam and the West. As shown by the basic concepts underlying Islamic law, the system of reasoning that is applied is quite different from the deductive system of logic that has come to dominate in the West since the European Enlightenment (Komesaroff, 2009). In the Islamic tradition the law is seen as the embodiment of the Divine Will and methods of elaborating it are understood as interpretive analyses that are conducted according to regulated processes of dialogue and negotiation.

For Islam, the principles and outcomes of reasoning call up and remain continuous with the long history of the culture on which it is based. Although what was done in the past does not inevitably compel repetition or preservation, respect for the decisions of past generations emphasises the historical durability and universality of those decisions. It is of the nature of Islamic thought that it draws on precedents and establishes a consistency with the pre-existing body of knowledge and
wisdom (Arkoun, 2003; and Siddiqui, 1997). This is quite different from the concept of reason that has prevailed in the West since at least the Eighteenth Century, according to which reason is a device to secure freedom for individuals and to exert control over both nature and other people (Komesaroff, 2008). Much of Western medicine assumes and draws on the Enlightenment conception of reason. Islamic doctors have to establish their own balance between these two concepts of reason.

The tension between “religion and secularism” refers not to different models of reason but to different concepts of power. As discussed above, in the West a clear distinction is drawn between religion and the state, which separates institutions of authority and power within the societies. Islam does not recognise this distinction, as a result of which all aspects of life, no matter how public or how private, are subject to the authority of the religious law. While from a Western point of view this is seen as limiting individual freedom and opposing pluralism and diversity, from the Islamic viewpoint it is the condition that imbues all aspects of life and experience with meaning and value. Contemporary societies—that of Jordan included—contains multiple poles of authority and interest, among which are those of doctors themselves, as well as the managers of hospitals and patients and their families. In addition, there are many settings in which the ancient religious knowledge no longer applies. Accordingly, health practitioners in Jordan struggle to find the correct balance between these two polarities.

Finally, the tension between “conservatism and pragmatism” refers to opposing models of social action. On the one hand is that based on a formal method of interpretation associated with rules, traditional practices and an historically embedded archive. On the other, is the possibility of shifting perspectives, analytical approaches and interpretive tools according to circumstances and needs. As a body of thought closely based on ancient texts and an elaborate array of ethical and legal precedents generated from them, Islamic thought and culture tend to be in this sense deeply conservative. This is the case, even though, as mentioned above, contending methodological approaches exist, and at times even radical change can be contemplated. Although in the West there is often also
strong resistance to change there are nonetheless powerful currents of thought that recognise the possibility of fundamental transformations in knowledge systems, as have been widely recognised in the development of Western science (Komesaroff, 2009). The third tension confronting health professionals in Jordan is that presented by the need to acknowledge different centres of ethical agency and the associated methods of social engagements associated with them.

8.7 Strengths and limitations

There have been few previous academic studies of clinical ethics in Jordanian hospitals, including the views of health care professionals about its nature and current role and future hopes about how it might develop. This study has clarified the role of Islam in relation to health care ethics. It has sought to identify obstacles and challenges facing the future development of clinical ethics in Jordanian hospitals. Its results can, to a significant extent, be generalised to other Arab cultures and Islamic societies.

Limitations of the study relate largely to the relative lack of resources, written protocols or guidelines on which it has been able to call, in clinical ethics in Jordan or in other Islamic settings. In addition, the sample population for the empirical studies was limited, consisting of health care workers in selected hospital settings in Amman. It excluded other health care settings, both within Jordan itself and more widely. There was only limited representation of practitioners from poorer areas, ethnic minorities (such as the Jordanian Bedouin population) and refugee communities. The military hospitals in Jordan, like the Royal Service Hospitals, differ from those studied here in some important bureaucratic respects. This raises questions about the representativeness of the sample, possible biases thereby introduced and the extent of the applicability of the findings.

The outcome of the quantitative study was used to guide and direct the qualitative project, including the open questions in the quantitative study that could be considered qualitatively. The reason for conducting the quantitative study first was to reveal the initial impressions of medical professionals towards clinical ethics, including both juniors and senior doctors. These impressions
enabled the researcher subsequently to explore the deep story of clinical ethics by interviewing in detail highly expert professionals rather than relying on the more superficially stated opinions from the whole sample. In view of the complementarity of quantitative and qualitative methodologies, however, it is possible for this iterative process to be continued and for the qualitative phase to be followed by a larger, more comprehensive quantitative survey. Such a survey could be potentially be undertaken in a future study.

Finally, it is appropriate to re-emphasise the following points: (1) this thesis does not presume to provide a definitive exposition of the significant features of, or differences between, faith traditions regarding clinical ethics; (2) for the purposes of this study, Islam is understood not merely as a set of religious propositions or beliefs but as a more generalised ethos or way of life, as discussed in the text; (3) it is not suggested that an effective program in clinical bioethics would be regarded as sufficient to address or resolve the full range of outstanding issues in health care in Jordan or elsewhere; (4) in Islam, as in the West, solutions or conclusions are rarely final or definitive, but rather should be seen in a fluid and evolving context of continuing reflection and dialogue.

8.8 Some suggestions for reform

Certain conclusions about the most favoured direction of change within the Jordanian health system may be modestly inferred from the empirical and theoretical findings of this study.

