Critical analysis of the Pakistan Medical Dental Council Code and Bioethical Issues

- FOUZIA KAZIM -
Master’s Thesis in Applied Ethics
Centre for Applied Ethics
Linköpings universitet
Presented June 2007

Supervisor: Prof. Dr. Marcus Duewell, Utrecht University
DEDICATED TO

My parents Mr. Muhammad Kazim Khan Barki and Mrs. Masooda Kazim for their immense support and inspiration.
ABSTRACT

Medical paternalism is a common practice in Pakistan, it can be justified on the principles of beneficence and non-maleficence in certain clinical situations but in the research medicine it can pose many ethical implications.

Islam is a communitarian religion but it provides full autonomy to the competent individuals. Pakistan Medical and Dental Council (PM&DC) codes of ethics have been formulated in line with the World Medical Association and it also states in its preamble that it follows Islamic bioethical laws. The PM&DC guidelines do not provide substantial system for obtaining consent from patients and the research participants. Neither does it comply with the Islamic bioethical laws nor with the International Declarations. The language used in the codes is ambiguous that can have different interpretations and there is no legal support from the civil law of the country. These factors supplemented with the cultural values have elevated the status of the physician and gives complete authority to them for medical decisions.

Medical paternalism in research medicine can be a violation of the dignity and autonomy of the research participants. Patients are used as means and commodities rather than end in themselves. The research involves risks of harms no matter how low these risks are – the matter of concern is that research participants are involved in research accompanied with risks about which they are not aware.
ACKNOWLEDGEMENT

I extend my profound appreciation to the staff of the Ethics Institute of the Utrecht University for having made possible my effort to widen my knowledge and strengthen my conceptual ability. My deepest gratitude goes to my supervisor Prof. Dr. Marcus Duewell who guided and enhanced my research aptitude. His support and encouragement became a motivation for me to exploit my virtuosity in the field of research. His thoughtful comments and guidance helped me to formulate my concepts in a coherent way. I am so very pleased that he was my mentor.

I am grateful to my professors Dr. Marcel Verweij, Dr. Mariette van den Hoven, Dr. Ineke Bolt, and Dr. Gijs van Donselaar. They have enriched and broadened my vision on bioethics, and sharpened my perception of diversified perspectives.

My special gratitude goes to my peer group and Dr. Gijs whose comments guided my stream of thought. I also want to thank my friends who gave me moral support here in my educational pursuit.

I avail the opportunity to thank my parents, Mr. Muhammad Kazim Khan Barki and Mrs. Masooda Kazim for their immense support and encouragement that I received from them throughout my academic career and especially during this programme. My special thanks go to my sister Mrs. Rubina Naem and sister in law Mrs. Naghma Haroon for their help and support during my research. My heartily gratitude goes to my friend Dr. Misbah Rashid who encouraged and inspired me during the entire course of this programme.

I want to thank all scholars whose work I cited and those who let me use the educational facilities and libraries in Utrecht. I want to thank all those who helped me in many ways and whose names I could not mention here.
## Contents:

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Human dignity and Autonomy in Islam.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter –I</td>
<td></td>
</tr>
<tr>
<td>(i)</td>
<td>Introduction</td>
</tr>
<tr>
<td>(ii)</td>
<td>Human dignity in Islam</td>
</tr>
<tr>
<td>(iii)</td>
<td>Personhood in Islam</td>
</tr>
<tr>
<td>(iv)</td>
<td>Autonomy in Islam</td>
</tr>
<tr>
<td>(v)</td>
<td>Beneficence in Islam</td>
</tr>
<tr>
<td>(vi)</td>
<td>Good Will in Islam</td>
</tr>
<tr>
<td>(vii)</td>
<td>Community vs Individuality</td>
</tr>
<tr>
<td>(viii)</td>
<td>Importance of Health in Islam</td>
</tr>
<tr>
<td>(ix)</td>
<td>Human dignity and Autonomy in Kantian Philosophy</td>
</tr>
<tr>
<td>(x)</td>
<td>Kantian Autonomy vs Beauchamp and Childress’s Principle of Respect for Autonomy</td>
</tr>
<tr>
<td>(xi)</td>
<td>International Declarations on Human Dignity and Human Rights</td>
</tr>
<tr>
<td>(xii)</td>
<td>Concluding Remarks</td>
</tr>
<tr>
<td>Page No.</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter –II</th>
<th>Islamic Bioethics and Critical Analysis of Pakistan Medical Codes of Ethics.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i)</td>
<td>Introduction</td>
</tr>
<tr>
<td>Part-1 (ii)</td>
<td>Bioethical Issues and Islamic Interpretation</td>
</tr>
<tr>
<td>(a)</td>
<td>Necessities overrule prohibition</td>
</tr>
<tr>
<td>(b)</td>
<td>Choice of the lesser of the two evils if both cannot be avoided</td>
</tr>
<tr>
<td>(c)</td>
<td>Acceptability of a deed depends upon the intentions</td>
</tr>
<tr>
<td>(d)</td>
<td>All things are lawful unless specifically prohibited</td>
</tr>
<tr>
<td>(iii)</td>
<td>Islamic Bioethical Issues</td>
</tr>
<tr>
<td>(a)</td>
<td>Guardianship of women</td>
</tr>
<tr>
<td>(b)</td>
<td>Consent</td>
</tr>
<tr>
<td>(c)</td>
<td>Euthanasia</td>
</tr>
<tr>
<td>(d)</td>
<td>Post-mortem in Islam</td>
</tr>
<tr>
<td>(e)</td>
<td>Abortion</td>
</tr>
<tr>
<td>(f)</td>
<td>Organ donation</td>
</tr>
<tr>
<td>(g)</td>
<td>Assisted reproductive techniques</td>
</tr>
<tr>
<td>Page No.</td>
<td>26</td>
</tr>
</tbody>
</table>
### Chapter –III
**Informed consent in Pakistan Medical and Dental Council's Codes: Theory and Practice.**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Introduction</td>
<td>43</td>
</tr>
<tr>
<td>(ii) Four Principles in the Codes of Ethics</td>
<td>43</td>
</tr>
<tr>
<td>(iii) Oath of Medical Practitioner</td>
<td>45</td>
</tr>
<tr>
<td>(iv) Informed Consent</td>
<td>46</td>
</tr>
<tr>
<td>(v) Different Kinds of Consent</td>
<td>49</td>
</tr>
<tr>
<td>(vi) Consent Procedure</td>
<td>50</td>
</tr>
<tr>
<td>(vii) Implicit Consent</td>
<td>51</td>
</tr>
<tr>
<td>(viii) Informed Consent and Research Medicine</td>
<td>52</td>
</tr>
<tr>
<td>(ix) Medical Decision-Making in Pakistan</td>
<td>53</td>
</tr>
<tr>
<td>(x) Concluding Remarks</td>
<td>57</td>
</tr>
</tbody>
</table>

### Conclusion
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Conclusion</td>
<td>58</td>
</tr>
<tr>
<td>(ii) Recommendations</td>
<td>60</td>
</tr>
</tbody>
</table>

### Bibliography

### Appendix
INTRODUCTION

My topic developed from my research in bioethical issues with special concern to Pakistan. I therefore, chose to write on the informed consent, procedures and application in medical practice in Pakistan. My greater concern was to critically analyse the Pakistan Medical and Dental Council (PM&DC) codes on consent, the social structure of the society, the jurisdiction and religion. I examined the code on consent and analysed whether it respected the autonomy and rights of the patients or not.

There has been no substantial research done on informed consent, bioethical issues and on the codes of PM&DC in Pakistan. The codes have been amended in accordance with the meeting of the World Medical Association held in 1983 but there are many weak areas that lead to mal practices in clinical as well as research medicine. A. M. Jaffarey and A. Farooqui conducted a research on the informed consent from the perspective of the physicians. This study provides insight into the concepts of physicians towards the informed consent procedure. Most of them were of the opinion that this procedure needs patience and time that is practically impossible for over worked physicians and that medical professionals know better what is good for the patients. The study revealed that physicians justify medical paternalism in Pakistan.

Problem of the Research:

Critical Evaluation of the content and procedures of informed consent in the Pakistan Medical and Dental Codes of Ethics.

i- Is the PM&DC code in compliance with the Helsinki Declaration or not?
ii- Is the code inspired by the Islamic bioethical laws?
iii- How the ethical code is followed in the medical practice in Pakistan.

Purpose of Research:

The purpose of my research is to inculcate a spirit of awareness among the general public and motivate change in the medical code. I also aspire for stimulation at government level to formulate laws that would support the medical code. One of my major concerns is to introduce the subject of Bioethics at graduate and higher level.
**Significance of Research:**
My research is a step forward in the field of Bioethics; it provides study in the content and procedures of informed consent and the bioethical code of Pakistan Medical and Dental Council. It will assist future researchers who take up the study of bioethical issues in Pakistan. At international level it would help in the comparative analysis with underdeveloped and developed countries. It will be a source of insight into the limitations of the procedures of the PM&DC and how these can be improved. The research will bring awareness and organizations may fund further researches in this field in Pakistan.

**Limitation of Research:**
In Pakistan a great deal of research is required on the health system, medical decision-making, confidentiality of information, consent procedure, resource allocation and the application of the codes of ethics in practice. My research concentrates on the content and procedure of consent as it is explained in the PM&DC codes of ethics. It is a descriptive and analytical study and I have provided information about the medical practices in Pakistan with the help of studies carried out and articles written by medical professionals. They have also contributed at a small scale in writing on the medical decision-making in Pakistan. I have also elaborated information from my personal observations on the consent procedures and medical practice in Pakistan. Due to the time limitation and level of research I have abstained from focussing on the wider perspective of qualitative and quantitative data collection. Though the topic needs a thorough and an elaborated empirical research, regarding whether the information is provided to patients or not and how far the consent procedure is followed according to the International Declaration as well as the Islamic bioethical laws, at this level of study and time factor it is not possible to carry it out to that extent.

There are government, semi-government and private hospitals in Pakistan and their different ethical norms is a field of wider study that is not a matter of research at this point. I managed to get an ‘informed consent form’ from a Federal Government hospital that provides legal protection to the hospital authorities and physicians and on the contrary it does not give any information for the patient or any protection for their rights.
Obtaining consent is to respect the human dignity; in the first chapter I therefore, dealt with the Islamic concept of human dignity, autonomy and personhood as embedded in the religious scriptures. The Islamic concepts of the human dignity, acknowledgment of autonomy of the individual and the concept of personhood have been compared to the Kantian philosophy. Though both these thoughts are on extreme ends one on religion and the other on secularism but still I found similarities in the systems of thought as both emphasize on the freedom of choice and autonomy.

The Islamic bioethical issues were studied in the second chapter. I chose to study the bioethical issues of Islam because Pakistan is an Islamic country and I wanted to see whether the medical codes comply with the Islamic bioethical laws or not. The PM&DC states that it will follow the Islamic bioethics but my research revealed that the former does not follow the Islamic laws. The PM&DC code is found ambiguous and many issues are not tackled; especially those of assisted reproductive techniques, sex selection of embryos, abortion, euthanasia and other issues as such.

The main objective of my research is elaborated in the third chapter, which concentrates on the content and procedure of informed consent in medical practice with emphasis on the social structure of the society and the beliefs of the people. The code of PM&DC on consent does not provide substantial protection to the rights of the patients and I find no support for it in the civil law. In Pakistan medical paternalism is much in practice because of certain factors in the society:

- Lack of awareness among the people.
- High illiteracy rate.
- Trust in the medical profession.
- The social structure in which the family decision becomes priority.
- Religious concepts that death is inevitable and the time of death are preordained according to the Will of God.

The physicians are neither obligated by the codes nor by the law to obtain the consent. The medical practitioners find justification for paternalism due to the factors...
mentioned above and due to the fact that this system cannot be applicable because of extreme work load, economic crises and scarcity of resources.

The PM&DC code is formulated as guidelines for medical practitioners and not for researchers and this could be a reason for not having extensively explained codes on consent procedure. Medical paternalism can be justified on the principles of beneficence and non-maleficence in clinical settings but in the research medicine it sprouts many ethical implications.

In my conclusion I have summed up the facts derived from my research and I have given proposals for improving the PM&DC code of ethics, formulation of the civil laws for the protection of patients and research subjects and promotion of awareness among public through media campaign.
CHAPTER-I
HUMAN DIGNITY AND AUTONOMY IN ISLAM

INTRODUCTION:

Human dignity is an important aspect in Islam. The religion advocates the dignity of humans at a universal level. It instructs to know oneself, to appreciate the family structure, to know the universe, to understand one’s position in the society, to create a just and a tolerant world, and above all to follow the teachings of Islam in its purest context – these are all fundamental aspects of human dignity. Islam uses the words: Izzah (honor), Karamah (nobility), Qeemah (value), Shraf (distinction) Fadilah (virtue).

God Himself considers human beings as the best of His creations. Humans are, “Ashraf-ul-Mukhlukat” (Khalaqnal insana fi ahsane taqbeem, The Quran), that is the finest of all creations who have been taught to read and write and who have been given honour and dignity; as the first revelation was:

"Read in the name of your Lord who created, created man from a clot of congealed blood. Read and your Lord is most Bountiful. He Who taught (the use of) the pen. Taught man that which he knew not. (Al-'Alaq 96:1-5)

In order to achieve the ideal of global bioethical values special attention is required towards a comparative evaluation of the Islamic concepts of human dignity with those of International Declarations.

In the first chapter I will endeavour to find out the philosophical concepts of human dignity, autonomy and personhood in the religious concepts of Islam and will try to find its parallels in the International Declarations and Kantian philosophy. The focus will be on the fundamental concepts of Islam for human dignity, autonomy and the community according to Quran, Sunnah and Shariah.
In Islam humans are the best of beings as they have the freedom to think and the will to act (al-Nahl 16:78; al-Mu'minun 23:78; al-Sajdah 32:9; al-Ahqaf 46:26; al-Mulk 67:23)

Islam is a duty-based religion and focuses more on the individual’s introspection, self-purification and self-evaluation that is why it stresses on the duties rather than rights. Every individual has a special status in the society with different roles and corresponding duties; these are explained in the Quran and elaborated in the Hadith. Therefore, every individual is answerable for his duties towards others. The philosophy of Islam advocates that if everyone fulfils his/her duties there cannot be any type of chaos and infringement upon the rights of others. This does not mean that there are no rights of individuals in Islam, but the strategy to achieve the objective of a fair society is different; though it also elaborates the rights of individuals.

God created the world for the humans (Luqman 31:20; al-Jathiyah 45:13) and humans as his vicars, His “Khalifah” and gave him the “Amanah” responsibility. (al-Baqarah 2:30; al-Ahzab 33:72)

All human beings should be treated with justice. No racism, no prejudices, no calling of names. Remember:

"The noblest of you in the sight of Allah are those who are the most pious among you." (al-Hujurat 49:13)

In Islam the pious man is not the one who only prays to God; living in seclusion, rather he is the one who lives among people and fulfils his personal, familial, social, economical, political and religious duties that is why Islam is known as a duty-based religion.

Kant gave a secular view of human dignity based on the capacity to reason, this capacity then leads to autonomy. According to him all human beings having the capacity to reason are autonomous and have dignity. The dignity of man according to him is based on the rational capacity and autonomy of human beings. Everyone is capable to legislate moral principles. Kant has given no qualifying criterion for an individual to legislate morality except rational capacity and autonomy. How can the
legislating power be weighed? Kant gives an idea of ‘good will’. He holds the view that only ‘good will’ is good in itself. All other goods are conditional, but the ‘good will’ is an unconditional good and it is the weighing criteria of any action.

According to the International Declarations, human dignity is related with human rights, that everyone has human rights because all human beings have an inherent human dignity. In the preambles of two international covenants adopted by United Nations in 1966:

“These [human] rights derive from the inherent dignity of the human person”.

Human dignity and its relationship with human rights is also stressed in the Universal Declaration:

“Everyone…is entitled to realization …of the economic, social and cultural rights indispensable for his dignity”.

“Ensuring … and existence worthy of human dignity”.

Human dignity is expressed in relation to human rights or autonomy but it is not clear, what human dignity is? According to the Universal Declarations every human being is equal in human dignity and possesses human rights.

**HUMAN DIGNITY IN ISLAM:**

Islam the youngest of all the monotheistic religions and the second largest in the world stresses on human dignity as an important principle. The Quran says that God has bestowed man with all the favours and given him the dignity and honour that he deserves:

---

"Indeed, We have honoured the children of Adam; provided them with transport on land and sea; given them for sustenance things good and pure; and conferred on them special favours, above a great part of Our Creation." (Al-Isra' 17:70)

The signs of human dignity and autonomy can be found in the value of human beings as the Vicars of God on this earth. According to Muhammad Iqbal, poet philosopher of the Indo-Pak sub-continent, “man is a co-creator with God”. Man reshapes and redesigns the universe with his intellect and creative powers. This capability gives superiority and dignity to man over all other creatures.

All human beings have equal rights and dignity there is no distinction except on the basis of good deeds. Islam is a duty-based religion, it assigns human beings a list of duties towards their fellow beings like personal, social, economical, political and duties towards God (prayers); so the term ‘right’ is not very common in the Quranic scriptures. Islam focuses on the dignity of the self and others – whether they are friends, relatives, neighbours or foreigners. It is the duty of all human beings to respect the dignity and autonomy of their fellowmen. In the last sermon Prophet Muhammad said:

“All mankind is from Adam and Eve, an Arab has no superiority over a non-Arab, nor a non-Arab has any superiority over an Arab; also a white has no superiority over a black, nor a black has any superiority over white except by piety and good actions”².

The status of men and women is also equal and the Quran stresses on the equality of men and women³. Education and learning is incumbent on all Muslim be it women or men in Islam. In a Hadith the Prophet Muhammad said:

---

² www.angelfire.com/md/jawadji/.
³ “Men who submit [to God] and women who submit [to God], believing men and believing women, obedient men and obedient women, truthful men and truthful women, steadfast men and steadfast women, humble men and humble women, men who fast and women who fast, men who guard their chastity and women who guard their chastity, men and women who remember God often – God has prepared for them forgiveness and great reward.” (sura 33:35; cf. 4:125
“The acquisition of knowledge is a duty imposed on every male and female”\(^4\).