There appears to be room for Jordanian doctors to pay more attention to the needs and interests of their patients. This may include doctors adopting a view of themselves as servants of their patients, families and their surrounding community. More attention may be paid to involving patients in clinical and ethical decisions. Hospital management may consider empowering doctors to give greater priority to patients’ interests over the calculation of profit and loss. Medical insurance may be extended to cover all people, to bridge the gap between public and private patients and enhance the justice of health care distribution.

Jordanian doctors may consider paying more attentions to their relationships with
their patients and their patients’ families. Adequate documentation of medical procedures and investigations may enhance clinical accountability and protect patients’ rights. Consent processes and approaches to privacy and confidentiality should be developed to reflect ethical, religious and social values.

Specifically, regulations should be introduced to enhance confidentiality and privacy, by protecting patient data and strengthening criteria relating to use in academic settings. Security of electronic data should be increased. Steps should be taken to ensure that confidentiality is not breached in teaching settings or in relation to personal interests and relationships, including through inappropriate communication between patients’ relatives and doctors. Such reforms would be facilitated by addressing overcrowding in hospital wards and emergency departments and providing sufficient and appropriate space for clinical assessments.

Uncertainties relating to abortion may be addressed by clarification of regulations and religious and technical roles. Conditions and processes relating to organ donation and transplantation also require clarification, with a specific need to limit the operation of commercial interests. The definition of brain death should be made precise and its religious, spiritual, judicial and social implications considered. The manner in which death and grieving are discussed and communicated by health care workers in general should be improved.

Religious and social considerations should be included by doctors in the management of their patients. The formation of committee of experts in religious and legal issues may facilitate this. Jurists should work more closely with doctors to respond to ethical issues.

Improved training is needed for Jordanian doctors in clinical ethics, covering how to deal with patients, their families, management, colleagues, clinicians, local norms, and religious and international demands. Doctors should receive training in Islamic affairs as well as technical and international standards. Clinical ethics should be taught to medical students and clinicians and medical curricula should be expanded to include a compulsory ethical component.
Clearly defined ethical standards in the form of explicitly stated codes and guidelines should be established through collaborations involving the Ministry of Health, clinical institutions, professional syndicates and medical associations. Health care standards should be aligned as far as possible with those developed in the West, taking into account differences relating to cultural norms and ethical principles.

Ethics committees should be established in Jordanian hospitals and their principles and processes of operation clearly defined in public documents. The primary purpose of such committees should be clearly stated to be the protection of patients’ interests rather than those of doctors or of a commercial nature.

8.9 Suggestions for further research

Further studies are needed to explicate more clearly the details of the relationship between clinical and religious perspectives in health care in Islam. Of particular importance is the extent to which the Western experience can be adapted or applied in Islamic settings. Studies are needed to clarify further the relationship between juridical and clinical perspectives. As mentioned above, further clarification is needed regarding a wide range of ethical issues, including organ donation and transplantation, abortion, brain death, withholding and withdrawal of treatment and other aspects of end of life care.

This research has focused primarily on the perspectives of doctors. Further studies are needed to extend the findings to the fields of nursing and allied health and to include the views of patients, their families and the broader community. A specific issue of relevance to Jordan is the clarification of different standards and principles of operation of military hospitals in comparison with other health care settings in the public and private sectors.

8.10 Conclusions

8.10.1 Islam and Western ethics

This thesis has argued that despite clear differences between Western and Islamic
ethics there are also many overlaps. Further, while Islam does incorporate some fixed assumptions—about the role of religion, women, the relationships between individual and community etc.—as a body of thought it is open to accommodating ideas and ethical viewpoints from other traditions and viewpoints.

This means that where issues arise about which no formal doctrine exists there is much scope for drawing on ethical guidelines originating in the West. However, in these cases a process of transcription of the ethical viewpoints into Islamic contexts is still required. Indeed, the recognition of the concept of guidelines itself reflects such a transcription. This process of translating across the cultures and philosophical systems is not always straightforward and on occasions requires detailed dialogue and scholastic work to achieve it. At the least, the key, fixed value components of Islam need to be complied with, covering both religious and social norms and preserving the primary emphasis on community, family and the broader social context.

For example, a Western guideline on obtaining consent for donation of organs of a dying patient may be expressed in terms of individual autonomy and the problem of overcoming the barriers created by the need to obtain agreement from the patient’s family or next of kin. From an Islamic viewpoint the proposed recommendations would need to be interpreted within a framework of community-based communication and in a manner that ensured consistency with concepts of personhood and bodily integrity in the sacred texts. While the outcomes may turn out to be the same the processes for generating them and the justifications taken to underpin them may, therefore, be very different.

In addition to this technical process of translation across theoretical and ethical paradigms, Jordanian doctors have to engage with the fundamental tensions confronting Jordanian society in the domains of reason, power and social action. Not surprisingly, this entire process often imposes significant pressures and creates substantial discomfort.

8.10.2 Opportunities and challenges
This thesis has revealed opportunities for the development of the ethics of clinical
practice in Islamic societies, as well as some obstacles and challenges. The opportunities derive from the rich tradition of Islamic thought itself, the fertile resource of Western ethics and the openness of the Islamic perspective to adaptation, accommodation and change. The challenges derive from the fixed values and requirements of Islamic culture and the multiple tensions within the realms of theory, power and action that permeate Jordanian society at the time of a rapidly changing, globalised world environment.

There are some specific challenges to which this work has drawn attention that will need to be addressed within Jordan, and perhaps more widely. These include the development of training programs in clinical ethics of both a theoretical and practical nature that are suitable and appropriate for an Islamic environment. They include the need for improved processes for consultation across the relevant disciplines, such as medicine, ethics, law and religion. They include improved communication among all these parties and patients, families and community members.

There is a need for the development of improved support services for doctors working in clinical settings. These may include clinical ethics services, a more effective ethics committee system and more positive and deliberate guidance from professional bodies and hospital management. As has been discussed in this thesis, this guidance may draw from Western resources, although the process of adaptation to the local environment will remain unavoidable.

Particular attention needs to be given to the problems of consent, paternalism, confidentiality and privacy. While these have meanings in Islamic societies that are quite different from those in Western settings, it is often the case that they are breached or disregarded altogether. A clearer view of the appropriate values involved is needed, along with the training and support services necessary to implement them.

Regardless of changes in the areas described above, deep problems in the internal culture of medicine, hospital management and social organisation more generally will undoubtedly remain. It is to be hoped that the development of a heightened
ethical awareness and greater competence in addressing ethical problems will be able to contribute to addressing these issues too.

8.10.3 Concluding words

In spite of the rich heritage of famous physicians, ethicists and philosophers in Islamic history, work remains to be done to develop a comprehensive approach to clinical ethics that is suitable and appropriate for the modern world. The outstanding task is a complex one, because it requires taking into account multiple factors. These factors include the social, cultural and political domains, the philosophical and religious bodies of thought involved and the diverse interests of the multiple stakeholders in any clinical encounter.

This thesis has stressed the rich resources contained within the tradition of Islamic ethics, the central role of community-based values, the focus on processes rather than principles, values or outcomes, the openness and flexibility of Islamic thought in the face of its commitment to fixed and unchanging values, the overlaps and divergences between Islamic and Western ethics, the possibilities for Islamic countries to draw on Western formulations of ethics as a resource, the overwhelming and irreducible importance of religion in Arab countries, the multiple tensions confronting Jordanian doctors, and the challenges of tribalism, corruption and other deep-seated social problems. The deep concerns and commitment of Jordanian health professionals have been described, along with their hopes for change and their identification of the major obstacles that need to be confronted.

The work has identified the need for a more modern educational process which may contribute to the development of a robust, responsive culture of health professionals with adequate competence in clinical ethics. It is hoped that this thesis will make some contribution to the achievement of this goal.
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Appendices

Appendix 1: Ethics Approval from Monash University

Monash University Human Research Ethics Committee

Approval Certificate

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the National Statement on Ethical Conduct in Human Research and has granted approval.

Project Number: 1603
Project Title: Clinical Ethics from the Islamic Perspective: Proposed Strategy for Health Service Management in Jordan
Chief Investigator: Professor Paul Koniaris
Expiry Date: 12/04/2022

Terms of approval - failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.

1. The Chief Investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst your hold a position at Monash University.
3. It is responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any unobtrusive or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Exploratory Statement must be on Monash letterhead and the Monash University complaints clause must include your project number.
6. Amendments to approved goals including changes to personnel must not commence without written approval from MUHREC.
7. Annual Report - continued approval of this project is dependent on the submission of an Annual Report.
8. Final Report - should be provided at the conclusion of the project, MUHREC should be notified if the project is discontinued before the expected completion date.
9. Monitoring - project may be subject to an audit or any other form of monitoring by MUHREC at any time.
10. Retention and storage of data - The Chief Investigator is responsible for the storage and retention of the original data pertaining to the project for a minimum period of 5 years.

Thank you for your assistance.

Professor Nip Thomson
Chair, MUHREC
CC: Mr Ali Obeidat

List of approved documents:

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Appendix 2: Supervisor Letter to the Minister of Health – Jordan

MONASH University
Office of the Pro-Vice Chancellor
Peninsula Campus

Paul Komesaroff MR, BS, BSc (Hons), PhD, FRACP, AM
Professor of Medicine

11th April 2017

His Excellency, Dr Mahmoud Al Sheiyah
Minister for Health
Jordan

Dear Dr Mahmoud Al Sheiyah,

It is my pleasure to introduce Mr. Alas Obeidat who is undertaking studies towards a PhD in the Faculty of Medicine, Nursing and Health Sciences at Monash University in Australia.

Mr. Obeidat wishes to conduct a study in Jordanian hospitals entitled: "Clinical Ethics from the Islamic Perspective: A Proposed Strategy for Health Service Management in Jordan". This study aims to explore the nature and content of ethical decision making in Jordanian hospitals. In addition, it aims to develop practical strategies to enhance ethical practices in clinical settings in Jordan. Participants will include practising clinicians in different disciplines and professional settings, including medical students. Data collection will take the forms of completion of a survey (which will take 10-15 minutes) and participation in a semi-structured interview (which will take up to 40 minutes). Participation will not be associated with any significant risk.

I would be grateful if you could kindly provide whatever assistance you are able to offer to Mr. Obeidat to ensure that his study is conducted successfully and for the benefit of the health care sector in Jordan.