There is no restriction on the choice of professional career between men and women the best example is found in the life of Khadija first wife of the Prophet Muhammad who was a businesswoman and had a commercial partnership with her husband. Women are allowed to participate in the practical and economic life of the society with equal rights and wages. Both men and women should keep the honour, chastity, respect and dignity according to Shariah.

**CONCEPT OF PERSONHOOD IN ISLAM:**

The concept of personhood is embedded in the religious language of Quran and described in different chapters with variety of references. Man has the highest status in the whole universe. One of the Quranic verses confirms man’s superiority,

> “And He has subjected to [your use] all that is in the heavens and the earth […]. Behold, in this there are signs for those who reflect”. (al-Jathiyah, 45:13)\(^5\).

> “It is We who have placed you with authority on earth, and provided you with means for the fulfilment of your life”. (al-A’raf, 7:10).

To stress the point at another place Quran says:

> “Do you not see that God has subjected to your [use] all that is in the heavens and the earth and has made His bounties flow to you in exceeding measure [both] seen and unseen? (Luqman, 31:20)\(^6\).


\(^6\) Ibid., p. 37.
Dr. Muhammad Hashim Kamali Professor of Law at the International Islamic University of Malaysia explains these verses as that God has given capabilities of reason and knowledge to man which places man to the highest status in the universe. Thus man is endowed with the capabilities of reason, which leads to autonomy, and free will of man. The Arabic word ‘taskhir’ means deriving benefits; the whole universe is subjugated to man in order to derive benefits for the mankind. This also points towards equal rights of all human beings there is no limit for nations or different groups of people. The difference between the Islamic science and knowledge and secular knowledge is that in Islam the quest for knowledge is aimed for the benefit of humanity as a religious duty.

Muzaffar Iqbal in ‘Islam and Science’ elaborates the characteristics, which distinguishes human beings from other creatures and qualifies them for human dignity and rights according to the Quranic theme. These are, “…human intellect (fahm, ‘aql) which is endowed with the power to comprehend that which lies beyond the realm of the five internal senses: hiss mushrtik (the sense that gathers all impressions); khayal (knowledge of the sentient kind); wahima (perception of the particular significations: evaluative, estimative); hafiza (sensitive memory) and mutakhayyila (intellective reason).” Thus capability to reason is the basis for human dignity in Islam.

The concept of personhood is embedded in the scripture of the Quran, though dignity is extended to mentally impaired which is based on the principle of benevolence and the duties of care towards needy and destitute people.

---

7 Humans are rational beings in Islam their capacity to think, decide and act makes them superior to all creatures. God’s appreciation for this rational being is reflected in the fact the He made the angels bow down to Adam. "And behold, We said to the angels: "Bow down to Adam;" and they bowed down: not so Iblis: he refused and was haughty: he was of those who reject Faith. (al-Baqarah 2:34)


9 Muzaffar Iqbal, Islam and Science, Centre for Islam and Science (CIS), Ashgate Publishing Ltd., Canada, 2002, p. 34.

10 The concept of personhood is implicitly placed in the religious language and Islamic concepts. Quran is a religious book therefore the language is not philosophical but the teachings of Islam ordain its followers to find the hidden meanings, comprehend and evaluate. Different verses give the concept of personhood though this term is not precisely mentioned in the scripture.
**AUTONOMY IN ISLAM:**

In Islam autonomy is a significant feature, a person has been given the freedom to make his or her decisions. A person is responsible for his acts and it is therefore advised that he should be careful in treading on the path of life, as he will be answerable for it. A person will be judged for whether he followed the religious obligations or not and also for his social behaviour. At many places it is quoted that the worldly acts of goodness are more virtuous as compared to religious duties to God (prayers) and it is for a person to create synchronization between the two. The concept of paradise and hell would have no significance if autonomy was not there.

A person is bestowed with the greatest capacity to reason and it is this quality that makes him superior to all living beings. The capacity to reason gives autonomy and dignity to an individual, any person not capable to reason as those mentally impaired, insane and retarded will not be held responsible for any act and will not be answerable for their behaviour at the time of judgement. This strengthens the idea that human dignity in Islam is based on the capacity to reason. Therefore rational capacity is the bases for human dignity and leads to the concept of personhood in Islam and is comparable to Kantian philosophy of human dignity and autonomy.

There are many verses in the scriptures that mentions establishment of just society, for instance, non-discrimination, justice in the payment of wages, banking system, business contracts, duties towards neighbours, duties towards minorities, system of *Zakat*, duties towards destitute people etc., and it is inferred that the establishment of a just society is the will of God which emphasis the importance of community. It is stressed in the fourteenth sura (chapter) as following:

“O Believers, establish justice, be witnesses for God, even if it goes against yourselves, or your parents, or relatives, whether rich or poor; God is closer than either”. (sura 4:134)\(^{11}\).

---

\(^{11}\) Serinity Young, ed., Encyclopaedia of Women and World Religion, Macmillan Reference USA, p 488.
The good of the community is the universal principle for the humanity. It is based on the golden principle of equality, if an individual does not like something for himself he should not recommend it for others and that he should not use others as means for his interests. For example research and knowledge are good and can be of great importance in the career of a researcher but to use others as means (without their consent) to attain ones goal is against the laws of Islam. The individual interest then comes into clash with the interests of others (community).

The autonomy of an individual is not random free choice it is limited first by the laws of Shariah and secondly by the good of community (universalizability). Besides these religious moral limitations human beings are given full autonomy; in one of the verses of Quran God says,

“So let whosoever will believe, and let whosoever will disbelieve…” (18:29)

“Surely We guided him upon the way whether he be thankful or unthankful” (76:3).

Islam means ‘submission to the will of God’ the submission to the ‘will of God’ is inferred as the consequences of an act, it does not mean that human beings should sit idle make no efforts and wait what is preordained. Man is responsible for his acts and deeds implying that he or she is free in making decisions and in making choices among the alternatives. Islam asks believers to follow the Islamic ethical norms and a good intention is adhering these norms – the commitment with the religious principles.

The laws of Shariah are though very important and are the foundations of an Islamic society but for the protection of life (in special circumstances) these laws can also be breached e.g., alcohol is forbidden in Islam but for the health and life, if there is no other alternative available it is allowed.

---

13 Ibid., p. 19.
Islam is a very flexible religion there is no supreme juridical-religious authority. Every believer is able to interpret the Quranic verses in the light of the sayings of the Prophet Muhammad; every individual is answerable for his own deeds. There are four schools of thoughts Hanafi, Shafi’i, Maliki and Hanbali, for the interpretation of the Quranic verses but there is no compulsion to stick to any one’s interpretation. The only limit is that the actions and interpretations must not contradict with the foundational principles of Islam. This evidently demonstrates that autonomy is one of the basic rights of human beings in Islam.

The Quran addresses people with variety of phrases like ‘o believers’, ‘o people’, ‘those who can reflect’, etc., there are many verses that ask for rational interpretation of the scripture and exploration of the universe and ask to search the truth (nature of reality). From these various verses we can infer that rationality is an important and distinguishing feature of human beings as explained in the Quran and this capability gives man autonomy and dignity.

BENEFICENCE IN ISLAM:

The will of God (Allah) is to establish a just and fair society. Helping the fellowmen in need – economically, psychologically and socially is recommended. This does not lead to paternalism; people are asked to be kind and helpful to others without infringing upon their liberties. The Quran addresses the Prophet Muhammad as a messenger of God and his task is only to convey the message of God to people; acceptance or rejection is the choice of people.

“There is no compulsion in religion” (sura 2:257).14

Beneficence means providing true knowledge, sincere advice or facilitating autonomy not imposing ones decision on others. Therefore, beneficence is just to facilitate autonomous decision-making for others – there are no signs of paternalism. Imam A. van Bommel explaining beneficence in an Islamic society remarked, “Truthfulness,

14 Op cit., Encyclopaedia of Women, p. 492.
unconditional goodness and mercy for the poor and destitute are among the qualities that belong to the blessed state…”

It is evident from the fact that there is no juridical authority in Islam like the Pope. The Muftis are specialist in the Islamic jurisprudence and the fatwas are not final verdict. People can disagree and there are possibilities of change and amendments in the fatwas.

GOOD WILL IN ISLAM:
The weighing criteria of deeds in Islam are ‘good intentions’ or ‘good will’. The Prophet Muhammad is reported to have said that rightness and wrongness of actions are based on the intentions:

“Actions shall be judged by intentions”.

All out efforts should be made with good will and good intentions following the ethical and religious codes of Islam. Consequences are not important in Islam that is why God asks men to make all efforts with good will and leave the responsibility of consequences upon God. Good will is following the ethical principles of Islam without any infringement, fraud or deceit. Commitment with Islam asks for the fulfilment of duties – and the Quran explains duties as personal, familial, social, economical, political, and duties towards God (prayers).

Islam is a communitarian religion therefore collective discussion and advices to fellowmen are common and recommended. It is mandatory on believers to give advices with good will and intentions, misleading other or deceiving are supposed to be a grave sin. Like Kantian philosophy the intrinsic good is ‘good will’ i.e., the commitment to fulfil duties and not the consequences of a particular action.

In my opinion the difference between the Islamic, Kantian and consequentialist approaches can be that Islam and Kantian philosophy provides ethical principles to be

16 Mufti is a specialist in the Islamic Jurisprudence and gives legal opinions according to Shariah (the Islamic Jurisprudence).
17 A Fatwa is a legal opinion given by a specialist in Islamic Jurisprudence Shariah.
followed for moral actions; and sometimes even adherence to moral principles does not lead to good intended consequence, therefore, both philosophical systems exempts individual from the responsibility of the consequences. The ethical principles of Islam and the Kantian categorical imperative are based on the intended consequences of moral actions. Moral action proceeds from following the prescribed ethical principles towards consequence whereas, consequentialism derive moral actions from the foreseen consequences.

In my opinion the concept of personhood, autonomy and dignity are similar in many respects in Islam and Kantian philosophy. The obvious difference is that the former has a religious language and the latter is philosophical.

COMMUNITY VS INDIVIDUAL:
The welfare of community is foremost for an Islamic society. This does not mean that it sacrifices the rights of individuals. The Islamic society is based on a duty-based morality which protects the rights of all citizens be they Muslims or non-Muslims; the best example can be found in the historic era of the Ottoman Empire. Islam is based on the universal principles of morality. The Prophet Muhammad is reported to have said:

“Seek for mankind that of which you are desirous for yourself…”

At another occasion he is reported to have said:

“The most righteous of men is the one who is glad that men should have what is pleasing for himself, and who dislikes for them what is for him disagreeable”\(^{19}\).

The good of the community thus is based on the golden principle. The community is preferred over the individual when the individual’s choice or decision cannot become a universal law. If someone does not want to be deceived he should not deceive

others. If concealing the truth lessens the evil then it is allowed but if it threatens others it is forbidden.

For instance to keep the confidentiality of HIV/AIDS patients is not recommended in Islam because they could be a threat to the health of the community. Every individual member of the community has equal dignity and right to keep good health therefore concealing information for the sake of an individual clashes with the rights of other members of the community thus concealment not recommended. But the discriminatory treatment is prohibited in Islam towards any disease or any group of people keeping their respect and dignity.

IMPORTANCE OF HEALTH IN ISLAM:
Islam puts emphasises on an individual’s health and that of the society. The medical profession has been considered as a prestigious and honourable career, because taking care of the patients is a sacred duty of the Muslims. In one of the Hadith the Prophet is reported to have invited the faithful to nurse the sick and serve them day and night; those who look after sick persons are blessed by 70,000 angels who constantly pray for them. Islam confirms that the medical profession is not only a career but also a form of prayer – service for the humanity. In Islam the life of humans is very precious, in a Hadith it is said that if you have saved the life of one human being it is comparable to saving the life of the whole humanity and if one takes the life of one human being it is like killing the entire mankind.

The duties of a Muslim are divided into two sections – duties to God Haqooq-ul-Allah and duties to the mankind Haqooq-ul-Ibad. The Prophet Muhammad is reported to have said that ninety percent of the Quranic verses are related to the duties of man to his fellow men. The former Grand Mufti of Egypt Hasanayn Muhammad Mukhluf, in 1952 fatwa recalled that the medical profession in Shariah has the status of fard-e-kafaya i.e., a duty that should be performed by a sufficient number of Muslims.

---

21 This hadith stresses the value of life that killing anyone without any legal reason is a grave sin and a heinous crime comparable to killing whole humanity and saving life is the highest virtue.  
22 Op cit., p. 32.
Islam means “peace and submission/surrender”\textsuperscript{23}, to the Will of God, this does not mean that people should sit idle and pray for health and do not make any effort to find cure. The submission and surrender is for the consequences, man is asked to make all out efforts with good will and leave the consequences upon God. Therefore medicine is not prohibited in Islam. Commenting on the importance of medical research Bommel remarked, “The laws of the world that God created are such that each result has its cause. Healing therefore is a result which has a cause”. That is why the Prophet is reported to have said:

“O servants of Allah, seek the cure, because Allah did not create a disease without creating its cure, except for one disease [death]”\textsuperscript{24}.

Seeking medical help is not against the faith or acceptance of the Divine Will. All four schools of thought agree on the recourse to medicine. There are few examples of individual mystics Sufis like Rabi’a al-Adawiya who refused medicine and even refused to pray to God for health.

**HUMAN DIGNITY AND AUTONOMY IN KANTIAN PHILOSOPHY:**

Kant gave a secular view of the human dignity based on the capacity to reason. Accordingly all human beings having the capacity to reason are autonomous and have dignity; and can legislate morality. There is no qualification for legislating the morality except the rational capacity. What can be the weighing criteria for legislating morality? Kant gives an idea of ‘good will’; moral actions can be weighed by ‘good will’. Good will according to him is an unconditional good while all other goods are conditional. There are three gifts of nature:

1. Talents of mind.
2. Gifts of Fortune.
3. Qualities of temperament.


\textsuperscript{24} Op.cit., Imam A. van Bommel, p. 20.
There are according to him three objects of passions:

1. Power
2. Honour
3. Wealth.

And the category of general good includes:

2. Entire well being and contentment with one’s conditions, under the name of ‘happiness’.

The conditional good mean that these can be good or can be bad. The goodness and badness of these depend on the consequences e.g., the talents of mind can also be used for evil purposes. The ‘Good will’ is a commitment with the categorical imperative that is the demand of rational capacity. Every other good can be judged by consequences but the goodness of the ‘good will’ is an end in itself. There is nothing, which can add or subtract the goodness of the ‘good will’, no matter what the consequences of any action are.\(^{25}\)

The rationality principle leads to a concept of ‘person hood’ in Kant’s thought. Only those human beings who have the capacity to reason are eligible for the human dignity. Though we do not find Kant’s views on the dignity of children and mentally impaired people we can only infer from his philosophical thoughts that those who are not yet mature enough but can have power to reason in the due course of development like infants and children, can have potential dignity – which is not comparable to human dignity; but those who can never be able to posses the capacity are not eligible for the human dignity, e.g. people with permanent mental impairments, comatose and those in the permanent vegetative state. They belong to the species of human beings biologically but are not persons as rational beings.

**KANTIAN AUTONOMY VS BEAUCHAMP AND CHILDRESS’S PRINCIPLE OF RESPECT FOR AUTONOMY:**

The rational capability gives autonomy to human beings. Autonomy in the bioethical principles of Beauchamp and Childress and that of Kant is very different. The Kantian

The concept of autonomy is not random free choice; autonomy according to Kant as Richard Dean explains, “…is the source of moral principles, not necessarily the object for which moral principles demand respect or special treatment”\(^\text{26}\). Autonomy thus for Kant is not a distinguishing characteristic for respect, rationality has special status which leads to autonomy. Autonomous choices of morality legislation are limited by the categorical imperative, an autonomous choice is not worthy of respect unless it is within the parameters of the categorical imperative.

The free will in Kantian philosophy must be free from all the internal and external constraints. So any choice made on the basis of strong desire or an inclination is not free because it is dictated by the inclination (internal constraint) and any choice made by coercion is dictated by the external constraint. Kant gives an idea of free will, which is beyond any kind of restriction, besides this he says that all choices must be made according to the categorical imperative.

According to Dean’s view Kant does not recognize any duty to respect for autonomy, and further that the concept of beneficence is also different in the Kantian philosophy. Beneficence is not doing or giving what we think is good it is rather in showing modesty and helping others to reach their ends. In the classification of duties beneficence is one of the imperfect duties so it is not obligatory. Perfect duties include “not to infringe upon others’ morally permissible decisions”\(^\text{27}\). So there is no scope for any type of paternalism in the Kantian philosophy.

Beneficence in Kantian philosophy does not clash with the human dignity and autonomy of an individual e.g., if X does something for the good or benefit of Y on the basis that X knows better what is good for Y, it hurts Y’s dignity, because in such a situation Y is not considered as a rational being able to make decisions. Here X manipulates Y according to X’s decision and manipulation is also against human dignity. Beneficence in Kantian philosophy is to make others way easy towards making rational autonomous choices. Kantian philosophy does not provide an umbrella of beneficence for any type of paternalism.


\(^{27}\) Ibid., p. 216
In the Kantian philosophy we do not find the principles of bioethics explicitly. His philosophy provides principles for bioethics implicitly and these can be inferred from his work. The rule of not telling a lie leads to an informed consent, i.e., complete information without deceit and misinformation, thus empowers patients for the autonomous decisions, beyond any kind of inclinations. Keeping a promise gives principle for the confidentiality in bioethics. The autonomy principle of Kant is substantially autonomous i.e., free from all types of the internal and external inclinations and keeps the human dignity of individuals.

INTERNATIONAL DECLARATIONS FOR HUMAN DIGNITY AND HUMAN RIGHTS:

Human dignity is related with the human rights, that everyone has human rights because all human beings have an inherent human dignity. In the preambles of the two international covenants adopted by the United Nations in 1966 the following can be read:

“These [human] rights derive from the inherent dignity of the human person”.