The project has received approval from the human research ethics committee of Monash University and will be conducted strictly in accordance with the ethical standards required by the university. I confirm that all the data to be collected, including in surveys and semi-structured interviews, will be dealt with in the strict confidentiality and will be used only for academic purposes, research and the development of ethics teaching curricula.

If further information is required I will be pleased to provide it at any time.

Kind regards,

Professor Paul Komesaroff FRACP, AM
Academic supervisor

Please address correspondence to: Private Consulting Suites, The Alfred Hospital, Commercial Road, Prahran, Victoria 3181, Australia; telephone: +61 417 51 20 29; e-mail: paul.komesaroff@monash.edu
Appendix 3: Survey to Hospital Doctors- English Version

A. Demographic Data

Please mark (x) against the most appropriate answer:

1- Please specify your age category
- 21-29 □ 30-39 □ 40-49 □ 50-59 □ 60 and more

2- Sex
□ Male □ Female

3- Marital status
□ Single □ Married □ Divorced

4- Years of experience ( )

5- Specialization ( )

6- Name of hospital ( )

7- Position:
□ Medical student □ Resident Doctor □ Team leader □ Manager

8- Academic qualification
□ Less than Bachelor □ Bachelor □ Master □ Doctorate

9- Please mention the name of your university and the country of your study

University ( ) Country ( )

10- Religion: □ Islam □ Other

11- Nationality: □ Jordanian □ Other
Part B: Questions

Please choose the most appropriate answer that may reflect your own perspective towards practicing the clinical ethics at your hospital

1- In general, would you say the clinical ethics at your hospital?
   - Good □ Fair □ Poor

2- How you would rate your awareness about clinical ethics in Jordanian hospitals?
   - Good □ Fair □ Poor

3- How you evaluate the ethical decision making at your hospital?
   - Rational □ Moderate □ Hesitant

4- What are the ethical basis being considered at your hospital?
   - Scientific □ Religious □ Social and others

5- How you define Clinical ethics:
   - Right and Wrong □ Legal or illegal □ Fair or Evil

6- Have you studied clinical ethics at the University?
   - Clear and complete □ Somehow □ Weak

7- I believe in Global Clinical Ethics to be demonstrated in my hospital:
   - Agree □ Neutral □ Disagree

8- I prefer that clinical ethics should be related to Islamic considerations:
   - Agree □ Neutral □ Disagree

9- I prefer that clinical ethics should be related to scientific and intellectual considerations:
10- I prefer that clinical ethics should be related social norms and traditional considerations:

11- I prefer that clinical ethics should be mutual from the diversity of scholars, clinical and non-clinical bodies:

12- I think that following both Qur’an and Sunnah as well as Ijithad of Muslims is suitable in ethical decision-making:

13- I can evaluate the effectiveness of ethical committees at the hospital as:

14- I prefer to consult the religious men (Muslims) before taking some ethical considerations:

15- In my hospital, some useful protocols and guidelines may help in ethical decisions:

16- The informed consent at my hospital could serve the meaning and considerations of clinical ethics as:

17- I prefer to have some further discussion and open communication with my patients before taking the ethical decision:

18- I believe that the concept of justice is being demonstrated at my hospital:
19- I believe that doctors are causing harm against their patients in terms of clinical setting:

20- I believe that doctors are causing harm against their patients in non-clinical settings:

21- Generally speaking doctors are always serving their patients’ interests rather than any different interest:

22- In this hospital I believe that the interventions of abortion are being conducted according to Islamic basis and regulations:

23- In this hospital I believe that the interventions of organ transplantation are being conducted according to Islamic basis and regulations:

24- In this hospital I believe that wearing hijab for women is being appreciated and respected from my own perspective:

25- There are visible considerations while male doctors examining female patients to match the Islamic demands and regulations

26- There is some specific considerations and preparations regarding death according to Islam demands and requirements:

27- Patients trust their doctors in this hospital:
28- In this hospital, doctors are respecting the confidentiality of their patients in terms of securing data, keeping secrets and trust communication:

☐ Agree  ☐ Neutral  ☐ Disagree

29- There are visible considerations and interventions confirming that doctors are respecting their patients’ privacy in terms of physical environments and territoriality:

☐ Agree  ☐ Neutral  ☐ Disagree

30- The informed consent is being practiced properly according to the demands and regulations of Islam

☐ Agree  ☐ Neutral  ☐ Disagree

Part C

Please write some words that may reflect your own opinion towards clinical ethics at your hospital and the obstacles that could be appeared:

Your opinion ……………………………………………………………
……………………………………………………………………
……………………………………………………………………

Obstacles ……………………………………………………………
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……………………………………………………………………

Thank you

Ala Obeidat, the researcher
Appendix 4: Survey to Hospital Doctors- Arabic Version
وصف الدراسة (العربية)

أشكركم على ذلك. والمعلومات في هذا البرنامج تأتي من مصادر معتمدة. إذا كنت بحاجة إلى مساعدة في المشاركة في هذا البرنامج، يمكنك الدخول إلى الموقع الإلكتروني للشركة وتلقي المساعدة.

ما هو هدف هذه الدراسة؟

هدف الدراسة هو دراسة طبيعة وتوزيع الازنات المختلفة في المناطق العربية، وذلك للإجابة على الأسئلة التي تتعلق بتأثير الازنات على الصحة العامة.{

هدف الدراسة في هذا النموذج هو معرفة الازنات المختلفة في المناطق العربية، وذلك للإجابة على الأسئلة التي تتعلق بتأثير الازنات على الصحة العامة.

تتضمن هذه الدراسة عدداً من الأسئلة التي تتعلق بتأثير الازنات على الصحة العامة، وذلك للإجابة على الأسئلة التي تتعلق بتأثير الازنات على الصحة العامة.

هذا النموذج يتناول في هذا النموذج عدداً من الأسئلة التي تتعلق بتأثير الازنات على الصحة العامة، وذلك للإجابة على الأسئلة التي تتعلق بتأثير الازنات على الصحة العامة.

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لكلًا: مفهوم قبض الجريمة على الأسلحة النارية:

- كيف يتعامل الأطباء مع الخصائص الإستراتيجية في افعال الجريمة.
- ما هي أثر الآثار الأخلاقية التي تزودها الأسلحة في الاعتداءات.
- ما هو التأثير الإضافي في الشغل القياعي الإستراتيجى في افعال الاعتداء.
- ما هي السمات المدنية للطبيعة والطبيعة في الحقيقة الإستراتيجية.
- ما هي النزاعات الإستراتيجية لل自然而 المتزعجلين في الاعتداءات الطبيعية والطبيعة.
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الاستبانة (Survey)

العنوان:

و بعد قراءة وصف هذه الدراسة يحترم:

الأمثلة العلمية من وجهة نظر إسلامية، استراتيجيات متوفرة لتطوير إدارة الأمراض الصحية.

في الأثناء تهدف من خلال التحكم والإجابة على هذا الاستبانة والتي تتكون من ثلاثة أجزاء وهي:

المؤشرات الإيجابية، أسئلة الدراسة وكذلك أنظمة الشخصيات والمشاركة، والتي تعكس

وجهة النظر فيما يتعلق برسالة الفتيان الإيجابية في المنظورات الأدبية، فيما أن البحث

المستقبل لإجابة على هذه الاستبانة هو 10 نقاط وسوف تعليم الإجابة ببساطة نداء وذلك

الإجابة الأكاديمية والبحث العلمي.

يجب أن يأتي من الإجابة على هذه الاستبانة يجري التحكم بإجابتها إلى سيطرة القسم في المختصرة.

التي تعمل بها ليتسنى ليتحاول جمعها بسهولة.

ولقد تم المعلومات يجري الإتصال مع الباحث غامرة على الرقم: 0797280811 أو 041415949555

الدكتور يوئ كودر

كلية الطب والجراحة والعلوم الصحية

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**التاريخ:**

*يرجى التذكر بوضع إشارة إزالة الإجابات التي تراها مناسبة.*
ب - أسئلة الدراسة

1. كيف تقيس الفهم والإدراك لديك فيما يتعلق بالأخلاقيات الطبية جيد مقبول ضعيف
2. كيف تقيس الفارق الأخلاقي المحلي في المستشفى جيد مقبول ضعيف
3. ما هي الأسس التي تتحكم العمل الأخلاقي في المستشفى علمية بحثية اجتماعية أخرى
4. كيف تعلمت الأخلاقيات الطبية صحيحة أو خاطئة قانوني أو غير قانوني غير أيسر
5. هل سيق وระست الأخلاق الطبية في جامعتك مقبولًا مطلوبًا ما صغير
6. أي بأن بالأخلاقيات الطبية العالمية يمكن تطبيقها في المستشفى مقبول لا لا لا
7. أفجل الأخلاقيات الطبية عندما تستند إلى أسس بيئة مقبول لا لا لا
8. أفجل بأن يكون مرشح الأخلاقيات الطبية عادي ومقبول لا لا لا

R

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لا يمكنني قراءة النص العربي من الصورة.
فقرات الاستبيان

ب- أسئلة الدراسة

13. أعتقد بأن الأطفال قد يسببون أنواع من الاضرار فيما يتعلق بالأمور الطبية

14. أعتقد أن الأطفال قد يسببون أنواع من الاضرار فيما يتعلق بالأمور الأخرى غير الطبية

15. بشكل عام فإن الأطفال يعملون على خدمة مراقبة أكثر من أي اعتبار آخر

16. اعتقد بأن الإجراءات المتعلقة بإجهاض الحمل تسبب مشاعر الدين الإسلامي

17. اعتقد بأن زيادة المعيشي والدعوة بها خرج ضمن مفاهيم الدين الإسلامي

18. أي أن إعداد الرأي للجهاز (من المصدر) هو محل إجحظ وتفاوت من وجهة نظر

19. أي أن هناك إجراءات معروفة من قبل الأطفال عند إجراء الفحوصات للمرض من النساء

20. وفقاً لمبادئ الشرعية الإسلامية

21. هناك اعتبارات محضة وخيارات خاصة للمريض الممتنع عن المراقبة وقواعد

22. الشرعية الإسلامية

23. لا أتفق

24. محدد

25. لا أتفق

26. توقع

27. محدد

28. لا أتفق
السؤال الأول

قدمت الأطباء أسرار مرضيهم وأعمالهم وعلومهم الخاصة بهم، ولا يعترف بها أحد.