Human dignity and its relationship with human rights is also stressed in the Universal Declaration:

“Everyone…is entitled to realization …of the economic, social and cultural rights indispensable for his dignity”, and that these are rights “ensuring … and existence worthy of human dignity”28.

The above Declaration refers to three main concepts i.e., human dignity, human beings, and human rights. The human dignity is not explained, the meaning is left for others to assume. It is also not clear whether human beings refer to everyone – competent, incompetent and also potential human beings. The concept of human rights is also vague, it is not clear whether it refers to the autonomy of individuals or

28 Op cit., Alan Gewirth, p. 10
there is a set of human rights that should be imposed on all human beings beyond
cultural differences paternalistically.

Joel Feinberg claims that human dignity is in the ability to assert claims\(^{29}\). This
concept denies the concept of an ‘inherent dignity’ according to which the human
dignity is the right of those who can claim for rights, who cannot claim for their rights
are then deprived of dignity. There are communities where people cannot claim rights
even though being competent; or in certain cultural norms people are not morally
trained to claim rights. Should we label those people as human beings without dignity
and without human rights?

Human dignity as ‘inherent’ right gives an equal intrinsic value to all human beings. It
does not seem to be contingent of assertive capacity to claim, rather a
necessary attribute of all human beings. According to Kant human dignity cannot be
substituted or replaced by anything else – it is priceless. This inherent human dignity
is also related with inalienable human rights. This raises different questions like, what
is the relationship of dignity and human rights? Is it equivalent to rights or is there
some kind of hierarchy? Is human dignity an antecedent or a consequent of human
rights?

Alan Gewirth distinguishes empirical and normative aspects of rights, and he is of the
opinion that whether rights are being provided or not to all human beings empirically,
human dignity as an inherent value remains unhurt. There are some socio-political
situations where people are not provided with basic human right but this does not
affect the normative value of human dignity.

“In the inherent sense, human dignity is not a quality that
waits for its existence on the empirical fulfilment or claiming
of positive legal rights; rather, it exists even in the absence of
such fulfilment; indeed, it is the ground or antecedent of the

\(^{29}\) Joel Feinberg, Rights, Justice, and the Bounds of Liberty: Essays in Social Philosophy, Princeton
rights insofar as they are morally justified, not their consequent”\textsuperscript{30}.

The inherent human dignity calls for the positive and negative rights; negative rights are those, which should be avoided like torture, insult, discrimination etc and positive rights are those, which should be provided as individual, social and economical rights etc. These rights are to be given to human beings having inherent human dignity. On the other hand according to Kant human dignity depends on the ability to reason.

Deryck Beyleveld and Roger Brownsword remarked that human dignity in the International Declarations could be interpreted as empowerment and constraint. According to the empowerment concept,

“It is the intrinsic dignity of humans that acts as the foundation for human rights...it is because human beings have dignity that they are entitled to respect from others – that is, by virtue of their dignity, human beings are entitled (a) to be recognized as members of the class of humans (a class of beings having value) and (b) to have the conditions in which they can experience their own dignity and exercise the distinctive human capacities that account for their dignity...if human dignity is equated with the capacity for autonomous action then this will feed through into a regime of human rights organized around a right to one’s autonomy”\textsuperscript{31}.

The human dignity concept in the Universal Declaration on the Human Genome and Human Rights shifts from the empowerment to constraint. The Declarations states, “The aim is not only to protect the individual, in his rights and his freedoms, since dignity concerns the human beings as such, in its [sic] largest sense”. Beyleveld and Brownsword remarked:

“In line with this larger agenda, the Declaration’s dignity-based concerns about human reproductive cloning and germ-line intervention seem to be less concerned with protecting autonomous choice than with preserving the sanctity of life or the integrity of the genome (as the ‘heritage of humanity’)…in these restrictive responses, we have the ingredients of human dignity as constraint”\(^32\).

The International Declarations on human dignity and human rights somehow have some implicit adaptability for different cultural values because clear explanation of these concepts is not available and is left for the reader to assume. The Human dignity and human rights could be interpreted differently in different cultural contexts.

**CONCLUDING REMARKS:**

The Islamic concepts of human dignity, autonomy and personhood are similar in many respects to the Kantian philosophy. The latter view is that of secular and the former is that of religion. There is no concept of absolute random freedom of choices both in Islam and in Kantian philosophy, Islam has the limitations of the foundational principles of religion and the Kantian philosophy has the limitations of the categorical imperative. Both systems are based on duty-based morality.

Islam is a flexible religion, which has the capability of adoption with the development of science and technology. ‘Ijtehad’ is the major tool towards new interpretations and novel decision-making. Scientific and technological development has posed new challenges that call for the revival of practice of the ‘Ijtehad’ in the Islamic world.

Islam gives importance to humans and to the dignity of human beings. Islam observes honour in the family ties; especially between husband and wife, love and mutual respect for children. In Islam the orphans are treated with utmost

\(^{32}\) Ibid., pp.40-41.
love and dignity; God despises those who dishonour the orphans: "Nay, but you honour not the orphans." (al-Fajr 89:17) In Islam a mother is to be treated with kindness; one should not even say the slightest word of hurting her feelings. Humans have dignity in Islam regardless of financial status, "So do not shout at those who ask (for help)" (al-Duha 93:10)

The Prophet Muhammad taught the universal dignity of all human beings. All human beings should be treated with justice. No racism, no prejudices, no calling of names. Islam teaches the human dignity in all aspects of life be it family structure, social structure, economical or political structure. In an Islamic political system, human rights hold a very strong position, justice, equality, fair dealing, shura not dictatorship. Islam speaks of freedom of thought, freedom of expression, freedom of speech, freedom of movement, freedom of decision. Islam teaches fair dealing, equity and justice when it comes to its teachings of economics.

Islam focuses on the society and human beings – the latter are to be given equality to become nourished mentally physically and spiritually. There were many atrocities in the world wars and after the World War II the Universal Declaration of Human Rights that was adopted by the United Nations organization on 10th December 1948 at Paris focused on the preservation of human rights, justice and human dignity. All covenants protect human rights such as the Declaration of Human Rights in the year 1966. It was also assured that there would be no derogation of human rights even in times of an emergency and in 1989 after the fall of the Berlin Wall, a world conference on human rights was conducted in Vienna in 1993 stressing on the human rights. In comparison to the International Declarations, most of the ideals are acceptable in the Islamic laws. Islam is a communitarian and duty-based religion therefore individual choices that are against the larger interests of community (safeguarding the individual rights of every member of the community) are not recommended. The International Declarations are

33 “Whosoever believes in Allah and the Last Day, let him speak good words or keep silent. Whosoever believes in Allah and the Last Day, let him honour his neighbour. Whosoever believes in Allah and the Last Day, let him honour his guest.” (Sahih Muslim, Hadith no. 67)
also stretched in between two the extremes of ‘dignity as empowerment’ and ‘dignity as constraint’, which indicate that the larger interests of the humanity cannot be sacrificed over the individual choices.

Islam gives importance to human life and the dignity of humans and it can only be recognized when equality, freedom and autonomy are up hailed. The pious and good people can only gain superiority over others. Islam abolished monarchy, and the system of priesthood. In Islam master and slave otherwise has no superiority over one another. The famous poet Allama Iqbal wrote in one of his poems that in performing ‘namaz’ (prayer) the master and the slave stand in one row and whilst they pray there is no master and no slave – this concept he developed from the practical aspect of life in which slave Balal Habshi gave the ‘Azan’ the call for prayers. No one is superior to another on the basis of caste, creed or religion and human dignity stands supreme.
CHAPTER II
ISLAMIC BIOETHICS AND CRITICAL ANALYSIS OF PAKISTAN
MEDICAL CODE OF ETHICS

INTRODUCTION:

The first part of this chapter will focus on the Islamic interpretation of bioethical issues. In the second part I will mention the codes of ethics of the Pakistan Medical and Dental Council (PM&DC) and compare it with the Islamic bioethical laws. My focus will be on the general Islamic interpretations. My research limitation will not allow me to discuss the in depth issues with reference to different schools of thoughts. There are no major differences in these schools like Shafi, Humbali, Malaki and Hanafi. Individual analysis according to different schools of thoughts requires separate research and it would not be possible to deal in this research.

PART- I

BIOETHICAL ISSUES AND ISLAMIC INTERPRETATION:

The modern science has changed many conventional views about life, death and parenthood. In some respects the progress and development in the medicine has elevated the quality of life but it has also created new ethical problems related with the quality and quantity of life, end of life decisions, parenthood, personal identity, etc.

New challenges call Muslim jurists to interpret the modern techniques in the light of fundamental principles of Islam. In Islam there are three sources from which to derive solutions i.e., the Quran, Sunnah and Shariah. The Quran consists of two types of commandments, ‘Muhkamat’ and ‘Mutashabihat’; Muhkamat explains direct commands like the division of the assets among family members, rights and duties of husband and wife, demarcation of relationships among family members, their rights and duties, about contracts, marriage and business, etc. where as ‘Mutashabihats’ are like similes which can be interpreted according to different situations within the limits
of fundamental principles of Islam. This is the living feature of Islam that it can be interpreted and has the capacity of adaptation with new challenges and environment. Any Muslim having knowledge of the Islamic principles is entitled to make decisions in a novel situation.

The principles followed in Islam for making a legal opinion are:

- Necessities overrule prohibition.
- Choice of the lesser of the two evils if both cannot be avoided.
- Acceptability of a deed depends upon the intention behind it.
- All things are lawful unless specifically prohibited. Similarly all things are juridically clean except those specified not to be.

**Necessities overrule prohibition:** This rule can better be explained by taking an example of food; Muslims use the term ‘Halal’ which is permitted and ‘Haram’ which is forbidden, such as pork is forbidden in Islam. The use and consumption of ‘Haram’ food is strictly forbidden but in the case of treating diabetic patients with insulin, which is obtained from pigs, in such case where the life and death becomes a matter it is permitted out of the necessity. Alcohol is forbidden but until alcohol free medicines are not available it is allowed.

Besides ‘Haram’ and ‘Halal’ there are other terms like ‘Makrooh’ means religiously disliked or discouraged but in the time of scarcity of food like famine or for the sake of life it can be taken; ‘Mashbooh’ means ‘suspected’ like there is no clear or direct commandment available in the Quran or Sunnah. In the hierarchical preferences first preference should be Halal, then Makrooh then Mashbooh and the least should be the Haram.

**Choice of the lesser of the two evils if both cannot be avoided:** In Islam the respect for the integrity of body (living or dead) is very important. One might think that the organ donation and transplantation could be a violation of the principle; in order to choose the lesser evil the respect for the integrity of body can be overruled by saving

---

34 Op cit, Bushra Mirza, p. 106.
the life of a dying person\textsuperscript{35}. Health is a greater good; in order to achieve the greater good Islam permits obtaining organs from the living donors as well as cadaver.

**Acceptability of a deed depends upon the intention:** All actions are to be judged on the basis of intentions, this is an important principle of Islam and all actions should be done with good intentions and for the welfare of people. Euthanasia is not permitted in Islam as life is sacred in all stages and there is no concept of uselessness of life. Taking anyone’s life means killing and it is not permissible; but giving lethal dose of painkiller with an intention to alleviate the pain and not to kill the person, might be acceptable in Islam\textsuperscript{36}.

**All things are lawful unless specifically prohibited:** There are direct commands in the Quran for some forbidden acts and food. A careful study is required in interpreting commandments in different scenarios, for instance, even though drinking and handling alcohol is forbidden but there is no problem in using it as solvent in perfumes or cologne or in creams or [medicine]\textsuperscript{37}.

An overview of the general principles, followed by Muslims for formulating a legal opinion ‘fatwa’ has been given above and now I will explain some bioethical issues and their Islamic interpretations.

**BIOETHICAL ISSUES AND ISLAMIC INTERPRETATION:**

New technology has blurred the conventional concepts of life and death, parenthood and personal identity. I will discuss these issues in the perspective of different interpretations given by different scholars.

**Guardianship of women:** According to the scriptures of Quran, man is the guardian of women in different roles like father, husband and brother. Men are responsible to protect and promote the well being of women; they have to provide and fulfil all the needs and requirements of women.

\textsuperscript{35} Ibid., p. 107.
\textsuperscript{36} Ibid., p. 107.
\textsuperscript{37} Ibid., p. 107.
In my opinion this duty of men has been misinterpreted in most of the Muslim countries, and misunderstood as men to have the authority to give the consent for every decision on behalf of the women. On the contrary women are entitled by Islam to give an independent consent for all the decisions of their life. The Quran entitles women to decide for their life partners independently “if they [men and women] agree between themselves in the proper way”\(^{38}\). It is better for them to discuss with their parents or guardians but the role of guardian is not to manipulate her decision or coerced her for certain decisions. Prophet Muhammad is reported to have obtained consent from his daughter Fatima before marrying her with Ali. The guardian can facilitate women’s autonomous decision-making but any type of coercion is not permissible.

Health and preservation of life is very important in Islam and there is no distinction on the basis of gender. Unlawful killing is prohibited in Islam and abortion at any stage is unlawful but for the well being of women if continuing a pregnancy threatens her health and life – abortion is allowed. Every individual is entitled to keep his or her good health, which leads to the entitlement of an individual and independent consent about health decisions. Infringement upon the commandments of the Quran are permissible for the well being of women which shows that any cultural practice cannot take precedence over the well being of women. Therefore there can be no distinction in male and female consent in health care decisions.

**Consent:** In Islamic Bioethics every individual be male or female is entitled to have complete knowledge of his or her physical condition and is permitted to make an independent decisions. For incompetent patients or potential agents their guardians are entitled to make health care decisions; in the absence of any guardian in Saudi Arabia state is responsible for the health related decisions\(^ {39}\). In an emergency physicians have to provide the necessary treatment if patient is unconscious without waiting for the consent procedure.

**Euthanasia:** Artificial life support techniques help to prolong life but at a certain level fails to elevate quality of life rather it is declines. Life is sacred at every stage

---

\(^{38}\) Op cit., Encyclopaedia of Women, p. 489.  
\(^{39}\) Op cit., Dariusch Atighetchi, p. 52.
and in all circumstances in Islam, it is the belief of Muslims that life is never purposeless or useless therefore ending life is not permissible. The concept of bearing pain is also different; Muslims believe that pain and sufferings is the test of their faith in God and He never gives any difficulty beyond one's capacities. Therefore there is no concept of an unbearable pain – and that bearing pain sheds sins of the individual. Therefore asking for euthanasia or voluntarily killing someone in order to relieve him or her from an unbearable pain has no place in the Islamic faith. The duty of Muslim physicians is to protect life at all stages.

The contours of life and death are blurred with modern life support techniques. Muslim scholars from different schools of thought had consensus on the concept of brain death that results from an irreversible damage to the brain.

“The classical legal definition of death connects death with the traditional signs, including complete cessation of the heartbeat. For most jurists, this factor is the sole criterion for legal (shar'i) death. Biological data about the function of the heart and other major activities, however, connect life with the brain…”

According to Islamic jurists, when the brain stops functioning and other functions are restored with the help of artificial support, these life support techniques can be stopped with the consultation of physicians and family members keeping only hydration and food supply.

Active euthanasia is not permissible in Islam but a lethal doze of painkiller that shortens the life with intentions of alleviating pain and not killing is permissible. Withholding aggressive life support is also permissible in Islam when death becomes an inevitable reality;

“The law permits a patient to refuse a death-delaying treatment or a doctor, after consultation with the patient, their family, and others

involved, to withdraw futile treatment on the basis of informed consent”\textsuperscript{41}.

Prolonging life with artificial support is neither in the interest of the patient or family nor in the interest of the community – on the basis of resources allocation.

In a vegetative state ventilators can be switched off according to Islamic jurists but hydration and artificial nutrition should not be stopped. It means that if the brain stem is functioning properly no matter if the cerebral cortex has an irreversible damage, the food supply should not be stopped and the patient should be preserved until he dies of natural death.

The concept of the sanctity of life though is important in Islam but it does not overrule the dignity of human beings. The Islamic bioethical laws in Saudi Arabia allow abortion of malformed foetuses on the basis of the quality of life thus overrules the sanctity of life. The Islamic jurists need to discuss the euthanasia issue in reference to quality of life issues. If abortion can be allowed for malformed foetuses on the basis of quality of life and human dignity (at the beginning of life) could life be terminated on the same ground afterwards (at the end of life)?

In the Quran God says that the scripture can be interpreted in a variety of ways and calls people to ponder into the deeper meanings. The language is religious and can be interpreted according to the latest scientific knowledge and progress. New technologies call for substantial study into the religious concepts about the sanctity of life, quality of life and meaning of death.

Once on a funeral the Prophet Muhammad is reported to have said: “How fortunate you are that you died while you were not afflicted with illness”. Muslims are asked to pray God to ease the death of the dying person; it implies that delaying the dying process is something evil that should be avoided. This can also imply that making someone’s death comfortable and relieving him from pain and agony can also be permitted in Islam. These issues call Islamic jurists for further discussion to seek the solutions.

\textsuperscript{41} Ibid,
Post-Mortem in Islam: Keeping the integrity of the body of living and dead is an important principle of Islam. No direct commands or statement in the Islamic jurisprudence concerning post-mortem are found. There is a need to balance between two principles, the integrity of body and keeping Justice. In one of the verses of the Quran, God (Allah) stresses the importance of justice:

“O Believers, establish justice, be witnesses for God, even if it goes against yourselves, or your parents, or relatives, whether rich or poor; God is closer than either” (sura Nisa 4:134).

In order to seek justice the integrity of the body has to be weighed. Justice is the most stressed principle in Islam, to find out the cause of death in order to provide justice to the victims – post-mortem becomes a necessity. A van Bommel, referred the fatwa verdict of Shaikh Yusuf Nasr al-Dajawi in reference to post-mortem in which he said:

“We do not have in jurisprudence books or any satisfactory statement on the topic…So we must have far sighted views which will take into account the stronger benefit which agrees with the spirit of the law which is good for every place and every time and which guarantees well being and happiness in this world as well as in the Hereafter. Thus we feel that post-mortem examination can be seen to be necessary in certain situations…”

In my opinion the importance of seeking justice in reference to post-mortem examination can be found in the second chapter of the Quran ‘sura Bakra’, to find out the cause of death and to provide justice to the victim’s family.

“And when you shed blood, then began accusing for it each other and Allah was to disclose what you were hiding. Then We said, "strike with a part of that cow to the slain. Allah thus will give life to the dead and shows you His Signs, so that you may understand”, (sura Bakra 2:72, 73).

Now forensic science is capable to get clues for the cause of death and signs of murderers – post-mortem is desirable in Islam. In the above-mentioned verses God miraculously gave life to the dead to identify the murderer; forensic samples taken

43 Op cit., Imam A van Bommel, pp. 21-22.
from the dead body reveals the truth (it is just like the dead identifies the murderer) i.e., the cause of death, time and mode of death.

**Abortion:** Life is sacred at all stages therefore; abortion is not permissible in Islam. This law can be overruled if the health and life of the pregnant woman is in danger for continuing a pregnancy. In Saudi Arabia from the 40th day to the first 4 months abortion is unlawful unless pregnancy harms the life of the pregnant woman. There is a specific procedure to perform the abortion. A three-member hospital committee has to prepare a report considering health reports of the pregnant woman and if abortion is recommended informed consent of the pregnant woman and her husband is necessary before operation. The abortion of a foetus within the first 120 days is approved if the foetus is affected by incurable handicap that can result in a miserable life of the child and family.

In Tunisia voluntary abortion is allowed within 3 months in the presence of at least five living children. In law there is no restriction of abortion throughout the period of pregnancy but the first 3 months are to be privileged. Abortion for population control is allowed in Tunisia – presenting a modern approach in the Muslim World.

**Organ transplantation:** Islam is a communitarian religion for the health and welfare of the community; organ transplantation is permissible both from living donor and cadavers. The principle of the integrity of the body can be overruled by the welfare of the needy on the basis of ‘necessity’ and ‘lesser evil’.

On the basis of the public interest and welfare jurists arrived at the consensus that blood and organ donation is permissible for good medical reasons and that the health of the donor should be protected. If living donors are not available then organs can be obtained from animals. Obtaining organs from corpses can be allowed to prevent greater harm to a living individual who might die without the transplant.

**Assisted reproductive techniques:** Islam promotes procreation therefore all assisted reproductive techniques are permissible only if the sperm donor and ova donors are

---

47 Op cit., Dariusch Atighetchi, p. 162.
husband and wife at the time of treatment – donation from third parties is not permissible. Islam gives a comprehensive social system that demarcates personal relationships – permissible and forbidden. Sperm and ova donation blurs the boundaries of permissible and forbidden relationships. Therefore careful analysis of the techniques and their applications is required. As the Quran states:

“Forbidden to you are your mothers, and your daughters and sisters and your father's sisters and mother's sisters and your brother's daughters and your sister's daughters, and your mothers who have given suck to you and your foster sisters and the mothers of your wives and daughters (your step daughters) who are in your care from the wives with whom you had intercourse but if you had not intercourse with them, then there is no harm in their daughters, and the wives of your sons who are of your loins and to have two sisters together except what has already passed. Undoubtedly. Allah is Forgiving, Merciful” (sura An-Nisa 4:23).

The sperm donor is the real father of the child therefore this practice can create a social problems in the society, where people may not be able to make distinctions between the ‘halal’ permissible and ‘haram’ forbidden relationship. Same is the case with ova donation. This practice blurs the concept of parenthood and siblings this is not only important for inheritance in the property but it can pose serious social problems in the future for marital relationships.

Surrogate motherhood is also not permissible in Islam as in the Quran God says: “None can be their mother except those who gave birth”48. This issue is not very clear because there is a concept of lactating mother in Islam – one who breast feeds; in circumstances if the real mother is not able to feed her child any other woman can be hired for lactation and she has the status of mother as it has been stated: ‘your mothers who have given suck to you and your foster sisters’. This verse gives a concept of mothers who do not give birth but are mothers and their children are foster sisters and brothers. Therefore in my opinion this concept needs debate and deliberation among Islamic jurists.

Surrogate motherhood also raises questions in the Islamic jurisprudence about ‘adultery’; from the penal point of view it is not punishable by the penalties of Shariah because there is no physical intercourse among the parties concerned. In my opinion if it is not adultery then it could be permissible. Another social problem that could be raised is the marital relationship that if this practice becomes popular it would create problems to find ‘halal’ permissible relationship for marriage.

In the above-mentioned verse it is clearly mentioned that men can marry daughters of their wives with whom they did not have intercourse. Therefore, this could not be the problem. Surrogate motherhood does not violate the lineage principle, it cannot be categorized as adultery according to the Islamic jurisprudence and it also does not pose future problems in marital relationships. In my opinion jurists need to deliberate on this issue by examining all the medical intricacies and Islamic law.

**Contraception:** Islam promotes procreation but besides this it also calls for a better living, education and training of children. Parents and especially father is responsible to provide good living to their children so that they can become good citizens.

Most of the Islamic jurists agree on using contraceptives for gap in births, to prevent transmission of hereditary diseases, and some agree for the population control on the basis of economic problems. All jurists agree that the measures should be taken independently with the consent of husband and wife – the state government should not impose it. Permanent sterilization is only permissible if there is a great threat of hereditary transmission of disease to off springs otherwise it is not recommended.

**Gene therapy:** Health is sacred in Islam therefore Somatic cell therapy is permissible as it alleviates the sufferings of patients. Most of the jurists and scholars have reservations on the stem cell therapy because it can be used to enhance the human qualities. Any therapy or technique that can be used for negative purposes or for heightening discrimination among people is not permissible in Islam.

---

50 Ibid., pp. 65-82.
51 Op cit., Bushra Mirza, p. 112.
PART-II

ISLAMIC BIOETHICAL LAWS AND PAKISTAN MEDICAL CODES OF ETHICS:

In this section I will focus on the code of ethics of the Pakistan Medical and Dental Council (PM&DC) to explore whether they are formulated according to the Islamic medical ethics or not.

**Euthanasia:** In Pakistan euthanasia is equivalent to killing and is not allowed. It is not explained as active or passive euthanasia. The term ‘euthanasia’ is not used in the code of ethics, rather the section has the heading of ‘End-of-Life Care’ there is no explicit code on euthanasia (Appendix-A). The code explains the end of life care as control of pain, other symptoms (not mentioned which symptoms) decisions on the use of life sustaining treatment and support of dying patients and families.52

Section 24.1 states very radically: “Futile treatment need neither be offered to patients nor be provided if demanded”. Further § 24.2 states: “The physician is not compelled to accede to demands by patients or their families for treatment thought to be inappropriate by health care providers”.53

Any explanation about passive or active euthanasia is not found nor there is any statement concerning administering a lethal dose of painkiller to alleviate pain or sufferings of the patients. About withholding the treatment the code gives all rights of decision-making to the physician even it cannot be provided on the request of patients or their families. This gives an impression of strong paternalism thus limiting the rights, dignity and autonomy of patients.

It does not mention anything about the surrogate decision-making, showing the authority of the physician in decision-making for competent as well as incompetent patients.

---

52 Pakistan Medical & Dental Council, Code of Ethics. available at www.pmdc.org.pk/ethics.htm - 188k
53 Ibid.,
Refusing treatment raises a moral debate on the difference between ‘killing’ and ‘letting to die’. Is there any difference between killing i.e., active euthanasia and letting to die ‘passive euthanasia’? Refusing or withholding the treatment can be categorized as passive euthanasia. The code does not refer directly to the practice of passive euthanasia, but indirectly and implicitly allowing on the discretion of the physician alone. Letting to die or killing can only be justified morally if the act is done with the consent of patient and good will of the physician\(^5\). Futility is not explained extensively in the code. According to Suzanne Kite and Stephen Wilkinson futility can be have three different meanings:

- A futile action can be the one that cannot achieve its purpose or goal no matter how often it has been repeated. It can be ineffective in relation to one goal but can be effective in relation to another, for example as a cure of disease any treatment can be futile but for palliative purpose it may not be futile.
- Normative futility is related with the best interest of the patient. A treatment is futile if it is unlikely to benefit the patient. Some treatments are harmful and some are both harmful and futile.
- Physiological futility is related to the medical treatment provided to patient as life supporting interventions. It can be futile if it is unlikely to achieve its clinical goals\(^5\).

The code of ethics does not explain how a treatment can be judged as futile whether on the basis of resource allocation and the scarcity of medical facilities or on the basis of the welfare of patient. The autonomy and the dignity of the patient are just overruled in this section portraying the strong paternalism. The oath of medical practitioners states: “I will protect human life in all stages and under all circumstances, doing my utmost to rescue it from death, malady, pain and anxiety”.


Section 24.2 abstains to provide medical care even to the ‘demand of patients’ it means that the end of life care is not only withheld for unconscious incompetent patients but also for competent patients, who demands for treatment which physicians consider as ‘futile’. On the contrary on the basis of self-determination principles that give rights to the patients for decision-making as Dan W. Brook states:

“It is important to recognize that sometimes patients may make treatment choices in the exercise of their self-determination that are bad, foolish or irrational and do not best serve their well-being even as determined by their own values. The importance of self-determination implies that even bad choices of competent patients must be respected”56.

According to Brook choices of the competent patients cannot be refused. Any treatment can be futile in respect to the cure of a disease but for palliative purpose it might not be futile, therefore refusing a competent patients from treatment considered on the basis of ‘cure’ as futile can add to the pain, malady, and anxiety (on the basis of palliative care). The code does not mention any procedure of consultation with the patient and his/her family any type of informed consent or counselling but radically states that the physician is not compelled to provide a treatment considered futile, showing strong paternalism.

**Abortion:** The code on abortion is not clear about the issues such as the time period, days or months of pregnancy; it merely states: “…according to law a pregnancy can be terminated only if there lies a serious risk to the life of the pregnant women”57. As compared to Saudi Arabia there is no explanation about the procedure and informed consent. How the decision will be taken for abortion and how this information will be given to the pregnant woman and her husband is not mentioned.

There is also no explanation or code about aborting severely malformed foetuses or sex selection. Besides this, there are many registered private clinics providing sex selection of embryos in Pakistan but I found no code of ethics about these facilities in

56 Op cit., Dan W. Brook, p 232.
57 Op cit., Pakistan Medical code of ethics.
the revised codes of the PM&DC. This is not a hidden practice because most of these clinics publish big advertisements in the local newspapers.

**Contraception:** The medical code of ethics has no section explaining the lawfulness of contraception or permissible methods. On the contrary there is a state sponsored campaign for population control in Pakistan.

**Organ donation:** Organ transplantation has helped in achieving the goal of medicine to some extent by preserving life, alleviating pain, and restoring the correct functioning of the body. This blessing is wrapped with many complex ethical problems. Resource poor countries are facing many ethical issues for organ donation, transplantation, allocation etc.

In Pakistan people sell their organs due to poverty and unemployment. There has been no substantial regulation or law to monitor this practice. Organ donation from live and dead donors is permissible in Pakistan.

The section 21.3 states: “the living donor should be counselled as to the hazards and problems involved in the proposed procedures, preferably by an independent physician”. The term ‘counselled’ is used in place of the informed consent; nothing is mentioned about the consent of living donors and advance directives of the dead or proxy consent. A statement in section 21.2 referring to dead donors says:

“If the family of the dead donor cannot take care of the funeral of donors body, then the transplant doctor involved in organ transplantation shall take care of transplantation and funeral”.

The arrangement for the funeral can be a sort of inducement to the poor families; it implicitly means that poor patients can be used as dead donors without obtaining any living wills, or consultation with the family. There is no direct law or code of medical ethics about assumed consent that gives authority to the physicians to obtain organs from all dead bodies without obtaining advance directives or proxy decision. In Pakistan more than 30% of people are living below the poverty line, in such circumstances arrangement of the funeral is a huge inducement for the family.
The term ‘counselling’ instead of the informed consent can also be used to manipulate live donors. The literacy rate is very low in Pakistan; physicians can counsel the donor that helping the needy is a good act in the eyes of God and one can survive with one kidney. This code is very weak according to the principles of autonomy, dignity, beneficence and non-maleficence.

Organ transplantation is a heinous business in Pakistan in which most of the specialist consultant physicians are involved. There are brokers ‘middle men’ who persuades poor unemployed young people to donate a kidney and pay them money as inducement. The receiver has to pay the inducement in cash to the donor, commission to the middleman and has to bear the expenses of the transplantation procedure. There are no regulations for the allocation of organs to the receiver, only those can get the transplant who can afford to pay a huge amount of money.

The code implicitly promotes the criminal practice that has made Pakistan an organ-harvesting place; people from other countries go there for transplantation. Weak consent procedure and high inducements have encouraged an ethically objectionable practice. One kidney is sold for almost $1648, which is a huge inducement in Pakistani currency for a donor, and a big amount to pay for poor Pakistani patients. Therefore the allocation of organs depends not on the needs or priority on the basis of medical conditions rather on the economical status of the receiver.

In the codes of the PM&DC, I do not find any section explaining the procedure of allocation of organs.

**Assisted reproductive techniques:** I found no code of medical ethics about the assisted reproductive techniques in the PM&DC. There are many registered private clinics providing assisted reproductive techniques in Pakistan, but PM&DC has no code of ethics related to this issue and about which procedure is permissible and lawful.

**Gene therapy:** No code of medical ethics concerning gene therapy about somatic cell therapy or stem cell therapy is found. The section about genetics in medicine only
describes the phenomenon of molecular genetics, it states that there are some ethical and legal responsibilities that accompany the flood of genetic information – these responsibilities are not explained neither there is any procedures explained on how to fulfil these ethical and legal responsibilities.

The PM&DC give no code of ethics about research or treatment for gene therapy. The reason could be that these techniques are very expensive and might not be done in Pakistan because of the meagre resources. I did not find any information on any research in this field going on in Pakistan.

**Concluding Remarks:** Islamic bioethics has a wider scope for progress and development. In most of the Muslim countries the progress is going on at a satisfactory pace. The PM&DC code of ethics devotes a section mentioning the difference between western bioethical values and Islamic bioethical values; the former as right-based and the latter as duty-based. In the PM&DC there is no Islamic jurist involved in formulating the bioethical codes in harmony to Islamic bioethics, the members of the council are registered physicians from all the four provinces who have formulated the codes of ethics.

Pakistan is an Islamic republic and it follows two parallel laws one is the Islamic jurisprudence and the other is the Pakistan Penal Code 1863. The PM&DC is supposed to follow the Islamic bioethical codes because it is under the umbrella of Islam and affirms this in its section 7.0. The critical evaluation of the code of PM&DC revealed that the Islamic bioethical concepts are not reflected in their medical code and at certain points it becomes rather ambiguous and it does not adhere to the Islamic bioethics.

Regarding ‘end of life care’ (passive euthanasia) the PM&DC in section 24.1 and 24.2 takes paternalistic decision against the will of the patient and his or her family and abstains from providing futile measures. The code of PM&DC is contrary to the Islamic bioethics that supports autonomy of patient and his family but PM&DC takes a paternalistic decision.
On the issue of abortion the PM&DC follows the Islamic bioethics in the preservation of life and in the sanctity of human well being but its bioethical code of preserving the foetus is ambiguous as there is no exact determination of the time factor at which it can be aborted.

I found no substantial progress in the Islamic bioethics in the perspective of Pakistan, many issues are not mentioned and a few of them have not been dealt with due attention. The sections on abortion, assisted reproductive techniques, gene therapy, organ donation, etc are not found with substantial clarity on the issues.
CHAPTER III
INFORMED CONSENT
IN PAKISTAN MEDICAL AND DENTAL COUNCIL’S CODE:
THEORY AND PRACTICE

INTRODUCTION:
The objective of this chapter is to focus on the codes of ethics on informed consent of the Pakistan Medical and Dental Council and critically examine it to note whether it is following the rules set by the World Medical Association the Declaration of Helsinki or not. I will also endeavour to examine as to what extent the Pakistan Medical and Dental Council code of ethics is inspired by the Islamic bioethical laws. It will also be my concern to observe that how closely it is knitted to the Islamic bioethical laws. This chapter will evaluate how consent is explained in the codes of ethics and how it is practiced. The strength and weakness of the statements will be evaluated.

The consent procedure in clinical and research medicine of a country is based on the cultural, religious and the social structure, therefore the social structure of Pakistan will be discussed briefly as the notion on consent of the Pakistan Medical and Dental Council is under study. Different factors will be kept in perspective that is the level of education of patients, their ability to comprehend the written matter, their understanding of the medical system and terminology, patient and physician relationship and how decision-making takes place in Pakistan – all these issues will be discussed in this chapter.

FOUR PRINCIPLES IN THE CODES OF ETHICS:
In developed countries stress is put on the patients’ rights and autonomy on the other hand in most of the developing, eastern and Southeast Asian countries medical decision-making is solely the discretion of the physician.

Medical paternalism is a common practice in Pakistan. The code of the Pakistan Medical and Dental Council mentioned the Islamic bioethical laws as duty-based and hence differing from right-based bioethical laws of western countries. In the first chapter I explored the concept of human dignity and autonomy in Islam in order to
find out the status of human being and the autonomy of competent individuals in Islam. I found that though Islam is a communitarian religion but it safeguards the rights, dignity and autonomy of individuals – the communitarian concept in Islam develops through respecting every individual’s rights. The Islamic bioethical laws explicitly maintain the autonomy and dignity of the patients. Therefore I do not find any justification for medical paternalism on the basis of duty-based moral principles of Islam.

The code of the Pakistan Medical and Dental Council (PM&DC) has been amended in accordance with amendments of the International Code of Medical Ethics, 1983 during the 35th Assembly held in Venice. In Pakistan, generally the consent is not obtained from the patients; the physicians make medical decisions and the family members of the patients are informed. In the clinical setting it can be justified on the basis of social restraints and economical reason but for research medicine this practice can lead to many ethical complications. The role of ethical review committees is very weak; thus leaving many ethical queries unresolved. The Pakistan penal code has no law for the rights of patients or for the research subjects. There are a few articles that come under the subject of negligence of duty – the negligence in a medical profession is explained in the article as not having proper qualifications and skills for medical practice. It does not include medical practitioners’ duties to safeguard patients’ rights.