لا أوافق  □  محايد  □  أوافق  □

هذه شواهد ملموسية وإجراءات صحيحة تؤكد إجراءات الأطباء الخصوصية لمرضيهم عند

لا أوافق  □  محايد  □  أوافق  □

بما فيهم معفوي الموقفة للسيدة (Consent) مع مفاهيم الشريعة الإسلامية

لا أوافق  □  محايد  □  أوافق  □
ج. يرجى التكرم بإعطاء رأيك بالأخلاقيات الطبية في المستشفى الذي تعمل به وكذلك العيقات التي تواجه مفهوم الأخلاقيات.

رأيك الشخصي بالأخلاقيات الطبية:

العيقات:

فقرات الاستبيان

الển

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Appendix 5: Interview Questions- English Version

- Qualitative Approach
- Face to face Semi structured interview,
- Period: 50-6 minutes
- Target: Expert doctors from managers and supervisors
- Place: Jordanian Hospitals

Questions

1- Would you talk about the definition of clinical ethics and some relevant meanings according to your perspective as an expert doctor?
2- What are the most important issues and dilemmas regarding ethical judgement that you mostly face in your clinical practice and the whole hospital?
3- Would you let me know about the factors or clinical issues that may construct the ethical agenda in this hospital and what is the role of surrounding community to shape this agenda?
4- Do you follow the international norms and regulations as well as protocols and guidelines of the western community? If yes please explain why?
5- It can be seen that the Muslim community prefer some religious situations to be existed in ethical judgement. Is that right? If yes please explain.
6- What is the detailed role of ethical committee in this hospital?
7- Is there a need to have a diversity from non-clinical scholars doing besides clinicians to have an ethical agenda? If yes, please specify
8- Would you please let me know about the role of clinical institutions and professional bodies in terms of training and different programs to have a meaningful ethics?
9- Please let me know about the alternatives and procedures that you may need to get your ethical decision rational and practical?
10- What are the most important obstacles that may face the ethical agenda in your hospital?
Appendix 6: Interview Questions- Arabic Version

أسئلة المقابلاة باللغة العربية (الأخلاقات الطبية)

1- ما هي مسؤولية الطبيب من الناحية الطبية والاجتماعية.
2- ما هي الدورات التي يرشدها الطبيب قبل أن يبدأ عمله (الدورة الدراسية للدورة الأولى).
3- ما هي الطبيعة العامة بين الطبيب والمريض.
4- أعت أنشطة على بعض الممارسة بشكل عام التي يتعذر على الطبيب وكيف يعالجها.
5- ما هي الارتباطات بين سلوكات الأطباء في المستشفى.
6- هل هناك أجهزة ومعايير خاصة لتدرب السلوكيات الطبية في المستشفى وإلى أي مدى.
7- كيف يعتمد الطبيب على بناء قراءة من الناحية الطبية والأخلاقيات. هل هناك معايير دولية أم محلية.
8- هل يعتمد الطبيب على النصوص العربية والأجنبية حول المشاكل الطبية من الناحية الفنية والاجتماعية.
9- هل هو دور المؤسسات الدينية كوزارة الصحة والجهات لتشجيع سلوكات الأطباء.
10- هل هناك دور المؤسسات الدينية في تحفيز وتشجيع سلوك الأطباء.
11- هل يفتتح مثالاً وجد عملاء آخرين كعمال الدين والاجتماع والسياسة وعلماء النفس ورائدات المجتمع المحلي في تشجيع سلوكات الصحة وسلوك الأطباء.
12- هل هناك لجان أخلاقية في المستشفى وما هي طبيعة عملها.
13- ما هي حسابات العمل الأخلاقي في المستشفى أن وجدت.
14- ما هي مهارات العمل الأخلاقي في المستشفى أن وجدت.
15- هل هناك فرص لتطوير الأطباء على العمل الأخلاقي.
16- ما هو دور الشريف الإسلامي في تشجيع المفهوم الطبي.
17- تحدث بإيجاز عن ما يلي:

- كونتم قريبا
- مهارات التواصل مع المرضى
- مفاهيم العائلة
- إذا المرضى
- الإحصاء مع مباني الدين الإسلامي
- زوايا إسلامية ومفاهيم الدين
- إعداد الأدبيات والإعلامية عن المرضى المستوفيون سريعا
- التحديات الأخلاقية المرضى المعشورة
- توصيات الطبيب في حالة بعدة مهام.
- أشياء أخرى
- ما هو تصور القاعدة الدينية؟ لا يضر ولا يضر

أخيراً ......................... كيف تعرف الأخلاقات الطبية بالمفهوم الشخصي
Explanatory Statement

Version 2

Chief investigator: Professor Paul Komesaroff
Student investigator: Ala Obeidat

Title: Clinical Ethics from the Islamic Perspective: Proposed Strategy for Health Service Management in Jordan.

Thank you for taking the time to read this information sheet which is for you to keep.

My name is Professor Paul Komesaroff from the Faculty of Medicine of Monash University in Australia. You are invited to take part in a research project which is a part of doctorate studies being undertaken by Ala Obeidat, a student researcher from Jordan at Monash University. Please read this explanatory statement in full before making a decision.

What is the study about?
This study aims to explore the nature and content of ethical decision making in Jordanian hospitals. Also it aims to develop practical strategies to enhance ethical practices in setting in Jordan.