The PM&DC precedes its codes referring to the four principles i.e., autonomy, beneficence, non-maleficence and justice. The section 9.2 states, “[medical practitioner is expected to] uphold the ethical principles of medical practice i.e., autonomy, beneficence, non-maleficence and justice”. I will evaluate how these four principles are dealt with in different sections referring to the patient-physician relationship and the patients’ rights.

---

58 Op cit., Pakistan Medical code of ethics.
59 Introductory Treatise to Pakistan Edition of Modi’s Medical Jurisprudence and Toxicology.
OATH OF MEDICAL PRACTITIONER:
The PM&DC formulated an oath for the physicians in the light of the World Medical Association General Assembly held in 1994, and the Islamic Medical Association Oath for Muslim Doctors. It states:

“I solemnly pledge myself to consecrated my life to the service of humanity… the health of my patient will be my first consideration; I will respect the secrets which are confided in me, even after the patient has died; …I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient; I will protect human life in all stages and under all circumstances, doing my utmost to rescue it from death, malady, pain and anxiety. To be, all the way, an instrument of Allah’s mercy, extending medical care to near and far, virtuous and sinner and friend and enemy.”

The oath contains the biomedical principles of beneficence, confidentiality and non-maleficence but the respect for autonomy is missing here. The statement referring to non-discrimination does not clearly mention respect for autonomy. One can be unbiased not discriminating patients and treating everyone paternalistically.

As an instrument of Allah’s mercy the status of physicians seems to be elevated as compared to other human beings. Muslims believe that life and death are in the hands of God and the time of death is preordained, therefore they submit to the will of God and do not complain. As an instrument of God’s mercy patients in Pakistan assume that they have to submit to the will or decisions of the physicians, though submission to the will of the physician is not an Islamic concept as such but it grew in Pakistani culture because of high illiteracy rate – that hinders the understanding of the true

60 Op cit., Pakistan Code of Ethics.
61 Every human being is a vicar of God. The concept of being an instrument of God is not only restricted for the medical profession. It is stressed for medical profession so that the status of physicians should not be elevated to the status of God who gives and sustains life. The verses of the Quran need to be interpreted with reference to the context in order to understand the meanings. Whenever a Muslim takes medicine he says ‘Allah Shafi’ God will cure. The concept of an instrument of God implies that man as vicar of God is entitled to reshape and redesign the universe with the power of his intellect but cannot create anything out of nothing. God has given autonomy and freedom to human beings therefore as an instrument of God a physician cannot deprive a patient of his autonomy.
nature of the religion. Dr. Farhat Moazam referring to her professional experience as a physician in Pakistan remarked:

“[H]e [father of a five years old patient] was signifying to me [physician] that just as he could not question God’s Wisdom and His Divine plans, when it came to decisions regarding corporeal matters of his ill child he put the same faith in me, the physician”62.

The submission to the will of God can be one of the many reasons that patients in Pakistan seldom complain against physicians and this can also be the reason of medical paternalism.

INFORMED CONSENT:
Informed consent is a hot-debated issue in bioethics. The information provided to patients is sometimes so technical that they cannot understand it and thus cannot make autonomous decision. Some patients do not want to know about their health conditions and physicians cannot impose the information on the patient to fulfil the consent procedure if they are not willing to know. The major problem ethicists are facing is to understand as to how they can formulate the informed consent that can help facilitate patients for autonomous decision-making?

The PM&DC provides a code of ethics for obtaining consent from patients and research participants but that code is not supported by the civil law – hence, serving only as guidelines for physicians and researchers and not substantial support for the rights of patients. The section on the ‘Duties of Physicians in General’ does not mention any clause for the physician’s obligation to obtain informed consent from his or her patient. In another section mentioning duties of the physicians to each other it states, ‘A physician shall observe the principles of the “Declaration of Geneva” approved by the World Medical Association. It is not clear whether this declaration is applicable for patients rights also or only for physicians and their colleagues, because it is not mentioned in the section on ‘Duties of Physician to the Sick’.

In a section on the patient-physician relationship the PM&DC holds that the patient share the responsibility of his or her health care with the physician. The section 10.1 states:

“Patients have the right to receive information from physicians and to discuss the benefits, risks, costs of appropriate treatment alternatives, and optimal course of action…” 63

The rights of patients call for obligations of physicians. The general duties of physician states:

“A physician shall, in all type of medical practice, be dedicated to providing competent medical services in full technical and moral independence, with compassion and respect for human dignity”.

This statement does not give a clear idea whether the human dignity is used as treating patients with respect or as the inherent dignity of an individual human being as an autonomous agent. It is also not clear whether the duty of the physician is to provide best medical competency with compassion on the basis of the beneficence principle paternalistically or with the consent of an autonomous agent.

Alan Gewirth holds that people might not be provided with their basic rights (like in countries with suppressive governments) but still they hold their inherent dignity. Therefore rights can be withheld without denying the entitlement or human dignity. Human being can have dignity; their rights can be infringed upon 64. In the code patients have been given the right to get information and take part in decision-making but there is no obligation on the part of the physician to provide information and facilitate patient in decision-making. In section 11.2.5 referring to ‘Care’ the additional duties of a physician includes:

“Treat all patients with dignity and respect, listen patients and respect their views, give patients (and provided patient agrees, family members)

---

63 Op cit., Pakistan Code of Ethics.
information (about their illness) in a way that they can understand, respect the rights of patients to be involved fully in decisions about their care, … adhere to veracity (truth telling) as judged in the patient’s interest”.

Additional duties can be interpreted in two ways; that additional duties are supplementary explanations of the obligatory duties or that obligatory duties are mandatory and additional duties are not compulsory to fulfil. If additional duties are extensive explanations of the obligatory duties then the code complies with the International Declarations providing all rights to patients for decision-making. On the other hand explaining the details of information section 11.2.6 states:

“The aim [to provide information] is to promote understanding and to encourage compliance with recommended therapy”[^65].

In Pakistan generally patients are asked to comply with the recommended therapy and they are not even explained about any side effects of the medicine or surgical intervention. This code also does not state that information must be provided to patients in order to enhance their understanding for autonomous participation in decision-making. It seems to be very paternalistic, the information is not meant to enhance or facilitate the patient for autonomous decision-making rather it is to make him or her to comply with the recommended treatment.

On the other hand from the physician’s perspective it is their duty to provide the best therapy to cure patients and sometimes their professional expertise clashes with the freedom of patients. Titia van Kleffens in her study observed that freedom of choice that depends on the information about alternative treatments is one aspect of autonomy. Patients need freedom in decision-making that depends on their own experience or life choices. This freedom of patients sometimes put physicians in a difficult situation of clash with their professional expertise and duty. Physicians usually stress patients for recommended treatment when the disease is curable and

respects the autonomy of patients when it is incurable\textsuperscript{66}. The study revealed that complete autonomy is not possible in clinical settings; in certain situations patients were pressured by physicians and sometime by the experience of the close ones or friends.

Illness can affect the abilities of patients, past experience and trust in physicians can also have an impact on the decision-making. With all these conditions one cannot avoid obtaining consent and informing patients about their health conditions and alternative treatment unless patients waive their right. In Pakistan generally patients are not informed about their health conditions rather they are told that everything would be fine. Physicians make medical decisions and inform the family members. Considering the medical practice the above code is not giving substantial right to patients for autonomous decision-making.

**DIFFERENT KINDS OF CONSENT:**

Consent can be of different kinds, explicit or expressed consent, implicit or tactic consent, and presumed consent. Implicit or tactic consent is inferred by the behaviour as going to a teaching hospital gives an implied consent to various roles of physicians, nurses and others in training.

“Presumed consent is …held to be…on the basis of what we know about a particular person’s choices or values, it reduces to either implied or express consent. …if consent is presumed on the basis of a general theory of human goods or of the rational will, the moral situation is more problematic”\textsuperscript{67}.

Presumed consent is mostly considered in obtaining solid organs from the cadavers. In some states it has been approved as a law, in the absence of any clear document as an advance directive against organ donation it is presumed that the deceased has no objection for obtaining organs. This type of presumed consent poses problems if the


deceased was unaware of the law. The necessity is that there should be at least a law that gives this authority. The civil or Shariah law in Pakistan has no article that allows obtaining organs from cadavers without advance directives or proxy consent of the family. The Pakistan Associations of the Blind offers volunteer advance directive cards for cornea donation, without this directive, physicians are not allowed to obtain organs from cadavers.

In the organ transplantation section the code does not mention about the advance directives or proxy consent from family rather there is a clause that authorizes physicians to obtain organs from cadavers and provide funeral arrangements for the deceased. This implies that organs can be harvested without obtaining consent by giving the inducement of a funeral arrangement to the poor patient’s families – which is against the law as well as human dignity.

CONSENT PROCEDURE:

The procedure for obtaining consent is not clearly mentioned in the codes of ethics, but it gives authority to hospitals for the consent procedure. Some hospitals obtain a signed consent document by the patient only for surgical intervention but not for other equally risky interventions. I managed to get a consent form from a Federal Government hospital in Islamabad (the capital city of Pakistan) that does not mention any detailed information for the patient or any protection to his/her rights. The statement is to protect the hospital authorities (as it is written in block letters to stress on) and the physicians from the responsibility of the consequences and prosecution; it states as,

“I hereby consent to an operation being performed upon…the nature and extent of such an operation; I leave entirely to the discretion of the Medical Officer performing the operation. I understand that anaesthetic may have to be for the operation. I will not hold any of the HOSPITAL STAFF responsible for any risks involved in or accidents occurring during or after the operation or anaesthesia” (Appendix-B).

---

68 Ibid., p. 66.
The consent form does not contain any further information it rather asks the patient to surrender his or her rights and protects the hospital authorities and physicians. In the code of ethics patients are entitled to get information as their right but the section 18.0 does not oblige the physician to obtain express consent from the patient.

“…[it is] Expected that physician will obtain explicit rather than implied consent…If a signed consent form is not required, and the treatment carries risk, clinicians should seriously consider writing a note in the patient’s chart to document that the consent process has occurred”.

The code only expects from the physician not oblige him or her to get explicit consent. Expectations can be fulfilled and can be denied. It also entitles physicians paternalistically to report on the patients’ behalf that consent procedure has taken place and this practice can be misused. It does not guarantee that actually the consent procedure took place. On the other hand it gives more authority and free hand to physicians. On the contrary, the World Medical Association Declaration (WMA) states:

“If the consent cannot be obtained in writing, the non-written consent must be formally documented and witnessed”\(^{69}\).

There is no clause mentioning witnesses for non-written consent in the PM&DC code of ethics.

**IMPICIT CONSENT:**

Implicit consent can be inferred by the behaviour of the patient as it is explained in the code that rolling up the sleeve can be an implicit consent for vein puncture. In general the consent procedure is very weak in Pakistan such as that only visiting the doctor or going to a hospital can be an implied consent for all the medical interventions.

\(^{69}\) World Medical Association Declaration of Helsinki, Ethical Principles for Medical Research Involving Human Subjects. available at [http://www.wma.net/e/policy/b3.htm](http://www.wma.net/e/policy/b3.htm).
All teaching hospitals provide free medical care that serves as an inducement for poor people. People go to a teaching hospital because of poverty but are supposed to have given implied consent for various roles of physicians, nurses and other trainers, thus limiting their autonomy. Only few hospitals obtain a signed consent form (usually by a family member) by the patient only for surgical interventions and the form does not even provide any information.

**INFORMED CONSENT AND RESEARCH MEDICINE:**

In reference to research a section on the ‘conflicts of interests’ is also very ambiguous. A conflict of interest is explained as something that occurs when primary and secondary interest clashes and secondary interests supersede the primary interests. In a clinical setting the health of the patients is the primary duty of physicians while in the research medicine scientific knowledge may be the primary interest. It further states in explaining the conflict as:

“The reference to ‘a set of conditions’ is important – having a conflict of interests is an objective situation and does not depend on underlying motives. Stating that someone has a conflict of interest does not imply a moral condemnation per se. It is the person’s action in the context of a particular situation or a lack of transparency that may be a cause for concern.”

In an ethical context the conflict of interest refers to the interests of two parties involved when the interest of one overrides the interest of the other. On the subjective level physicians may face a conflict between their two roles i.e., as a physician and as a researcher and there cannot be any division of primary and secondary interests because both careers are important to him. From the perspective of duties their primary interest should be to cure and care the interest of the patients and their personal prestige as a successful researcher should be the secondary interest. On the other hand for a researcher who might not be a physician of the patient the primary interest may be the scientific knowledge.

---

70 Op cit., Pakistan Code of Ethics.
The code of ethics is formulated for medical and dental practitioners and not for the researchers. This could be one of the reasons that the code for research is not clear. It states that if there is an objective evidence of clash of interest found then it could be a matter of concern. The statement uses ambiguous terms like ‘may be a cause for concern’. On the contrary the WMA specifies clearly:

“In medical research on human subjects, considerations related to the well-being of the human subject should take precedence over the interests of science and society”\textsuperscript{71}.

The PM&DC code of ethics does not provide a strong statement for the protection of patients participating in the research.

The statements of the PM&DC codes of ethics are vague. The sections are randomly arranged and a few of them are repeatedly quoted with few changes in the terminology, the sections about the consent are being spread out in different sub divisions with different statements. In the organ donation section I do not find any code or statement about informed consent, the consent has been replaced with counselling which can have different meanings and can be interpreted differently. Informed consent implies that complete information about the positive and negative effects of an intervention should be made explicit and left to the patients or volunteers to decide but counselling gives a different idea.

**MEDICAL DECISION-MAKING IN PAKISTAN:**

The medical code has been formulated considering international standards although there are some weak areas as discussed above. The real practice is somewhat different from the guidelines. There can be many reasons for conflict between theory and practice. The PM&DC in the segment on ‘The Teaching of Medical Ethics’ states in section 8.2:

“All the medical and dental colleges running MBBS (Bachelor of medicine and bachelor of surgery) and BDS (Bachelor in dental surgery)\textsuperscript{71}.

\textsuperscript{71} Op cit., Helsinki Declaration.
Courses, College of Physician and Surgeons of Pakistan and Universities running the Postgraduate Medical Courses in Pakistan are advised to incorporate medical ethics into their curriculum”.

The revised curriculum designed by the PM&DC for MBBS and BDS Courses do not contain ethics as part of the course study. In the guiding principles, it authorizes universities to introduce English, Information Technology and Ethics as additional optional subjects and it is on the discretion of the institution to introduce these subjects. A few medical institutions in Pakistan have inducted Medical Ethics as an optional subject. This could be one of the reasons that physicians and researchers are not well equipped with the knowledge of ethical principles that leads to a wide gap between the theoretical ethical principles of the PM&DC and medical practice.

The medical decision-making gives a different picture in Pakistan; in the developed countries the decisions are patient-centred whereas in Pakistan they are family centred. Mostly the decisions are made in consultation with family or sometimes families are just told about the decision made by the physicians. Patients are seldom consulted for their healthcare decisions. In most of the cases patients are not informed about the prognosis or diagnosis. Dr. Farhat Moazam in her article ‘Families, Patients and Physicians in Medical Decision-Making: A Pakistani Perspective’, remarked that family and doctor are involved in medical decision-making while the patient is almost out of the scene; he or she is often not informed about his or her prognosis or diagnosis. The doctor is expected to direct rather than just facilitate medical management.

“In Pakistan, family-centred decision-making works in tandem with an active, directive roles assumed by the physician that stresses the principles of beneficence and non-maleficence rather than patient autonomy”.

This statement evidently explains the real practice of medical paternalism in Pakistan. There is one physician for 1,432 patients in Pakistan. Fawad Aslam et al hold that

---

72 Op cit., Pakistan Code of Ethics.
explaining risks needs patience and time, especially communicating with illiterate patients – it is impractical to expect from over worked and underpaid physicians to do this\textsuperscript{74}. Fawad Aslam \textit{et al} tried to justify the medical paternalism from the perspectives of physicians. In my opinion this justificatory attitude of the physicians is promoting and strengthening medical paternalism in Pakistan.

A study conducted by A. M. Jaffarey and A. Farooqui at a teaching Hospital in Karachi, Pakistan, on informed consent from the perspective of physicians, revealed that most of the medical professionals abstain from disclosing information due to the apprehensions that patients will consult any other physician who will present a rosy picture ‘trust me nothing will go wrong’. Therefore disclosing information can affect their medical practice and income. It also revealed that physicians with busy practices were reluctant to give more time to their patients in providing information. Most of the physicians were of the opinion that they know better and can decide what is in the best interest of the patient. Some of them hold that communication with illiterate people is difficult and time consuming thus impractical in a busy medical practice\textsuperscript{75}.

In general relying on the expertise of the physicians is the cultural value of the Pakistani society. Medical science and technology are believed to have limits that cannot defeat death. The time of death is preordained and is seen as the Will of God. These religious believes also provides protective shield to physicians that is why patients or their families seldom suit case against physicians or hospital authorities. Another reason could be the legal system which does not provide any substantial support to such type of litigation\textsuperscript{76}.

In my opinion it is hard to believe that consent procedure for clinical trials can take place in such a societal value system and medical practice. Medical paternalism can be justified on the basis of social norms, religious beliefs and high illiteracy rate in the clinical settings but for clinical trials or research medicine many ethical concerns sprout. Though the PM&DC code of ethics provides guidelines complying (to some


\textsuperscript{76} Op cit., Farhat Moazam, pp. 32-33.
extent) with the International Declarations but without support from civil law, awareness among people and cooperation of physicians in facilitating autonomous decision-making – these codes fail to protect the rights of patients and research participants.

The medical paternalism in clinical settings arises many ethical queries about how the consent can be obtained from patients who are involved in clinical trials when they are not even informed about their health conditions? It implies that either patients are involved in research without their express informed consent or that there is no research being conducted in Pakistan. The second assumption cannot be accepted because physicians have been doing research in Pakistan. The College of Physicians and Surgeons of Pakistan (CPSP) promotes research and training in medical professions and it was established 45 years ago. The guideline of the CPSP for writing research articles mentions ‘patients as research subjects’, which provides strong evidence that patients are involved in research – therefore the first assumption is also rejected.

The guideline for writing a research article available on the website of the CPSP (Appendix-C) does not mention that informed consent from the participants and approval from ethical review committee are required for publication of the article. For Dissertation writing it asks for consent from patients if their photographs need to be published in the thesis – no consent forms are required for participation in the research. This indicates that informed consent and approval from ethical review committees are not a matter of concern for physicians and researchers for indigenous research projects. This practice in research medicine can be a violation of the dignity and autonomy of research participants. Patients are used as means and commodities rather than ends in themselves. Research involves risks of harms no matter how low these risks are – the matter of concern is that research participants are involved in research accompanied with risks about which they are not aware. This practice also violates the principles of beneficence and non-maleficence.
CONCLUDING REMARKS:
The Pakistan Medical and Dental Council (PM&DC) guidelines do not provide a substantial system for obtaining consent from patients and research participants. It neither complies with the Islamic bioethical laws nor with the International Declarations. The language used in the code is ambiguous that can have different interpretations and there is no legal support from the civil law of the country. These factors supplemented with the cultural values that elevate the status of physician and gives complete authority to them for medical decisions.

Medical paternalism can be justified in clinical setting but in research medicine it has many ethical implications. It seems impractical to believe that informed consent can be obtained from patients participating in clinical trials especially considering the medical practice in Pakistan. Fawad Aslam et al portrayed physician’s attitude and justified medical paternalism; it gives an insight into the authoritative behaviour of medical professionals.

In my opinion medical professionals can change the consent procedure. They can help facilitate patients for autonomous decision-making – the social value system is a weak justificatory argument for medical paternalism. Aslam’s arguments give an implicit idea that physicians are reluctant to discuss with patients especially with illiterate patients (half of the population is illiterate in Pakistan) because they are over worked and underpaid. Illiterate people cannot read and write but this does not mean that they cannot understand. Aslam’s argument justifying paternalism is not very strong rather it is against the inherent dignity of human beings – considering them not worthy to discuss their health conditions with them is a violation of their dignity. It implicitly entails that medical paternalism is not the outcome of social and religious values but the attitude of medical professionals. A. M. Jaffarey & A. Farooqui’s study also revealed that physicians’ personal interests and their attitude towards illiterate people are the main hindrance in obtaining consent. Most of the physicians showed paternalistic attitude in claiming that they know better and can decide what is best for the interest of the patient. Therefore religious beliefs and the social structure of the society are weak justifications for the medical paternalism.
CONCLUSION

My research mainly focused on the content and procedure of informed consent in the Pakistan Medical and Dental Council (PM&DC) codes of ethics. Pakistan is an Islamic country and I explored the extent to which the PM&DC code complies with the International Declarations and the Islamic bioethical laws.

The code of the PM&DC does not comply fully with the Helsinki Declaration and Islamic bioethical laws. It does not attend some sensitive issues and there are no sections of medical ethics found on assisted reproductive techniques and sex selection of embryos whereas these medical interventions are available in many private registered hospitals. The sections on abortion are also not clearly mentioned.

The PM&DC code also does not clearly mention the issue of ‘euthanasia’ albeit it is replaced by the phrase ‘the end-of-life care’. The decision for the end of life care is solely at the discretion of the physician. The code states that futile treatment will not be given even on the request of the patient or his/her family members. It implies that even if patient is competent and he/she requests for treatment, the physician considers it futile – the treatment will authoritatively or paternalistically refused. It has not been explained whether this refusal is because of the scarcity of resources or for the welfare of the patient; there are many such ambiguities in the code.

In the organ donation section the ‘consent’ is replaced by ‘counselling’ for live donors, which creates ambiguity. Counselling has different meanings and purposes while consent is meant to facilitate autonomous decision-making. For obtaining organs from cadavers I do not find any code or clause mentioning advance directives or consultation with family members. On the other hand it implies that physicians can obtain organs from poor patients and that if the family members cannot afford it the physicians should offer funeral arrangements. One third of the population of Pakistan lives below the poverty line and funeral arrangements are a big inducement for them. This practice echoes the ‘Tuskegee’s’ trials; physicians do not obtain advance directives or proxy consent from family members they obtain organs and arrange the funeral.
Consent procedure has been left to the discretion of hospital authorities. There is no proper guideline about how the consent procedure should take place. It has been expected from physicians that they will obtain expressed consent but it is not mandatory in the code. Generally consent has not been obtained in Pakistan. Fawad Aslam et al hold that in order to provide information to patients especially illiterate people patience and time is required and expecting from over worked and underpaid physicians to fulfil high moral standards is impractical; therefore it implies that information is also not provided to patients about their health conditions. Physicians usually direct paternalistically and do not inform them about their health or alternative therapies for making autonomous decisions.

It is then hard to believe that in such medical practices, informed consent can be or is being obtained from those patients who participate in the research trials. Principles of beneficence and non-maleficence can justify medical paternalism to some extent in clinical practices but for research medicine without consent human beings are being used as means and commodities – violating human dignity, beneficence and non-maleficence principles.

I have analysed how the consent procedure is followed in medical practice in Pakistan with the help of limited studies conducted by medical professionals on informed consent from the perspective of physicians that give some insight into the attitude of medical professionals in Pakistan. Most of the physicians were reluctant to provide information to their patients because:

- It needs patience and time is needed to convey information and with a busy clinical practice they want to examine more patients within less time. Giving more time to one patient will affect their medical practice and income.
- Physicians know better what is good for their patients therefore there is no need to discuss with them.
- Communication with illiterate is difficult and requires more patience and needs more time; to expect from over worked and underpaid physicians to follow these high ethical norms is impractical.
In my opinion, religious values, the social structure of the society and high illiteracy rate are not strong justifications for medical paternalism. It is true that illiterate people are not able to read or write but it does not mean that they cannot understand. Physicians can help facilitate patients to make autonomous decisions. Fawad Aslam et al and A. M. Jaffrey & A. Farooqui’s study reveal that medical paternalism persists in Pakistan mostly because of the authoritative attitude of physicians.

**Recommendations:**

The code of PM&DC does not provide substantial protection to the rights of patients and research participants and it has no support in the civil law of the country as well. With these major drawbacks there are other hindrances such as, unawareness of the patients about their rights and non-cooperation of the medical professionals in facilitating autonomous decision-making. Following are my recommendations for the improvement of consent procedure:

There is a need to initiate a mass movement for the awareness of the rights of patients and formulation of laws for the rights of patients and research subjects.

The PM&DC is required to formulate a substantial system for obtaining consent that should be mandatory for all hospitals.

There is a need for additional codes specifically focussing on the research subjects.

Kidney transplantation and donation has become an abusive business in Pakistan. Middleman persuades poor young people to donate a kidney and earn money. There is a dire need of legal and ethical regulations especially for this practice.

Introduce the subject of Bioethics at graduate and higher level. Promote research and launch it as a compulsory subject in the medical profession.

A few studies have been conducted on informed consent that only portrays the perspective of the physicians, there has been no study conducted on consent procedure from the perspective of the patients.
Research in the bioethical issues and evaluation of the medical codes of ethics should be promoted to facilitate understanding of the ethical problems and help to solve them.

Qualitative and quantitative research is recommended in Bioethics.
Bibliography:


College of Physicians and Surgeons of Pakistan. available at www.cpsp.edu.pk/-1k.


www.angelfire.com/md/jawadji/.
The Pakistan Medical and Dental Council

The Statutory Regulatory & Registration Authority for Medical & Dental Education and Practitioners for Pakistan

The Pakistan Medical and Dental Council

Code of Ethics

for Medical and Dental Practitioners

Made in exercise of the powers conferred by Section 33 of Pakistan Medical & Dental Council Ordinance, 1962 and approved by the Council in its meeting held on 11th July, 1968 at Karachi, and revised by the Council in its 48th session held on 6th and 7th December 1974 at Lahore; and revised in its 97th session held on 29th and 30th December 2001 at Islamabad.

The Pakistan Medical and Dental Council
Code of Ethics - 2001

Introduction

The Medical and Dental Council of Pakistan exists to maintain the register of Medical and Dental practitioners, regulate the standards of medical practice, protect the interests of the patients, supervise medical education, and give guidelines on ethical issues.

The medical profession is best regulated internally by the doctors themselves. With this privilege comes the responsibility, that doctors regulate their professional affairs through the Pakistan Medical and Dental Council, in the most effective way.

Both doctors and their patients have the right for making independent decisions. However, the code of ethics provides a set of principles prescribed by the Pakistan Medical and Dental Council, which doctors can use as guidelines in the varying situations, in line with their judgment, experience, knowledge and skills. Whilst the principles guiding medical practice rarely change, application of these principles to new situations will require frequent revision and publication.

This revised Code of Ethics have been prepared by the active participation of the honourable members of the Council. The assistance provided by Prof. Syed M. Awais and Prof. Jamsheer Talati during all stages of preparation of this document is highly appreciated.

The draft was approved by the Council in its 97th session held on 29th and 30th December 2001 at Islamabad, with the recommendation that draft will be circulated among the members of the Council and any recommendations received within one month will be included. Most of the recommendations received from the members have been incorporated in the draft. The final draft was approved by Executive Committee during its meeting on 15th August, 2002.

Prof. Muhammad Hayat Zafar

President,

Pakistan Medical and Dental Council

Contents

1.0 Preamble
2.0 Jurisdiction of the Pakistan Medical and Dental Council
3.0 Purpose
4.0 Applicability
5.0 Oath of Medical and Dental Practitioners
6.0 Duties of Medical and Dental Practitioners
7.0 Medical Ethics in Islam
8.0 The Teaching of Medical Ethics
9.0 Expectations
10.0 Fundamental Elements of Patient – Physician Relationship
11.0 Ethical Standards of Professional Competence, Care and Conduct.
12.0 Confidentiality
13.0 Conflict of interest
14.0 Truth Telling
15.0 Advertising
16.0 Certificates, Reports and other documents
17.0 Business and contractual obligations
18.0 Consent
19.0 Teaching Photography and Consent
20.0 Research Ethics and Consent
21.0 Organ Transplantation and Consent
22.0 Adoption
23.0 Resource Allocation
24.0 End-of-Life Care
25.0 Genetics in Medicine
26.0 Procedures for Review of the Code
27.0 Procedure for Enforcement of Code
28.0 Glossary.
The abbreviation; “RMDP” will be used to indicate Registered Medical and Dental Practitioner(s), throughout the document.

1.0 Preamble

History and legal framework

The Pakistan Medical and Dental Council (PMDC) Code of Ethics outlines the ethical principles and standards which determine the responsibilities and conduct of Medical and Dental professionals registered with the PMDC.

This Code of Ethics made in exercise of the powers conferred by Section 33 of Pakistan Medical & Dental Council Ordinance, 1962, is a revision of the code of ethics approved by the Council in its meeting held on 11th July, 1968 at Karachi, and subsequently revised by the Council in its 48th session held on 6th – 7th December 1974 at Lahore. This revision has been approved by the Council in the 97th session held on 29th and 30th December 2001 at Islamabad.

2.0 Jurisdiction of the Pakistan Medical and Dental Council (PMDC)

The Pakistan Medical and Dental Council was duly constituted under the Medical & Dental Council Ordinance No. XXXII, 1962, in June 1964 and is empowered to:

a) Look after Public interest – by maintaining proper medical/dental standards.
b) Supervise Medical/Dental Education in the country.
c) Maintain a register of qualified doctors and dentists, qualifying from duly recognized institutions.
d) Take such disciplinary actions, which may be required for criminal convictions or serious professional misconduct of a doctor. The Council is not an Association or a Union for protecting professional interests.

3.0 Purpose

3.1 The code is intended to provide guiding principles for use in every day practice for the Registered Medical and Dental Practitioners (RMDP) in their roles in regard to patients, students, community, colleagues, researchers and citizens (people).

3.2 The Code of Ethics is a public document which endeavours to educate its members and the public on professional ethics. It is intended for the welfare and protection of the individuals and societies with which the profession interacts. It states the responsibility of professionals to society and individuals; and the rights of an individual. It serves public interest.

3.3 When a Registered Medical or Dental practitioner’s conduct or practice and consequently registration,
are questioned, these are the principles and standards against which s/he will be judged.

The Code of Ethics provides general guidelines, and any disciplinary committee designated by the PMDC will judge each case on its merits. This is not a comprehensive document and interpretation will depend upon circumstances. The Registered Medical and Dental Practitioner will be given opportunity to justify their actions to a Disciplinary Committee.

4.0 Applicability

This Code is applicable to all registered Medical and Dental Practitioners.

5.0 Oath Of Medical And Dental Practitioners

[Adapted from the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948; and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968; and the 35th World Medical Assembly, Venice, Italy, October 1983; and the 46th World Medical Association General Assembly, Stockholm, Sweden, September 1994. and the Islamic Medical Association Oath for Muslim Doctors.]

At the time of being admitted as a member of the medical profession:

I solemnly pledge myself to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude which is their due;

I will practice my profession with conscience and dignity;

The health of my patient will be my first consideration;

I will respect the secrets which are confided in me, even after the patient has died;

I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;

My colleagues will be my sisters and brothers; and I will pay due respect and honour to them.

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient;

I will protect human life in all stages and under all circumstances, doing my utmost to rescue it from death, malady, pain and anxiety. To be, all the way, an instrument of Allah’s mercy, extending medical care to near and far, virtuous and sinner and friend and enemy.”

I make these promises solemnly, freely and upon my honour.

6.0 Duties of Medical and Dental Practitioners (International Code of Medical Ethics)

Drawing on the Declaration of Geneva, the WMA formulated a more detailed code of ethics which was approved by the 3rd Assembly of the WMA meeting in London in 1949. The International Code of Medical
Ethics was subsequently amended in 1968 by the 22nd Assembly of the WMA in Sydney and again in 1983 by the 35th Assembly held in Venice. The text, as amended, reads as follows:

**Duties of Physicians in General**

A physician shall always maintain the highest standards of professional conduct and should actively participated in continuous Medical Education.

A physician shall not permit motives of profit to influence the free and independent exercise of professional judgement on behalf of patients.

A physician shall, in all type of medical practice, be dedicated to providing competent medical services in full technical and moral independence, with compassion and respect for human dignity.

A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

The following practices are deemed to be unethical conduct:

Self advertising by physicians, unless permitted by the laws of the country and the Code of Ethics of the Pakistan Medical Association.

Paying or receiving any fee or any other consideration solely to procure the referral of a patient or for prescribing or referring a patient to any source.

A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences.

A physician shall act only in the patient’s interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.

A physician shall use great caution in divulging discoveries or new techniques or treatment through non-professional channels.

A physician shall certify only that which he has personally verified.

**Duties of Physicians to the Sick**

A physician shall always bear in mind the obligation of preserving human life.

A physician shall owe his patients complete loyalty and all the resources of his science.

When ever an examination or treatment is beyond the physician’s capacity he should summon another physician who has the necessary ability.

A physician shall preserve absolute confidentiality on all he knows about his patient even after the patient has died.

A physician shall give emergency care as a humanitarian duty unless he is assured that others are willing
and able to give such care.

**Duties of Physicians to each other**

*A physician shall behave towards his colleagues as he would have them behave towards him.*

*A physician shall not entice patients from his colleagues.*

*A physician shall observe the principles of the “Declaration of Geneva” approved by the World Medical Association.*

**7.0 Medical Ethics and Islam**

In Islam, human beings are the crown of creation and are Allah’s viceregents on earth. They are endowed with reason, choice and responsibilities, including stewardship of other creatures, the environment and their own health. Muslims are expected to be moderate and balanced in all matters, including health. Illness may be seen as a trial or even as a cleansing ordeal, but it is not viewed as a curse or punishment or an expression of Allah’s wrath. Hence, the patient is obliged to seek treatment and to avoid being fatalistic.

Islamic bioethics is intimately linked to the broad ethical teachings of the Holy Qur’an and the tradition of the Prophet Muhammad (Peace be upon him), and thus to the interpretation of Islamic law. Bioethical deliberation is inseparable from the religion itself, which emphasizes continuities between body and mind, the material and spiritual realms and between ethics and jurisprudence. The Qur’an and the traditions of the Prophet Muhammad (Peace be upon him) have laid down detailed and specific ethical guidelines regarding various medical issues. The Qur’an itself has a surprising amount of an accurate detail regarding human embryological development, which informs discourse on the ethical and legal status of the embryo and fetus before birth.

Islamic bioethics emphasizes the importance of preventing illness, but when prevention fails, it provides guidance not only to the practicing physician but also to the patient. The physician understands the duty to strive to heal, acknowledging Allah as the ultimate healer. Islamic bioethics teaches that the patient must be treated with respect and compassion and that the physical, mental and spiritual dimensions of the illness experience be taken into account.

The main principles of the Hippocratic oath are, although acknowledged in Islamic bioethics, but the invocation of multiple gods in the original (Greek) version, and the exclusion of any god in later (Western) versions, have led Muslims to adopt the Oath of the Muslim Doctor, which invokes the name of Allah. It appears in the 1981 Islamic Code of Medical Ethics, which deals with many modern biomedical issues such as organ transplantation and assisted reproduction. In Islam, life is sacred: every moment of life has great value, even it is of poor quality. The saving of life is a duty, and the unwarranted taking of life a grave sin. The Qur’an affirms the reverence for human life in reference to a similar commandment given to other monotheistic peoples: “On that account We decreed for the Children of Israel that whosoever killed a human being… it shall be as if he had killed all humankind, and whosoever save the life of one, it shall be as if he saved the life of all humankind.” This passage legitimizes medical advances in saving human lives and justifies the prohibition against both suicide and euthanasia.

The Oath of the Muslims Doctor includes an undertaking “to protect human life in all stages and under all circumstances, doing [one’s] utmost to rescue it from death, malady, pain and anxiety. To be, all the way, an instrument of Allah’s mercy, extending … medical care to near and far, virtuous and sinner and friend and enemy.”