Why you have been invited to take part
You have been invited to participate in this study because you are a decision maker in a clinical setting. Your participation will help to establish a strategic ethical agenda and curricula for Jordanian hospitals.

Possible benefits
There will be no direct benefit to you from participating in this study. However, your participation will contribute to understanding of the ethical problems faced by doctors in Jordan and responses to them. It will also help us to develop training programs for doctors in ethics.

What does the study involve and what potential risks or inconveniences are there?
The study will involve the following:
1. Quantitative study (questionnaire). All participants will be doctors, including managers, consultants, specialists, academics, resident doctors, researchers and members of ethics committees, as well as medical students in their 5th and 6th years. This survey will take 10-15 minute and cover all clinical departments.

2. From the same population sample, participants from various levels of decision making will be asked while filling in the questionnaire to take part in face to face interviews, depending on their experience and their positions or professional rank. The interview questions will aim to expand the responses to the quantitative survey. A brief discussion about clinical ethics will be undertaken to clarify the concerns of the study. Qualitative interviews will take about 40 minutes and will be recorded but will not include identifying details of the participants. Medical students will be excluded.

3. The questions will cover the following: How do doctors think about ethical issues in clinical settings? What ethical issues do clinicians encounter in their practices? What
are the roles of religion in clinical decision making? What are the practical and theoretical resources that are needed to enhance ethical decision making? What practical strategies, including education, curriculum, clinical institutions and actions taken by professional associations, are needed to enhance ethical decision making in Jordanian hospitals? What are the obstacles and challenges that face doctors with respect to ethical decision making in Jordanian hospitals?

4. No risks are associated with participating in this project beyond those associated with everyday life. Some minor inconvenience could be experienced owing to the duration of interview (40-50 minutes). No names of individual participants will appear in any published materials.

How much time will the study take?
Participants will be asked to fill in 10-15 minute survey and 40 minute semi-structured interview with the researcher about similar issues.

You can withdraw from the study
Participation is voluntary and you are under no obligation to take part. You may withdraw from further participation at any time until you have completed the survey and/or the interview.

How will the information you give for the study be kept private?
The researchers will use electronic recorders during the interview and access to electronic records will be limited to the researchers themselves. No identifying information about any of the individual participants will be published or disseminated in any other manner.

How will this information be stored and protected?
All electronic data will be securely stored in an electronic data base. Paper copies and filled questionnaires will be kept in special boxes and stored safely. Survey questionnaires will not include names of participants but rather code numbers. The code will be kept separately. Data will be retained for 5 years.

For further information please contact the researchers

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Monash University-Australia
Email: Paul.Komensaroff@monash.edu
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Faculty of Medicine, Nursing and Health Sciences
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Email: alia.obeidat@monash.edu
Ph: +962 797290811 (Jordan) or +61 415084555 (Australia)
الشروط الخاصة بالدراسة ( البروتوكول )

المعلومات الأولية:

العلومات الأولية:

الوضوح والشفافية في إعداد هذه الشروط الخاصة بالدراسة، وأود أن أعرب عن تضحيتي: أنا

البروفيسور يو. ك. ووسوف من كلية الطب في جامعة موناش، استثماري أرباح بكم في المشاركة في هذه

الدراسة وهي جزء من مطلبات الدكتوراه من إعادة تدريب الطالب علاج علاجات مرض الأورام.

وعلى الرغم من وتيرة التصرف هذه البيانات قبل إغلاق القرار بالمشاركة:

ما هو هدف هذه الدراسة

تهدف هذه الدراسة إلى اكتشاف طريقة وموائمات القرار الخلقي في المستشفيات الأوروبية، وتفهم

كأن ذلك الكتل في تطوير استراتيجيات عملية للتدريب والتعليم في الأوراق في مشاركة الأوروبية في الأوراق. 

تمامًا دعومنا للمشاركين في هذه الدراسة

في الطبقة المعنية وموضوعية وتعداد عدد من مشاركين في هذه الدراسة وذلك بهدف

تأسسي أجهزة وتنظيمات أوروبية مهتمة في مستشفيات الأوروبية.

الفوائد المتوقعة من الدراسة

هناك أن يوفر غير ملائم كاعتماد مشارك في هذه الدراسة وهذا لجودة الأفكار وانحلالية هي

في الخبرة على المشاكل التي تواجه الأطباء عند إعداد القرارات الأخلاقية في العمل الطبي وكذلك

تطوير برامج تدريبية للأطباء لتعامل مع هذه الأساليب.

ما الذي يتضمن هذه الدراسة وما هو جوهر الملاحظات فيها

لأولى الدراسة مريحة (الإنابة)

جميع الأطباء من فئات الأطباء ممثلي مخالفة بالإنابة على ممارسة الإشباري واتخاذ الإشباري منهم

الأخلاقين والخالدين والخاليين والخالدين من أم توضيح في جوانب الأخلاق، وذلك على سبيل المثال في

الأخلاقيات في ممارسة الطبية والمشاهد.

ولكن إذا كنا ننظر في فئة العينة فهذه الأسئلة لimestone في الإجابة على الإستفادة كبيرة، وذلك من خلال جميع الأسئلة الطبية.