Islamic bioethics is an extension of Shariah (Islamic Law), which is itself based on 2 foundations: the Qur’an, whose basic impulse is to release the greatest amount possible of the creative moral impulse and is itself “ a healing and a mercy to those who believe” and the Sunna (the aspects of Islamic Law based on the Prophet Muhammad’s (Peace be upon him) words of acts).
To respond to new medical technology, Islamic jurists, informed by technical experts, have regular conferences at which emerging issues are explored and consensus is sought. Thus, over the past few years, these conferences have dealt with such issues as organ transplantation, brain death, assisted conception, technology in the intensive care unit and even futuristic issues such as testicular and ovarian grafts.

If secular Western bioethics can be described as rights-based, with a strong emphasis on individual rights, Islamic bioethics is based on duties and obligations (e.g. to preserve life, seek treatment), although rights (of Allah, the community and the individual) do feature in bioethics, as does a call to virtue (Ihsan).

8.0 The Teaching of Medical Ethics

The Curriculum Committee of the PMDC will ensure that adequate information on the Code of Ethics is included in the undergraduate medical college curriculum; and that case studies have been prepared and disseminated to provide guidance to practitioners.

8.1 The goal of teaching medical ethics is to improve the quality of patient care by enhancing professional performance through a consideration of the clinician’s values, beliefs, knowledge of ethical and legal construct, ability to recognize and analyse ethical problems, and interpersonal and communication skills; and consideration of the patient. Students should be able to identify, analyse and should attempt to resolve common ethical problems of medical and clinical nature.

8.2 All medical and dental colleges running MBBS and BDS Courses, College of Physician and Surgeons of Pakistan and Universities running the Postgraduate Medical Courses in Pakistan are advised to incorporate medical ethics into their curriculum.

8.3 Relevant books and journals should be made available in the central and departmental Libraries of the medical institutions, and publication of papers on issue related to medical ethics must be encouraged.

8.4 The PMDC exhorts its members to develop strategies for dissemination of information about ethics and ethical issues to their colleagues and students, public and patients; and specifically when teaching medical students.

9.0 Expectations

The PMDC expects each practitioner to:

9.1 promote the fundamental principle of responsibility of physicians to the right of individuals and societies to stated standards of professional competence, appropriate care, conduct and integrity of Medical and Dental Practitioners;

9.2 uphold the ethical principles of medical practice i.e. autonomy, beneficence, non-maleficence, and justice;

9.3 ensure the protection of individuals (patients) against harassment, discrimination and exploitation;

9.4 take their responsibilities as a teacher seriously.

9.5 be responsive to cultural and religious sensitivities; and

9.6 declare in a transparent manner, any potential conflict of interest.
9.7 inculcate these values in students, through instruction and role modeling.

9.8 promote the education of the public on (a) health issues and (b) their rights to quality care.

9.9 ensure continuation of practice only when in normal physical and mental health

9.10 bring colleagues to comply with these generally accepted norms of practice and expose physicians and dentists deficient in competence, care and conduct.

10.0 Fundamental Elements of Patient – Physician Relationship

Patients share with physicians the responsibility for their own health care.

10.1 The patient has the right to receive information from physicians and to discuss the benefits, risks, costs of appropriate treatment alternatives, and optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, and to receive independent additional professional opinions.

10.2 The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients (or next of kin) may accept or refuse any recommended medical treatment in writing.

10.3 The patient has the right to courtesy, respect, dignity, and timely responsiveness to his or her “health needs”.

10.4 The patient has the right to confidentiality.

10.5 The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient.

11.0 Ethical Standards of Professional Competence, Care and Conduct

11.1 Conduct of Medical practitioner:

In all dealings with patients, it is expected that the interest of the patient and the advantage to the patient’s health will be the major consideration to influence the practitioners’ conduct (defined as character and behaviour as a citizen and professional) towards them. The physician patient relationship should be developed as one of trust.

11.1.1 A Professional shall always maintain and demonstrate a high standard of professional conduct by:

- being in conformity with the principles of honesty and justice.

- not permitting motives of profit to influence (free and independent exercise of) professional judgment

- working with colleagues in ways that best serve patient’s interests.

- not paying or receiving any fee or any other consideration solely to procure the
referral of a patient or for prescribing or referring a patient to any source.

- maintaining the honourable tradition by which the physician is regarded as a friend to all persons of any class, caste, colour, religion, sex, ethnicity, occupation, creed, religion and social status.

- being honest, factual, objective, unbiased as a reviewer for scientific material for publication; for funding purposes; and when providing reference, ensuring that comments are honest, justifiable, unbiased, and contain evidence on the subject’s competence, performance, reliability, and conduct, taking steps to ensure the accuracy of any public communications including the communication of degrees, institutional affiliation, extent of services offered, and credentials.

11.1.2 The RMDP will not assist an unregistered person to practice / teach medicine or dentistry, or associate professionally with such a person performing the functions of a practitioner. which knowingly will make a registered practitioner liable to disciplinary action. This does not preclude a medical practitioner from imparting proper training to medical students, nurses, midwives and other paramedical personnel, provided the doctors concerned keep a strict supervision over such individuals when treating patients.

11.1.3 The RMDP will not knowingly make false, misleading or deceptive statements.

11.1.4 The RMDP will deal honestly with colleagues, respecting their rights and privileges and that of other health professionals.

11.1.5 Forgery, theft, fraud, indecent behavior or any other offence liable to be seen as moral turpitude is liable to disciplinary action.

11.1.6 The RMDP shall use great caution in divulging discoveries or new techniques or treatment through non-professional channels.

11.1.7 A physician shall owe his patients complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond the physician’s capacity he should consult another physician who has the necessary ability.

11.1.8 Prisoners who are ill must be treated in the same manner as other sick people. However, doctors have a right to take appropriate precautions if they think there is a possibility of physical violence by the patient.

Where a suspect refuses consent to a medical examination, the doctor unless directed to the contrary by a court of Law, should refuse to make any statement based on his observation of the suspect other than to advise the police whether or not the suspect appears to require immediate treatment or removal to hospital.

This does not of course, preclude the doctor from making a statement in Court based on such observation in circumstances where the accused later gives his consent to disclosure.
11.1.9 Doctors should normally ask permission from a patient before making a physical examination. In the case of minors, the child’s guardian should be present or give permission for the examination. For any intimate examination the patient irrespective of age, is entitled to ask for an attendant to be present. Such requests should be acceded to whenever possible.

11.1.10 Personal relationships: Any form of sexual advance to a patient with whom there exists a professional relationship is professional misconduct. A RMDP’s professional position must never be used to pursue a relationship of an emotional or sexual nature with a patient, the patient’s spouse, or a near relative of a patient.

11.1.10.1 Sexual misconduct: Sexual contact with patient or patient’s spouses, partners, parents, guardians, or other individuals involved in the care of the patient is liable to lead to exclusion from the register.

11.1.11 RMDP will ensure that they do not engage in harassment of any person, including employees, patients, students, research assistants and supervisees. [The following constitute harassment: when single, multiple, or persistent acts of abusive verbal language, demeaning speech, insult in front of juniors, sexual innuendoes, sexual solicitation, physical advance, throwing objects, and other threatening unacceptable gestures.] Physicians should not use language that will interfere with the work of others.

11.1.12 Abuse of professional knowledge, skills and privileges is unacceptable conduct: Any registered medical/dental practitioner found guilty of causing an illegal abortion or prescribing drugs in violation of the Dangerous Drugs Act, or who becomes addicted to a drug, or is convicted of driving under the influence of alcohol or any other drug, is liable to be suspended or have his/her name removed from the Register.

11.1.13 No RMDP should accept illegal gratification.

11.2 Care

The patient-physician or patient-dental practitioner relationship constitutes a fiduciary obligation, requiring physicians to be responsible to serve the interests of patients above their own financial or other interests.

11.2.1 The practitioner is expected to provide a quality of care for a patient which is timely, compassionate and respects human privacy and dignity, is non-discriminating and does not exploit vulnerable situations. Gross negligence in respect of professional duties may justify suspension or removal from the Register.

11.2.2 The RMDP will bear in mind the obligation of preserving life and will not discriminate on the basis of age, sex, gender, class, race, ethnicity, national origin, religion, sexual orientation, disability, health conditions, marital discord, domestic or parental status, criminal record, or any other applicable bias as proscribed by law, and ensure that personal beliefs do not prejudice patient care.
11.2.3 The RMDP should not exploit persons over whom they have direct or indirect supervisory, evaluative, management or other authority, such as students and patients, supervisees, employees or research participants; whether for personal, professional or economic reasons.

11.2.4 The RMDP should delegate to a student or other physician, only those responsibilities that such persons, based on their education, training and experience, can reasonably be expected to perform either independently or with the level of supervision provided.

11.2.5 The RMDP shall additionally:

- identify themselves to patients whom they are treating
- treat all patients with dignity and respect,
- listen to patients and respect their views,
- give patients (and provided patient agrees, family members) information (about their illness) in a way that they can understand,
- respect the rights of patients to be involved fully in decisions about their care,
- ensure that conflict of interest does not prevent them from performing their professional work in an unbiased manner,
- adhere to veracity (truth telling) as judged in the patient’s interest.

11.2.6 **Details of Information:** Patients do not always fully understand the information and advice given to them by doctors. They should be encouraged to ask questions. These should be answered carefully in non-technical terms if necessary with or without information leaflets. The aim is to promote understanding and to encourage compliance with recommended therapy. The doctor should keep a note of such explanation and it is felt that the patient still does not understand, it may be advisable to ask the patients permission to speak to a relative.

11.2.7 **Maternity care:** Registered medical practitioners who agree to undertake the antenatal and delivery care of a woman should clearly inform her, in advance, the arrangements for delivery.

In Pakistan, according to law a pregnancy can be terminated only if there lies a serious risk to the life of the pregnant women.

11.2.8 **Procedures:** Patients undergoing procedures or treatment of any sort have the right to be informed as to which doctor or doctors are to be involved.

11.2.9 **Fees:** Doctors fees should be appropriate to the service provided. Patients are entitled to ask how much a doctor is going to charge.
11.2.10 Second Opinion: Patients are entitled to a second or further medical opinion about their illness. If requested, RMDP must either initiate or facilitate a request for this and provide the information necessary for satisfactory referral.

11.2.11 Communication with Patients: Many complaints to the council refer to lack of communication, or discourtesy, on the part of the doctor. Where differences have arisen between the doctor and the patient or the patients relatives there is much to be gained and rarely anything to be lost by the expression of regret by the doctor. Feeling that any such expression would amount to an admission of liability may have inhibited doctors. This is not necessarily so.

11.3 Competence

The RMDP will attempt to maintain the highest levels of competence in their work more specifically the skill in diagnosing, clinical decision-making, planning, implementation, monitoring and evaluation of intervention and teaching; and will accept responsibility for their actions.

They will therefore:

11.3.1 only undertake tasks for which they are qualified by virtue of education, training or experience; and know their limitations.

11.3.2 keep abreast of latest information about their subject through continuing education;

11.3.3 ensure that their approach to patient management is consistent with current research, literature and practice;

11.3.4 have an approach that favours competent clinical care through a careful assessment of the patient's problem, based on elicitation and analysis of the patient's history and physical examination; careful decisions on need for further investigation and request for additional consultation, appropriate management and prompt action where indicated, an approach that shuns internet prescribing or telephonic prescribing except when the physician is cognizant of the individuals past medical history

11.3.5 acquire the knowledge and skills to provide proper training and supervision to their students so that such persons perform services responsibly, competently and ethically; and will be honest and objective in the assessment and certification of performance of students supervised;

11.3.6 monitor and maintain an awareness of the quality of the care provided by himself/herself through a review of carefully recorded data; and respond constructively to assessments by self and peers which identify need for further training or education;

11.3.7 recognise the realistic efficacy of investigation and medication and use technology and medicine only where appropriate;

11.3.8 restrict prescription of drugs, appliances or treatments to only those that are
beneficial to the patient.

11.3.9 Treatment without direct patient contact: Prescribing of medications by practitioners requires that the physician should demonstrate that a documented history and physical examination and drug reaction history are available; that there has been a sufficient dialogue between the patient and the doctor on options in management, and a review of the course of the illness and side effects of the drug.

11.3.10 The PMDC accepts that in an emergency, during on call or cover call, or when in a partnership the case records are available, a physician may prescribe a new prescription without seeing the patient.

12.0 Confidentiality

The physician has a right to and should withhold disclosure of information received in a confidential context, whether this be from a patient, or as a result of being involved in the management of the patient, or review of a paper, except in certain specific circumstances where s/he may carefully and selectively disclose information where health, safety and life of other individual/s may be involved.

12.1 The practitioner cannot seek to gain from information received in a confidential context (such as a paper sent for review) until that information is publicly available.

12.2 There is no legal compulsion on a doctor to provide information concerning a criminal abortion, venereal disease, attempted suicide, or concealed birth regarding his patients to any other individual or organization. When in doubt concerning matters, which have a legal implication, the practitioner may consult his/her legal adviser.

12.3 The professional medical record of a patient should not be handed over to any person without the consent of the patient or his/her legal representative. Generally speaking, the state has no right to demand information from the doctor about his patient, save when some notification is required by statute such as in the case of communicable diseases. When in doubt, a legal advisor should be consulted.

12.4 A presiding judge, may, despite the physician claiming the knowledge and communication is confidential overrule this contention and order or direct the witness to supply the required information. The doctor has no option but to comply unless willing to accept imprisonment for contempt of court.

13.0 Conflicts of interest

A conflict of interest “is a set of conditions in which professional judgement concerning a primary interest tends to be unduly influenced by a secondary interest.” In the clinical context the primary obligation of physicians is to their patients, whereas in the research context scientific knowledge may be the primary interest. A secondary interest may be of a financial nature, but it may also consist of personal prestige or academic recognition and promotion. In research involving patients, the research interests, although often in concordance with patients’ interests, are secondary to clinical care and may conflict with it. A typical example of conflict of interest related to personal gain in physician self-referral. In above mentioned definition the reference to “a set of conditions” is important – having a conflict of interest is an objective situation and does not depend on underlying motives. Stating that someone has a conflict of interest does not imply a moral condemnation per se. It is the person’s action in the context of a particular
situation or a lack of transparency that may be a cause for concern.

13.1 The practitioner must act in patient’s best interests when making referrals and providing or arranging treatment or care. No inducement, gift or hospitality which may affect or be seen to affect judgment may be accepted. Neither will a practitioner offer such inducements to colleagues.

13.2 Financial or commercial interests in organizations providing health care or in pharmaceutical or other biomedical companies, must not affect the way that patients are prescribed, treated or referred.

13.3 Financial or commercial interest in an organization to which a patient is to be referred for treatment or investigation must be declared to the patient.

13.4 Before taking part in discussions about buying goods or services, any relevant financial or commercial interest which the practitioner or the practitioner’s family might have in the purchases, must be declared.

14.0 Truth Telling

In the practice of medicine, truth telling involves the provision of information not simply to enable patients to make informed choices about health care and other aspects of their lives but also to inform them about their situation. Patients may have an interest in medical information regardless of whether that information is required to make a decision about medical treatment.

The physicians should strive to create a “true impression” in the mind of the patient. Thus, truth telling requires that information be presented in such a way that it can be understood and applied. By contrast, deception involves intentionally leading another to adopt a belief that one holds to be untrue.

Patients should be told the truth because of the respect due to them as persons. Patients have a right to be told important information that physicians have about them.

15.0 Advertising

15.1 When publishing or broadcasting information the practitioner must not make claims about the quality of services nor compare services with those provided by colleagues. Announcements must not, in any way, offer guarantees of cures, nor exploit patients’ vulnerability or lack of medical knowledge.

15.2 Published information about services must not put pressure on people to use a service, for example by arousing ill-founded fear for their future health. Similarly, services must not be advertised by visiting or telephoning prospective patients, either in person or through a deputy.

15.3 Practitioners may announce any change of address or hours of practice in the local press either once in three papers or three times in the same paper, on three consecutive days, and the announcement should be made in a normal manner and not unduly prominently as by big advertisements.

15.4 Nameplates may be fixed at the residence and on the premises where the medical/dental
practitioner practices and at his residence. The nameplate should not be ostentatious.

16.0 Certificates, Reports and other documents

When RMDP are requested for certificates, medical reports birth or death certificates and any other documents, such documents should be factual to the best of their knowledge. Due care should be taken in regard to stating the date on which the patient has been examined.

17.0 Business and contractual obligations

Physicians and dentists must ensure that they do not engage in any behaviour that negatively impacts directly or indirectly on patient care. Business and contractual obligations must never interfere with clinical decisions or negatively impact on patient care in any way. Physicians are discouraged from entering into business or other arrangements that include financial incentives; sharing of fees including refund based on successful outcomes and payments for referral of patients for laboratory investigations or other procedures except when a partnership is publicly known to exist.

18.0 Consent

Consent is the “autonomous authorization of a medical intervention by individual patients.” Patients are entitled to make decisions about their medical care and have the right to be given all available information relevant to such decisions. Patients have the right to refuse treatment and to be given all available information relevant to the refusal.

Consent may be explicit or implied. Explicit consent can be given orally or in writing. Consent is implied when the patient indicates a willingness to undergo a certain procedure or treatment by his or her behaviour. For example, consent for venipuncture is implied by the action of rolling up one’s sleeve and presenting one’s arm. For treatments that entail risk or involve more than mild discomfort, it is expected that the physician will obtain explicit rather than implied consent.

Signed consent forms document but cannot replace the consent process. There are no fixed rules as to when a signed consent form is required. Some hospitals require that a consent form be signed by the patient for surgical procedures but not for certain equally risky interventions. If a signed consent form is not required, and the treatment carries risk, clinicians should seriously consider writing a note in the patient’s chart to document that the consent process has occurred.

When taking consent the physician should consider issues of adequate disclosure, the patients capacity, and the degree of voluntariness.

In the context of patient consent, “disclosure” refers to the provision of relevant information by the clinician and its comprehension by the patient. Disclosure should inform the patient adequately about the treatment and its expected effects, relevant alternative options and their benefits and risks, and the consequences of declining or delaying treatment and how the proposed treatment (and other options) might affect the patient’s employment, finances, family life and other personal concerns.

“Waiver” refers to a patient’s voluntary request to forego one or more elements of disclosure. For example, a patient may not wish to know about a serious prognosis (e.g., cancer) or about the risk of treatment.

“Capacity” refers to the patient’s ability to understand information relevant to a treatment decision and consequences of a complying or not complying with a treatment decision. A person may be “capable” (have adequate capacity) with respect to one decision but not with respect to another. When any doubt exists, a clinical capacity assessment by
a third party may be required. In addition to assessing general cognitive ability, specific capacity assessment, determines the patient’s ability to appreciate information and implications of action.

“Voluntariness” refers to a patient’s right to make health care choices free of any undue influence. However, a patient’s freedom to make choices can be compromised by internal factors such as pain and by external factors such as force, coercion and manipulation. In exceptional circumstances -- for example, involuntary admission to hospital -- patients may be denied their freedom of choice; in such circumstances the least restrictive means possible of managing the patient should always be preferred. Clinicians can minimize the impact of controlling factors on patients’ decisions by promoting awareness of available choices, inviting questions and ensuring that decisions are based on an adequate, unbiased disclosure of the relevant information.

Special circumstances affecting the consent process are listed below

18.1 The Unconscious Patient

Consent may be implied or assumed on the grounds that if the patient were conscious they would consent to their life being saved.

18.2 The Violent Patient

A doctor asked to examine a violent patient is under no obligation to put him/herself in danger but should attempt to persuade the person concerned to permit an assessment as to whether any therapy is required.

18.3 The Mentally ill

Of the doctor is in any doubt as to the patient’s capacity to consent it is advisable to seek specialist opinion as well as discussing the matter with parents, guardians, or relatives.

18.4 The Mentally Handicapped

The doctor should attempt to obtain consent but, depending on the degree of handicap, may have to consult with the patient’s parents or guardians, and, in particularly difficult cases to obtain a second opinion.

18.5 Children

Children are entitled to considerate and careful medical care as are adults. If the doctor feels that a child will understand a proposed medical procedure, information or advice, this should be explained fully to the child. Where the consent of parents or guardians is normally required in respect of a child for whom they are responsible, due regard must be given to the wishes of the child. Also, the doctor must never assume that it is safe to ignore the parental/guardian interest.

19.0 Teaching Photography and Consent

19.1 Medical and dental students must identify themselves by name and must obtain permission from patients before examining them. It is advisable to limit the number of students examining any one patient.

19.2 The taking of photographs or videos for instructional purposes also requires permission. As far as possible these photographs and videos should be done in such a manner that a third party cannot identify the patient concerned. If the patient is identifiable, he or she should be informed about the security,
20.0 Research Ethics and Consent

When conducting medical research involving human subjects, investigators should remember their obligations with respect to individual patients. Ethical conduct of research requires that a human subject must participate willingly, having been adequately informed about the research and given consent; that there is a favourable balance between the potential benefit and harm of participation; and that protection of vulnerable people is ensured. In any clinical trial there must be genuine uncertainty as to which treatment arm offers the most benefit, and placebo controls should not be used if equally effective standard therapies exist. When doubt exists, researchers should consult the existing literature and seek the advice of experts in research ethics.

20.1 All research projects involving human subjects, whether as individuals or communities, or the use of fetal material, embryos and tissues from the recently dead, should be reviewed and approved by an Ethical Review Committee of the institution before the study begins.

20.2 It is essential that written consent be obtained if patients are to be involved in clinical trials. The aims and methods of the proposed research, together with any potential hazards or discomfort, should be explained to the patient. The Consent document must be clearly written using non-technical language as to be understandable to subjects and use local language in addition wherever applicable.

20.3 In situations where study subjects are too young or too incapacitated, as well as the mentally ill or unconscious person, consent to take part in research may be unobtainable. Research is best avoided unless it can be shown to be relevant and potentially beneficial to the patient and there is no objection from parents or relatives.

20.4 Medical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person.

20.5 The right of research subjects to safeguard their integrity must always be respected. Every precaution should be taken to respect the privacy of the subject, and the confidentiality of the patient’s information.

20.5.1 Research results must always preserve patient anonymity unless permission has been given by the patient to use his or her name.

20.6 Volunteers and patients may be paid for inconvenience and time spent, but such payment should not be so large as to be an inducement.

20.7 Refusal to participate in research must not influence the care of a patient in any way.

20.8 Declaration of Helsinki

The PMDC supports the resolutions and draws attention to the Declaration of Helsinki adopted by the 18th World Medical Assembly and revised by the 48th World Medical Assembly.

21.0 Organ Transplantation and Consent

21.1 A doctor involved in organ transplantation has duties towards both donors and recipients.

21.2 Prior to considering transplant from the dead donor, brain death should be diagnosed, using currently accepted criteria, by at least two independent and appropriately qualified clinicians, who are also
independent of the transplant team. If family of the dead donor cannot take care of the funeral of donors body, then the transplant doctor involved in organ transplantation shall take car of transplantation and funeral.

21.3 Living donors should be counseled as to the hazards and problems involved in the proposed procedures, preferably by an independent physician.

22.0 Adoption

Doctors should remember that in cases of proposed adoption there are several parties involved all of whom need continued support and counseling. Pregnant women who are considering giving up their babies for adoption should be helped to approach advisory bodies / attorneys as the circumstances may be.

23.0 Resource Allocation

All resource allocation decisions must be transparent and defensible. Questions of resource allocation are difficult and can pose practical and ethical dilemmas for clinicians. The unequal allocation of a scarce resource may be justified by morally relevant factors such as need or likelihood of benefit. To what extent the physician’s fiduciary duty toward a patient should supersede the interests of other patients and society as a whole is also a matter of controversy. However, the allocation of resources on the basis of clinically irrelevant factors such as religion or gender is prohibited.

24.0 End-of-Life Care

End-of-life care requires control of pain and other symptoms, decisions on the use of life-sustaining treatment, and support of dying patients and their families.

24.1 Futile treatment need neither be offered to patients nor be provided if demanded. A treatment is qualitatively futile if it “merely preserves permanent unconsciousness or fails to end total dependence on intensive medical care or when physicians conclude (either through personal experience, experiences shared with colleagues, or consideration of reported empiric date) that a medical treatment has been useless.

24.2 The physician is not compelled to accede to demands by patients or their families for treatment thought to be inappropriate by health care providers.

25.0 Genetics in Medicine

Molecular genetics is concerned with the process by which the coding sequences of DNA are transcribed into proteins that control cell reproduction, specialization, maintenance and responses. Inherited or acquired biologic factors that result in an error in this molecular information processing can contribute to the development of a disease. Medical genetics involves the application of genetic knowledge and technology to specific clinical and epidemiologic concerns. Although many common diseases are suspected of having a genetic component, few are purely genetic in the sense that the genetic anomaly is adequate to give rise to the disease. In most cases, genetic risk factors must be augmented by other genetic or environmental factors for the disease to be expressed. Moreover, the detection of a genetic anomaly not help us to predict the severity with which the syndrome will expressed.

Certain ethical and legal responsibilities accompany the flood of genetic knowledge into the current practice of medicine. This is because of 3 general characteristics of genetic information: the implications of genetic information are simultaneously individual and familial; genetic information is often relevant to future disease; and genetic testing often identifies disorders for which there are
not effective treatments or preventive measures.

26.0 Procedures for Review of the Code

The Code will be reviewed every five years by a committee set up by the PMDC.

27.0 Procedure for Enforcement of the Code

The PMDC may take disciplinary action (on the basis of recommendations of a disciplinary committee) against members who violate the code.

27.1 Process for initiating complaints

27.1.1 The Secretary will take note of complaints received from lay public or fellow-practitioners, mentioning the details of complainant.

27.1.2 Process for addressing complaints: Complaints will be examined and investigated by the standing Disciplinary Committee of the PMDC which will forward its recommendations to the Executive Council. The Disciplinary Committee will investigate possible infractions, and will seek relevant information from persons and records, in order to reach a decision on whether the code has been violated. If disciplinary action is requested, the case will be referred to the Executive Committee.

27.1.3 The Executive Committee will recommend to the Council prescriptive action in disciplining the member. The Executive Committee will review and endorse the Disciplinary Committee actions if it agrees, or ask for a further review of the case by another or the same or expanded Disciplinary Committee or disagree or modify the recommendations on the basis of available information. It will then pronounce the disciplinary decision.

27.1.4 The Full Council will be informed of the decision in the next Full Council meeting. The PMDC ratifies the decision.

27.1.5 The matter will be referred to the Court if needed.

27.1.6 Disciplinary action: The disciplinary action may either be an admonition, a temporary suspension for a specified period or life long expulsion from membership of the PMDC. The PMDC will when making the latter decision will consider whether it is in public interest to retain the name of the practitioner on the Register. The PMDC expects that every member will report infringement of the code by a fellow member in the interest of patient. In minor infractions, it is expected that members will advise the individual on a one on one basis. If this fails to bring about corrective behaviour the matter should be brought to the attention of the PMDC.

27.2 Constitution of the Disciplinary Committee

The Disciplinary Committee should be constituted as per regulations for Registration of Medical & Dental practitioners.

27.3 A claim of ignorance cannot be made as the PMDC regulations will be sent to every Registered Medical or Dental Practitioners and will be available on the website.

27.4 Publication

The name of individuals, who have been expelled from the register of the PMDC, will be displayed in the PMDC Gazette and regional health authorities will be informed.

28. GLOSSARY

Competence

Ability and skill in diagnosing, clinical decision-making and management.
Care

The quality of interaction with a patient.

Conduct

Character and behavior as a citizen and professional

Veracity

Accuracy of statement

Fiduciary

Held or given in trust

Copy Rights ©2001 PMDC All rights reserved.
Operation Consent Form

Federal Government Services Hospital,
Islamabad

I HEREBY CONSENT to an operation being performed upon:

Name ........................................

My ....................... Name ..............................

the nature and extent of such an operation, I leave entirely to the discretion of the Medical Officer performing the operation.

I understand that anaesthetic may have to be for the operation.

I will not hold any of the HOSPITAL STAFF responsible for any risks involved in or accidents occurring during or after the operation or anaesthesia.

Date :  Signature

Address :

PCPPI—264 (96) FGSH—13-2-96—10,000 Bks.
APPENDIX- C

COMPONENTS OF A RESEARCH ARTICLE
There are five essential components of an original/research article
1. Abstract/Summary
2. Introduction
3. Material & Method
4. Result
5. Discussion.
These can be remembered with the help of the acronym, IMRAD that stands for :
= I = Introduction,
= M = Material & Method
= R = Result,
= A = And
= D = Discussion.
Key words are included with structured abstract. Additional components are acknowledgement (which is optional) and the References. Hence the manuscript of all research articles should contain the following sections:-

Essential Components
Title page: The complete title of the manuscript, the name of the authors with their highest qualifications, the department or institution to which they are attached, address for correspondence with telephone numbers and fax number, if possible.
Abstract/Structured: All original articles should have a structured abstract. Usually the limit ranges from one hundred fifty to two hundred fifty words. The abstract should be in structured form and should have headings of objective, design, settings, subjects, interventions (if applicable), main outcome measures results and conclusions.
Key Words: Below the abstract give few key words, which should not more than ten. These key words are used in cross-indexing the article and are usually published with abstract. Use terms from the Medical Subject Headings (MeSH) which are standard medical headings given in the list of index medicus, e.g Glomerulonephritis, Paraplegia, Infertility. If suitable MeSH terms are not yet available for recently introduced terms, present term may be used.
Introduction: This should describe the purpose of the article and the Research Methodology, Biostatistics & Medical Writing Workshop rationale for the study. It should neither review the subject extensively nor should it have data or conclusions of the study.
Material: Material refers to the subjects and apparatus
SUBJECTS: are patients or person on who study was done their age, sex, mean age, and standard deviation, and other relevant characteristics should be given.
APPARATUS: refers to the main device used to measure the observation, this may be a laboratory equipment, surgical procedure, questionnaire, or a clinical method e.g. a laboratory instrument for Hemoglobin estimation, a procedure to remove the stone from bile duct, a questionnaire developed to know the effect of poverty on nutritional status or clinical criteria to assess the severity of pain.
Method: METHOD is the procedure of data collection. Mention the study design, place where study was conducted, procedure of data collection. Mention the name of statistical test and software program wherever applied.
RESULTS must be presented in the form of text, tables and illustrations. The contents of the tables should not be repeated in the text. Instead, a reference to the table number must be given.

DISCUSSION should emphasize the present findings and comparison should be made of variations or similarities with other works done in the field. The detailed data should not be repeated in the discussion. It must be mentioned whether the hypothesis in the article is true, false or no conclusions can be derived.

OPTIONAL COMPONENTS are added only whenever applied. These are as follow: ACKNOWLEDGEMENT if desired, it should be included after the discussion and before references.

LETTER OF UNDERTAKING signed by the main author must accompany all manuscripts: Sample Letter of Undertaking This is to confirm that the original / review Article / case report titled submitted for publication in has not been published in any other journal and if accepted for publication, it will not be published in any other medical journal in Pakistan or overseas.

Name of author (In capital) Signature

Research Methodology, Biostatistics & Medical Writing Workshop

DISSERTATION WRITING

**General Information:** Dissertation is a detailed discourse on a subject especially submitted for a higher degree in a University (Oxford Dictionary). The CPSP dissertation is a document that contains relevant details of the research work conducted by the fellowship trainee relating to the problem selected. The objective of writing a dissertation is to develop skills in fellowship trainees for: Collection and compilation of data, Analyzing and reviewing relevant literature available on the subject (both national and international), developing medical writing habits as an art for writing scientific articles in medical journals.

The other advantages of writing a dissertation include:
1- Cultivating an inquiring mind
2- Encouraging in depth study of common problems afflicting our people
3- Generation of scientific data locally
4- Keeping abreast of new developments locally and abroad
5- Understanding the fundamentals of research

**Rules and Requirements**

To prepare a dissertation acceptable to the CPSP, the rules and requirements prescribed below must be followed while writing.

**Approval:**
1- The research work or study must be started after receiving the approval of synopsis / research protocol from RTMC, CPSP.
2- The research work or study must be planned in such a way that the entire study, including dissertation writing, is completed during the training period.
3- The topic and research methodology must be the same as laid down in the synopsis/research protocol approved by the RTMC, CPSP.
4- Patients in the photograph(s), if included in the dissertation, must not be identifiable or the photographs must be accompanied with a written consent of the patients. Colored photographs are to be preferred.
5- Photomicrographs, if included in the dissertation, must have internal scale markers and symbols, arrows or letters in contrast to the background.
6- If tables, figures, diagrams, photographs, photomicrographs or any other type of illustrations are reproduced from published literature, they must be properly acknowledged in the dissertation.

Research Methodology, Biostatistics & Medical Writing Workshop Only standards terms and abbreviations must be used if needed in the dissertation. When using for the first time, a full word or phrase, together with its abbreviation in bracket (except for standard measurement units), must be mentioned. A list of all abbreviations used in the text must also be attached in the dissertation.

The information about patients such as names, initials or hospital numbers must be kept confidential, especially in illustrative material.

Contents: It is essential that a minimum of one-third contents of the dissertation should be from the trainee’s own research work or study. The statistical tests mentioned in the dissertation must have proper references to enable an assessor or reader to verify the reported results. Statistical terms, abbreviations and symbols must be defined. Any computer program, if used, must also be specified.

The illustrations in the dissertation must be accurately drawn, on separate pages and numbered serially. Each figure / diagram must have a legend. Free hand lettering is not accepted. Measurement, units of length, height, weight and volume mentioned in the dissertation must be in metric system i.e., meter, kilogram and liter.

Format: Each section of the dissertation must be started on a new page. The section in part 1, from "Dedication" up to the list of "Abbreviation", should be serially numbered in Roman number while the rest should be serially numbered in Arabic numerals. The Dissertation must contain 15,000 to 20,000 words i.e., about 80-100 A4 size pages, typed or computer-printed with double space, on one side of each page. It must have 4-cm margin, at all 4 sides of each page. All pages must have serial numbers at upper right hand corner. It must not contain any typographical errors or spelling mistakes. The font size should be 12. Font should be New Times Roman or Arial or Verdana.

Language: The writing of dissertation must be planned in such a way that continuity of the theme is maintained. It must be written in trainee’s own words and style. The language must be simple, direct and precise. Verbosity must be avoided. Direct quotations must be minimally used. If quoted, these must be given within inverted commas with full acknowledgment.

The statements, other than trainee’s own, must be supported with reference citation. The trainee, who plagiarizes or copies someone else’s Dissertation, will Research Methodology, Biostatistics & Medical Writing Workshop be liable for a punitive action by CPSP, which may include debarring him/her from appearing in FCPS examination for lifetime. Each table must be typed or computer-printed with double space, on a separate page. It must be numbered consecutively, in order of citation and inserted at the appropriate place in the text. Symbols and abbreviations, if used, must be explained in the footnote of each table.

Special Cases: If the trainee wishes to change the supervisor, he must intimate the original supervisor in writing that he/she is applying for a change of supervisor and submit documentary evidence with full justification(s) to RTMC. The trainee must obtain approval in writing from RTMC, CPSP for changing the supervisor originally approved by the CPSP. The Supervisor must endorse the certificate annexed at "B", before the dissertation is submitted to RTMC, CPSP. In case the trainee, who has already acquired a Fellowship from CPSP, desires to appear for FCPS in any other specialty, he/she may submit a fresh Dissertation or his/her 2 published papers on the chosen specialty in JCPSP or journals listed in Index Medicus as the main author.
Submission: Certified copies of dissertation must be submitted to CPSP, through the Supervisor for assessment and approval, at least one year before the date of examination in which the trainee desires to appear. The dissertation must be secured with spiral binding. The CPSP will get it bound permanently after acceptance. The dissertation must be submitted along with the paid bank challan or a bank draft / pay order issued in the name of CPSP, on account of Dissertation fee and binding charges. Once the dissertation is submitted to CPSP, it must not be submitted to any other institution for a postgraduate diploma or degree. Violation of this rule will render the trainee liable to punitive action by CPSP, which may include cancellation of Fellowship. The trainee may write an article based on his/her approved dissertation and submit it to the Journal of CPSP. Such an article must have the name of trainee as the first author. Research Methodology, Biostatistics & Medical Writing Workshop.