ما يكون من نفس كمية العينة في الإجابة، ستتمكن بعض المرضى من مختلف فئات الممارسة في

المسكن مع محاولتهم للенная العينة بحيث في حالة توليد، ومع ذلك، مع التجربة أن يتضمن هذا إلى المؤامع في

الإجابة الارتباط في الاستفادة أو المريض، وتليمد أيضًا ملاحظة الواقع الأخلاقي. لا يمكن محاصرة

لละمه لسيمي العين، على ما يظهر الأخلاق في البدء بإجراء المقابلة. سوف تستمر هذه المقابلة

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حوالي 40 دقيقة وستتم تجربتها دون أي تفاعل مع الشخص المشارك في المقابلة، وهذا سيتم إصداره على الصورة كلية الطب من المشاركة:

ثالثاً: سوف تجربة تقديم الأسئلة التالي:

- كيف يتم التعامل مع الأعراض الأخلاقيات في الحال الطبقي؟
- ما هي النماذج الأخلاقيات التي نواجهها أثناء علاج الحال الطبقي؟
- ما هو النموذج الذي نشأ تفاعليه الحالات الطبية؟
- ما هي النماذج الطبية والسلوكية الملائمة في تفاعليه الحالات الطبية؟
- ما هي النماذج الطبية والسلوكية الملائمة في تفاعليه الحالات الطبية؟
- ما هي النماذج الطبية والسلوكية الملائمة في تفاعليه الحالات الطبية؟

رابعاً: ليس هناك أي منعطفات تتعلق بالمشاركة في هذه الدراسة ولكن هناك بعض الإرشادات التي قد تحدث للمشاركين في هذه الدراسة (المشاركين). قد يسمح ذلك لل Респتيت دوت التسجيل تداول 40 دقيقة. ولكن، يمكن توظيف الأدلة على خلال تشريح القلب العادية على الأطباء من هذه الدراسة. كما أنه لا يوجد أي ذكر للمشاركين في المقابلة أو الإشارة في أي أصل.

كم من الوقت سوف تستغرق هذه الدراسة؟
سوف يضيع الوقت الإضافي على الإشارة حوالي 10 إلى 15 دقيقة وسنستغرق المقابلة حوالي 40 دقيقة، وسوف يتم إجراء بعض الاستنتاجات الأساسية في المقابلة بشكل موسع.

هل يمكن للمشارك أو المشارك في هذه الدراسة الإحساس منها?
نعم، بالنسبة للتطبيق، فإن هذه المشاركة ستسير بإمكانيات بدون طلب مسبق. إذا انتهت هذه الدراسة أو التوفيق على المقابلة بالمشاركة، وتشمل مع ذلك إتمام تحقيق الحق في الإشارة من المشاركة في الوقت الذي تحدده القوانين، الإشارة والطبيعة.

كيف يمكن لهذه الدراسة والحوار مع المعاملة بأن تكون سرية؟
للباحثين الحل في إنشاء التخفيات الإلكترونية أثناء المقابلة. ولكن جميع هذه التخفيات سوف تعمل بسرية تامة من خلال جامعة موشن، ولا يمكن أحد استخدامها إلا الباحثين الذين يتقدمون.

كيف يمكن لهذه المعاملة بأن تكون طبيعية ومحفزة؟
جميع السجلات المراد في البحث سوف تتم تحت إشراف الباحثين، وسوف تتم تلك في قاعدة البيانات الخاصة، أما فيما يتعلق بالإرشادات فإنها سوف يتم بعضها في منشورات خاصة بعد
### مع إطلاعات الطلاب

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<tr>
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<tr>
<td>Office: 006/14</td>
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Appendix 8: Consent form

Consent form

Participants: Doctors in Jordanian Hospitals

Project: Clinical Ethics from the Islamic Perspective: Proposed Strategy for Health Service Management in Jordan

Chief Investigator: Professor Paul Komesaroff
Co-investigator: Alia Obeidat

I have been asked to take part in the Monash university PhD project specified above. I have read the explanatory statement and hereby consent to participate voluntarily and I may withdraw consent at any stage.

I consent to the following:
1. Take a part in a questionnaire for about 15 minute
   Yes ☐ No ☐
2. Take a part in semi-structured interview for about 40 minute
   Yes ☐ No ☐
3. Audio recording of the interview discussion
   Yes ☐ No ☐
4. I wish to receive a copy of final results
   Yes ☐ No ☐

Name of participant:
Signature:
Date:
 formulaire الموافقة المسية (كونسلت)

المشتركون: الأطباء في المستشفيات الأردنية

المشروع: الأخلاق الطبية من رؤية النظر الإسلامي: استراتيجيات مثيرة لإدارة الخدمات الصحية في الأردن

الباثرون: بروفيسور بول كوسوف - باحث رئيسي

علاق معلومات بالمساعد

قد تم اختياري كمشرف الدراسة على فترات هذه الدراسة وهي عرفة تكوينها في جامعة سانتا، وفكر في ما من جام
 فيها من شروط وأهمية الدراسة على الأسئلة الموجهة بشكل إجباري وليس إجباري وإلي الحق في الإسهام منها في أي
 وقت أثناء

ربما ذلك قد وافقت على ما يلي:

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1. الإجابة على استمارة المقابلة 100 متصل
2. الإجابة على استمارة الاستجابة
3. الموافقة على تسجيل المقابلة
4. أرغب في الحصول على نتائج الدراسة

رعة: د. ن.م.

اسم المهم:

التوقع:

tاريخ: