



King Khalid University

College of Medicine

Department of Internal Medicine

Applied Medical Ethics

A Guide for Medical Students
MED 431 — Medical Ethics
Fourth Year MBBS Program

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Start reading ↓

Foreword

Medical ethics is not a subject that exists separately from the rest of medicine. It is woven through every clinical encounter: every conversation in which you must decide how much to tell a patient, every moment when you witness conduct that troubles you, every prescription you write, every patient you care for at the end of life. Medical ethics is the practice of medicine, seen from the inside.

This book grew out of the MED 431 Medical Ethics course and follows the design of the course specifications and syllabus. Every chapter moves from foundational principles to their application in clinical scenarios drawn from real daily clinical practice. It is designed as a practical companion — to be read before each scheduled lecture in order to facilitate fruitful discussion during class.

Several features of this book reflect the context in which you study and will practice medicine:

- Islamic ethics is not treated as a separate appendix but integrated throughout every chapter. The principles of the Quran, the Sunnah, and Islamic jurisprudence (fiqh) are not supplementary to good medical ethics — they are one of its richest foundations. Where Islamic scholarly consensus is relevant to a clinical decision, it is presented clearly and with its jurisprudential basis.
- Saudi regulatory frameworks are given prominence. The SCFHS Code of Ethics, the Law of Practicing Healthcare Professions, the Saudi Guidelines for Informed Consent, the MOH Patient Bill of Rights, and while still undergraduate, the KKU student conduct regulations, are not abstract bureaucratic documents. They are the specific framework within which you will practice, and you are expected to know them.
- The Saudi and Islamic clinical context takes outmost priority. The challenges of disclosure in a family-centered culture, the role of Islamic religious authority in end-of-life decisions, the specific patterns of pharmaceutical industry interaction in this region — these are addressed as they actually arise, not as Western problems translated into an Arabic setting.

Each chapter follows a consistent structure: learning objectives, section content, key terms, case vignettes for discussion, and a further reading list. The case vignettes are designed for small group discussion and seminar work — there are no simple answers, and you are encouraged to engage with the complexity they present rather than seeking abstract solutions.

I **assembled** this guide from medical ethics books and literature I consulted during my early days as a course coordinator and instructor. This is an internal student learning resource, not a publication. All relevant references are acknowledged at the end of each chapter; students who wish to deepen their understanding are encouraged to consult them.

At the time of writing this guide, the medical ethics course (MED 431) is still taught in two parts: the applied medical ethics (English part) and the Islamic medical jurisprudence (الفقه الطبي) taught by colleagues from College of Shariah. However, this guide is enriched with the needed Islamic background that it can be a standalone in the future.

I am deeply grateful to my colleagues who generously gave their time to review, revise, and enrich the chapters of this guide: **Prof. Abdullah Alsabaani, Prof. Ibrahim Alnaami, Prof. Ali Aseeri, Dr. Mohammed Alshehri, Dr. Ibrahim Tawhari, Dr. Hayfa Alhefdi, Dr. Asma Alhabbash, and Dr. Abdulaziz Abudasser**. Their expertise, critical insight, and commitment to the education of our students have made this guide considerably better than it would otherwise have been

Medicine is a privilege. The patients who allow you to examine them, to learn from their illnesses, and eventually to care for them extend a trust that your training has not yet fully earned. Ethics is how you honor that trust — not once, at graduation, but continuously, through every decision of your professional life.

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How to Use This book

This book is organized into five thematic parts corresponding to the major domains of medical ethics you will encounter in clinical practice:

Part One — Foundations

Chapters 1–3 introduce the history of medical ethics, the major ethical theories, the four principles of biomedical ethics, and the concept of medical professionalism — both as a student and as a future doctor.

Part Two — The Doctor–Patient Relationship

Chapters 4–7 examine patient rights, autonomy and informed consent, privacy and confidentiality, and the ethics of truth-telling and communication. These chapters are directly relevant to your daily clinical encounters from Day 1 of your clinical courses.

Part Three — Special Clinical Topics

Chapters 8–12 cover the ethics of women's and reproductive health, surgery, end-of-life care, organ donation, and patients with special needs. These chapters address the most ethically complex clinical scenarios you will encounter.

Part Four — Research and Publication

Chapters 13–15 address research ethics, scientific publication ethics, and the ethics of artificial intelligence in medicine and academia. These chapters are increasingly relevant as you begin to engage with research and evidence-based practice.

Part Five — Public Health and Systems Ethics

Chapters 16–18 cover public health and preventive medicine ethics, Saudi healthcare law and regulations, and the ethics of the pharmaceutical industry and private sector.

Chapter Structure

Every chapter contains the following elements:

1. Learning Objectives — specific, measurable outcomes for each chapter, aligned with the MED 431 course outcomes.
2. Numbered Sections — organized, detailed coverage of the chapter's topic with integration of Islamic ethics throughout.
3. Key Terms — a summary table of the essential vocabulary of the chapter, including relevant Arabic terms.
4. Case Vignettes for Discussion — four clinical cases per chapter, designed for small group discussion. There are no single correct answers. You are expected to reason through ethical issues, identify the principles at stake, and defend a position.
5. Further Reading — selected key references for students who wish to explore topics in greater depth.

Guidance for Case Discussions

The whole assessment scheme in the MED 431 course is built upon ethical scenarios with case vignettes that present ethical questions. Thus, it is important to train yourself in thinking of the principles of medical ethics in practice (applied medical ethics!). When approaching a case vignette, a useful framework is to ask the following four questions in order (drawn from the Jonsen, Siegler, and Winslade four-topic framework):

1. Medical Indications: What are the clinical facts? What are the goals of treatment? What does beneficence require?
2. Patient Preferences: What does the patient want? Is the patient competent? What does autonomy require?
3. Quality of Life: What is the patient's experience of their illness and treatment? What does beneficence as satisfaction require?
4. Contextual Features: What family, institutional, legal, cultural, or financial factors bear on this decision? What does justice require?

Then ask: What does the Islamic framework add or require? Are there specific Quranic verses, Prophetic traditions, or scholarly rulings (fatwa) that are directly relevant? Does the Islamic position converge with or diverge from the secular bioethical analysis?

Chapter 1: What Is Medical Ethics?

In 1962, a hospital in Seattle had just learned to keep people with failing kidneys alive indefinitely on a new dialysis machine — but there were far more patients than machines. Unable to treat everyone, the hospital handed the choice to an anonymous committee of ordinary citizens — a lawyer, a minister, a homemaker, a banker — who decided which patients would be dialysed and live, and which would be turned away to die. When a magazine exposed their work under the title “They Decide Who Lives, Who Dies,” the public was stunned. The doctors had the power to save lives; what they lacked was an agreed way to decide whom to save. That gap — between what medicine can do and what it ought to do — is the subject of this book.

Learning Objectives

By the end of this chapter, you should be able to:

1. Define medical ethics and explain why it is a core component of medical education.
2. Trace the historical development of medical ethics from ancient civilizations to the present day.
3. Describe the major ethical theories and explain how each applies to clinical decision-making.
4. Articulate and apply the four fundamental principles of biomedical ethics.
5. Explain the foundations of Islamic medical ethics and their relationship to contemporary bioethics.
6. Distinguish between ethics and law and understand how they interact in medical practice.

1.1 Why Study Medical Ethics?

Every day, doctors make decisions that profoundly affect the lives of their patients. Some of these decisions are straightforward — which antibiotic to prescribe, when to order an investigation. But many are not. Should you tell a patient the full truth about a terminal diagnosis if the family has begged you not to? Is it ethical to withdraw life support from a patient who left no written instructions? Who should receive the last available ICU bed when two equally ill patients arrive at the same time?

These are not gaps in medical knowledge. They are ethical dilemmas — situations in which two or more legitimate values conflict, and where there is no simple algorithmic answer. The ability to recognize, analyze, and navigate such dilemmas is not a soft skill at the margins of medicine. It is a core clinical competency, as essential as reading an ECG or managing sepsis.

Medical ethics is the branch of applied ethics that deals with questions arising from the practice of medicine and the delivery of healthcare. It asks: What should be done? What is right? What do we owe our patients, our colleagues, and society? This book will not give you a formula that produces the correct answer to every ethical question. What it will give you is a structured way of thinking — a set of principles, frameworks, and habits of moral reasoning that allow you to approach hard cases with clarity, consistency, and compassion.

1.2 A Brief History of Medical Ethics

Ancient Civilizations

Codes governing healing are among the oldest written documents in human history. The Code of Hammurabi (Babylon, c. 1754 BCE) set out fees for surgery and specified punishments for physicians whose patients died or were harmed. In ancient Egypt, physicians were expected to follow established protocols recorded in medical papyri — an early recognition that medicine carries accountability.

The Hippocratic Tradition

The most enduring legacy of ancient Greek medicine is the Hippocratic tradition, associated with the medical school on the island of Cos (c. 460–370 BCE). The Hippocratic Oath established foundational principles: the duty to act in the patient's best interest, the duty to avoid harm (*primum non nocere*), the duty of confidentiality, and the prohibition of sexual relations with patients. Hippocrates treated medicine as a profession — a vocation with internal moral standards distinct from trade or commerce.

Islamic Medicine and Ethics (8th–13th Centuries)

While Europe entered its early medieval period, Islamic civilization produced a flowering of medical science and ethics. Ishaq ibn Ali al-Rahawi (9th century CE) wrote *Adab al-Tabib* (The Conduct of the Physician), widely considered the first book in history dedicated entirely to medical ethics. He described physicians as "guardians of souls and bodies" and wrote twenty chapters covering topics that remain relevant today.

Ibn Sina (Avicenna, 980–1037 CE), whose *Canon of Medicine* dominated medical education for five centuries, embedded ethical considerations throughout his clinical writing. He described the physician's obligation to treat the whole person — body, mind, and soul — and emphasized the importance of the patient's trust. The Islamic medical ethics tradition was grounded in Islamic theology and jurisprudence (*fiqh*), particularly in the concept of *maqasid al-shari'ah* — the objectives of Islamic law, which include the preservation of life, intellect, progeny, wealth, and religion.

The 20th Century: Catastrophe and Reform

The modern field of bioethics was, in large part, born out of moral horror. The Nazi medical experiments of World War II — in which prisoners were subjected to hypothermia, high-altitude depressurization, forced infection, and surgical experimentation without consent — shocked the world. The Nuremberg Trials (1945–1946) produced the Nuremberg Code (1947), which established for the first time in international law that voluntary informed consent is an absolute requirement for human experimentation.

In the United States, the Tuskegee Syphilis Study (1932–1972) revealed that abuses were not confined to authoritarian regimes. 399 Black men with syphilis were deliberately left untreated and deceived about their condition for forty years, even after penicillin became available. The public exposure of Tuskegee

directly led to the Belmont Report (1979), which articulated three foundational principles for research ethics: respect for persons, beneficence, and justice.

1.3 Major Ethical Theories

Deontology (Duty-Based Ethics)

Associated with Immanuel Kant (1724–1804), deontology holds that some actions are intrinsically right or wrong, regardless of their consequences. Moral duty — not outcome — is what matters. For Kant, the fundamental moral rule is the categorical imperative: act only according to that maxim by which you can also will that it should become a universal law. In clinical medicine, a deontological approach insists that it is wrong to lie to a patient even if the lie would cause less distress — patients must be told the truth because they have an inherent right to know.

Consequentialism (Outcome-Based Ethics)

Consequentialism holds that the morally right action is the one that produces the best overall outcome. The most influential form is utilitarianism, associated with Jeremy Bentham and John Stuart Mill, which holds that we should act to maximize happiness and minimize suffering across all affected parties. In public health, consequentialist reasoning justifies quarantine: even though it restricts individual freedom, the harm prevented to the wider population outweighs the individual's loss of liberty.

Virtue Ethics

Rooted in the philosophy of Aristotle and revived in contemporary bioethics, virtue ethics shifts the central question from "What should I do?" to "What kind of person should I be?" The virtues relevant to medicine include honesty, compassion, prudence, courage, justice, and integrity. A virtuous physician does not need to consciously consult a rulebook before sitting at a patient's bedside and explaining bad news with care — compassion and honesty are part of who they are.

Islamic Ethical Theory

Islamic ethics is fundamentally theocentric — moral obligations derive from Allah's commands as revealed in the Quran and Sunnah and interpreted through Islamic jurisprudence (usul al-fiqh). Key jurisprudential principles with direct medical applications include: La darar wa la dirar (لا ضرر ولا ضرار) — "Do no harm and cause no harm to others"; Al-darurat tubih al-mahzurat (الضرورات تبيح المحظورات) — "Necessity permits what is prohibited" (الضرورات تبيح المحظورات); and Al-maqasid al-shari'ah — the five objectives of Islamic law (preserving life, intellect, progeny, wealth, and religion) (حفظ النفس, العقل, العرض, المال, الدين).

1.4 The Four Principles of Biomedical Ethics

In 1979, Tom Beauchamp and James Childress published *Principles of Biomedical Ethics*, now in its eighth edition and arguably the most influential work in contemporary bioethics. They proposed four *prima facie* principles — meaning principles that are binding unless overridden by stronger competing considerations — as a common framework applicable across different moral traditions.

Principle 1: Autonomy

Autonomy (from Greek: autos = self, nomos = law) means self-rule — the right of a competent person to make informed decisions about their own life and medical care, free from coercion or undue influence.

Respecting autonomy requires: providing patients with honest, complete, and comprehensible information; ensuring decisions are voluntary; and respecting the decisions of competent patients, even when you disagree with them. A 45-year-old adult refuses a life-saving blood transfusion. She is fully competent and understands the consequences. The principle of autonomy requires that her refusal be honored.

Principle 2: Beneficence

Beneficence means acting in the patient's best interest — actively doing good, not merely refraining from harm. It is the affirmative moral obligation to promote patient welfare, which encompasses physical, psychological, social, and spiritual dimensions. Beneficence can conflict with autonomy when a patient refuses treatment that the physician believes would help them. The historical tendency to override patient preferences "for their own good" is called paternalism — once the default of medical practice, now recognized as ethically problematic when applied to competent adults.

Principle 3: Non-maleficence

Primum non nocere — "first, do no harm" — is perhaps the most ancient principle in medicine. Non-maleficence requires that physicians not inflict harm on patients, and that potential harm of any intervention be weighed carefully against its expected benefits. The obligation is not to avoid all risk — virtually every medical intervention carries some risk — it is to ensure that the benefit justifies the risk, and that patients understand and consent to that balance.

Principle 4: Justice

Justice in healthcare has multiple dimensions: distributive justice (the fair allocation of scarce healthcare resources — who gets the transplant, the ICU bed, the expensive medication?); rights-based justice (respecting patients' rights to healthcare, dignity, and non-discrimination); and legal justice (upholding laws and professional regulations). Justice is perhaps the most challenging principle in practice because it operates at the level of systems, policies, and populations — not just individual patient encounters.

1.5 Ethics and Law: Overlapping but Not Identical

Medical ethics and medical law are related but distinct. They often point in the same direction — both prohibit operating on a patient without consent. But they are not synonymous. Law sets a floor of minimally acceptable behavior, enforced through legal sanctions. Ethics often demands more than the law requires. A physician who tells a patient the bare minimum required to obtain legal consent may be acting lawfully but not ethically.

Moreover, laws differ across countries while core ethical principles are more universal. A practice legal in one country may be deeply unethical; a practice restricted by law in one jurisdiction may be ethically mandatory in another context. As a future doctor practicing in Saudi Arabia, you will need to know both: the ethical principles that guide practice, and the specific laws and regulations governing medicine in Saudi Arabia. If it happens that you went abroad, you also need to be familiar with the laws that govern practice in the country you go to. Active euthanasia is one of the controversial topics in medical ethics. While permissible in some foreign countries, it is ethically unacceptable and prohibited in Islam and by law in Saudi Arabia.

1.6 The Structure of an Ethical Dilemma

Not every difficult situation is an ethical dilemma. Some difficult situations are primarily clinical (what is the diagnosis?), organizational (how do we manage this with limited resources?), or emotional (this is painful for everyone). An ethical dilemma has a specific structure: there is a decision to be made — inaction is itself a choice; there are at least two morally defensible options; each option violates at least one ethical principle or causes some moral harm; no option is clearly superior on all ethical dimensions.

Recognizing this structure is the first step in ethical reasoning. The second step is analyzing which principles are at stake, what the consequences of each option are, and — crucially — what the patient values and wants. The chapters that follow provide detailed frameworks for approaching specific types of dilemmas.

Key Terms

Term	Definition
Medical ethics	The study of moral rules and principles governing the practice of medicine
Bioethics	The broader field of ethics applied to biology, medicine, and healthcare
Autonomy	The right of a competent person to make informed decisions about their own care
Beneficence	The duty to act in the patient's best interest
Non-maleficence	The duty to avoid causing harm — <i>primum non nocere</i>
Justice	The fair distribution of benefits and burdens in healthcare
Deontology	Ethics based on duties and rules, regardless of consequences
Consequentialism	Ethics based on outcomes — the right act produces the best result
Virtue ethics	Ethics focused on the character and moral dispositions of the agent
Paternalism	Overriding patient preferences on the grounds of acting for their own good
Maqasid al-shari'ah (مقاصد الشريعة)	The five objectives of Islamic law: preserving life, intellect, progeny, wealth, and religion

Case Vignettes for Discussion

Case 1.1 — The Withheld Diagnosis

A 60-year-old man is admitted with advanced lung cancer. His family approaches you before his consultation and asks you not to tell him the diagnosis, saying "he will lose all hope and die faster." The

patient himself has not asked you to withhold any information and appears alert and competent. Which ethical principles are in conflict here? How would you proceed?

Case 1.2 — The Paternalistic Physician

A senior doctor performs a procedure without proper consent, using the justification: "He's my patient — I know what's best for him." The patient did not object but was clearly not informed of the risks. A medical student witnesses this. Is this an ethical issue, a legal issue, or both? What should the student do?

Case 1.3 — The Last Ventilator

Your hospital has one remaining ventilator. Two patients need it simultaneously: a 30-year-old with reversible respiratory failure, and a 65-year-old professor with a chronic condition in acute respiratory distress. Both have equal medical need, but the younger patient has a higher probability of survival. How do the four principles apply? Does justice require you to consider age?

Further Reading

- Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 8th ed. Oxford University Press; 2019.
- World Medical Association. Declaration of Geneva. 2017 revision. wma.net
- Al-Jarallah J. Akhlaqiyyat al-Tibb (أخلاقيات الطب). 2021.
- Saudi Commission for Health Specialties. Code of Ethics for Healthcare Practitioners. 2014.
- World Medical Association. Medical Ethics Manual. 3rd ed. 2015.

Chapter 2: The Professional Student

In March 1984, an eighteen-year-old college student named Libby Zion died in a New York teaching hospital within hours of admission. The doctors at her bedside were exhausted junior trainees, deep into shifts of more than thirty hours, lightly supervised and juggling dozens of patients at once. Her father, a journalist, refused to let the matter rest, and his campaign exposed a training culture that pushed its learners past the point of safety. The outcome was a wave of reforms limiting working hours and demanding proper supervision. For a student stepping onto the wards for the first time, her death carries a clear lesson: knowing the limits of your competence — and asking for help before you exceed them — is not weakness but a duty. This chapter is about what it means to learn medicine responsibly.

Learning Objectives

By the end of this chapter, you should be able to:

1. Define professionalism in the context of medical education and explain why it matters.
2. Identify the core attributes of a professional medical student.
3. Define academic integrity and describe its major violations: plagiarism, cheating, fabrication, and ghostwriting.
4. Apply university and college rules and regulations to everyday student conduct.
5. Communicate professionally with patients, colleagues, teachers, and administrative staff.
6. Recognize the sources of ethical dilemmas unique to medical students in clinical training.
7. Describe the principles of e-professionalism and use social media and digital communication responsibly.

2.1 The Decision You Have Already Made

You chose medicine. That decision — whether it came to you at the age of ten or the night before your application deadline — carries consequences that most other careers do not. Medicine is not simply a job. It is a profession, and a profession that places demands on its members that go beyond technical competence.

The word profession derives from the Latin *profiteri* — to declare publicly. When you enter medical school, you make an implicit declaration: that you will place your patients' interests above your own convenience, that you will maintain standards of honesty and integrity even when no one is watching, and that you will accept the moral obligations that come with access to people's bodies, lives, and secrets.

Those obligations do not begin when you graduate. They begin today. The habits of thought, behavior, and character you develop as a student are the habits you will carry into clinical practice. The medical student who copies in an exam is practicing a version of the doctor who falsifies a patient's records. Professional identity is not granted at graduation; it is built — or neglected — incrementally, through thousands of small choices.

2.2 What Is Professionalism?

Professionalism is one of the most widely discussed and contested concepts in medical education. The Saudi Commission for Health Specialties (SCFHS) defines professionalism as: "A collection of values, attitudes, behaviors, and relationships that act as the foundation of the healthcare profession's contract with society."

Three elements of this definition deserve attention. Values and attitudes come first. Professionalism is not primarily a set of rules to follow; it is a set of inner dispositions — honesty, compassion, integrity, humility — that, when genuinely held, produce professional behavior naturally. Behaviors are the visible expression of those inner values: punctuality, appropriate dress, respectful communication, honest self-assessment. A

contract with society reminds us that professionalism is not merely about personal character — society grants physicians extraordinary privileges in exchange for consistent fulfillment of obligations.

The SaudiMEDs Framework — the national competency framework for Saudi medical graduates — identifies professionalism as one of its six core themes, alongside medical knowledge, clinical skills, communication, research, and community service. It expects graduates to demonstrate commitment to professional development, ethical practice in all clinical situations, accountability to patients, colleagues, and the healthcare system, respect for patients' dignity, culture, and autonomy, and Islamic values integrated into professional practice.

2.3 Academic Integrity (six fundamental values)

Academic integrity is the moral code of scholarship. It requires that all academic work — assignments, examinations, research projects, presentations — represents your own honest effort, properly attributed. The International Center for Academic Integrity identifies six fundamental values: honesty, trust, fairness, respect, responsibility, and courage.

Honesty

Honesty means representing work truthfully and accurately. In the academic context, this includes reporting data as collected, citing sources correctly, and acknowledging the contributions of others. A student who misrepresents their clinical log hours or embellishes a case report violates honesty. In clinical practice, dishonesty — falsifying a drug administration record, concealing a near-miss, or misreporting a physical finding — can directly harm patients.

Trust

Trust is the foundation upon which academic and clinical communities function. Faculty trust students to complete their own work; patients trust physicians to act in their best interests; colleagues trust one another to share accurate information. When a student submits a colleague's notes as their own, they erode trust within the cohort. When a physician fabricates consent documentation, they betray the patient's trust and place themselves and their institution at legal and ethical risk.

Fairness

Fairness requires that all students be evaluated by the same standards and that no student gain an unfair advantage over another. Sharing examination questions, requesting preferential grading, or exploiting relationships with faculty to obtain better placements are all violations of fairness. This value extends to clinical work: fair resource allocation, equitable access to procedures and learning opportunities, and unbiased assessment of patients regardless of background are all expressions of fairness in medicine.

Respect

Respect encompasses regard for persons, processes, and the integrity of the academic community. It means treating peers, patients, and supervisors with dignity; acknowledging the rules of assessment as legitimate; and honouring the intellectual work of others through proper attribution. Disruptive behaviour in clinical settings, dismissive treatment of junior colleagues, and failure to obtain proper consent for using a patient's case in a presentation are all failures of respect.

Responsibility

Responsibility means taking ownership of one's actions and their consequences. A student who copies another's work cannot blame stress, time pressure, or the availability of that work — the choice, and its consequences, remain their own. In clinical practice, responsibility means following up on results you ordered, completing a handover properly, and reporting errors even when doing so is uncomfortable. It is the antidote to the diffusion of accountability that makes systems unsafe.

Courage

Courage is the willingness to do the right thing even when it is difficult, unpopular, or personally costly. It means reporting a colleague's misconduct, speaking up when you observe an error, challenging a senior when patient safety is at risk, and refusing to participate in academic dishonesty even under peer pressure. Courage is what transforms ethical knowledge into ethical behaviour. Without it, understanding principles is insufficient — the moral life of a physician requires the willingness to act on them.

2.4 Examples of academic integrity misconduct

Plagiarism

Plagiarism is the presentation of someone else's words, ideas, data, or images as your own without proper attribution. Forms include: direct plagiarism (copying text verbatim without quotation marks or citation); paraphrasing plagiarism (rewording another's ideas without credit); self-plagiarism (resubmitting your own previously submitted work as new); mosaic plagiarism (stitching together phrases from multiple sources without attribution); and AI-generated plagiarism (submitting text generated by an AI tool as your own original work).

Cheating, Fabrication, and Ghostwriting

Cheating in examinations — using unauthorized materials, communicating with other students, obtaining questions in advance — is a direct fraud against the institution and against every student who prepared honestly. Fabrication means inventing data, results, or sources. Ghostwriting is the submission of work written entirely by someone else — whether a paid service, a fellow student, or an AI — as your own. Each violates academic integrity and represents a failure of character that, if uncorrected, will manifest in professional life.

2.5 University and College Regulations

As a medical student at King Khalid University, you are governed by: KKU Student Conduct Regulations (academic integrity, attendance, examination conduct, dress code); the SCFHS Code of Ethics (which applies to all healthcare practitioners, including trainees); and Ministry of Health Regulations (governing conduct in affiliated teaching hospitals).

The most commonly applicable regulations for students involve attendance (minimum requirements exist for all lectures and clinical sessions), dress code (a professional appearance appropriate to the clinical setting is mandatory), examination conduct (violations are documented and may appear in your permanent academic record), and mobile phone use in clinical areas (hospital regulations exist for reasons of infection control, patient privacy, and professional focus).

2.6 E-Professionalism and Social Media

Social media has transformed how medical students communicate, learn, and present themselves to the world. It has also created an entirely new domain of professionalism challenges. The AMA, BMA, and SCFHS have all issued guidance on this topic.

The Permanence Problem

The fundamental difference between a spoken comment in the hospital corridor and a post on social media is permanence and reach. A thoughtless remark to a colleague may be forgotten. The same remark posted online may be screenshotted, shared, reported to your medical school, and recovered years later during a licensing investigation. Assume that anything you post could be read by your patient, your dean, a journalist, or a licensing board. Post accordingly.

What Constitutes a Professionalism Violation Online?

Common violations include: breaching patient confidentiality (posting identifying details about a case, even without using the patient's name — combinations of diagnosis, age, hospital, and date can identify an individual); derogatory or discriminatory language about patients or colleagues; inappropriate images in clinical settings; blurring personal and professional identity; and misrepresentation of qualifications.

Practical Guidelines

Separate professional and personal accounts where possible. Pause before posting: ask whether the content could embarrass you, your institution, or your patients. Never post patient information, even anonymized, without explicit ethical approval. Disclose your student status when discussing clinical topics publicly. Regularly review your own online presence and audit what is publicly visible.

2.7 Core Attributes of a Professional Medical Student (in training)

Honesty and Integrity

Honesty means telling the truth — to patients, to supervisors, and to yourself — even when the truth is uncomfortable. Integrity means alignment between your stated values and your actual behavior; it is what you do when no one is looking. In clinical practice, honesty will require you to say "I don't know" when you don't, to acknowledge errors rather than conceal them, and to give patients information they may not want to hear.

Empathy and Compassion

Empathy is the capacity to understand another person's experience from their perspective. Compassion adds to empathy the motivation to relieve suffering. Research consistently shows that empathy in medical students declines during clinical training — particularly in the third and fourth years. This decline is not inevitable, but it requires active resistance. The patient on the ward is not a "case" or a "learning opportunity"; they are a person experiencing fear, pain, and vulnerability.

Critical Self-Appraisal

The ability to assess your own knowledge, skills, and performance honestly — including recognizing your limitations — is one of the most important and most difficult professional attributes to develop. The Dunning-Kruger effect (the cognitive bias whereby incompetent individuals overestimate their own

competence) is well documented in medicine. Students (and doctors) who are unaware of what they do not know pose a genuine clinical risk.

Responsibility and Reliability

Patients, supervisors, and colleagues must be able to depend on you. Responsibility means completing assigned tasks, following up on results, attending scheduled commitments, and taking ownership of your role in a patient's care. Reliability means doing these things consistently. A lapse that seems minor in the student context — failing to review a case you were asked to present — can translate in clinical practice into a delayed diagnosis or a broken promise to a patient.

2.8 Ethical Dilemmas in Medical Student Training

Witnessing Unprofessional Conduct

Perhaps the most common ethical challenge facing medical students is observing a senior colleague behave unprofessionally or unethically. The pressure to remain silent is powerful — you are junior, you depend on this person for teaching and assessment. But silence makes you complicit, and it deprives patients of protection they deserve. The ethical course is to act: for immediate patient safety risks, speak up in the moment; for non-urgent unprofessional conduct, report through appropriate channels — your course coordinator, the clinical tutor, or the professionalism officer.

The Hidden Curriculum

Medical professionalism is taught explicitly in courses like this one, but it is also transmitted through what educators call the hidden curriculum: the unspoken norms, behaviors, and values that medical students absorb by watching how senior doctors actually behave. You are not merely a passive recipient of the hidden curriculum. You are already contributing to it. How you treat the cleaner who mops the ward, the medical secretary who processes your paperwork, and the fellow student who is struggling — these behaviors establish norms that your peers observe and absorb.

Key Terms

Term	Definition
Professionalism	The values, behaviors, and relationships that fulfill medicine's contract with society
Academic integrity	The ethical obligation to ensure all academic work represents one's own honest effort
Plagiarism	Using another's words, ideas, or data without proper attribution
Self-plagiarism	Resubmitting previously submitted work as if it were new
Fabrication	Inventing data, results, or sources
Falsification	Manipulating data to produce a desired result
Ghostwriting	Submitting work entirely produced by another person as one's own
E-professionalism	The application of professional standards to online and digital conduct
Hidden curriculum	Unspoken professional norms transmitted through observation of role models
Karama (كرامة)	The inherent dignity of every human being, grounded in Islamic theology
SaudiMEDs Framework	The Saudi national competency framework for medical graduates

Case Vignettes for Discussion

Case 2.1 — The Group Assignment

A group of five students is assigned a 2,000-word essay on informed consent. Three students write their sections; two contribute nothing but submit the work under their names and receive the same grade. The two non-contributing students argue that no plagiarism occurred. Are they right? What are the ethical issues? What should the contributing students do?

Case 2.2 — The Clinical Ward Post

A medical student posts a photograph on Instagram of herself at the nurses' station in her white coat. In the background, a patient's name and diagnosis are visible on a whiteboard. A classmate who sees the post tells her privately. What should each party do? What are the ethical obligations?

Case 2.3 — The Observed Procedure

During a urology rotation, a student observes a senior consultant catheterize an elderly confused patient without introducing himself, explaining the procedure, or asking for consent. Afterward, the consultant asks the student to document the procedure in the patient's notes. What ethical issues are present? What should the student do about the documentation request and about the conduct observed?

Case 2.4 — The Examination Whisper

During a multiple-choice examination, the student seated next to you whispers an answer to a question. You did not ask for the help, and you know the answer independently. You do not respond. Later, you discover the student reported you to the supervisor, claiming you were the one who whispered. What are the ethical dimensions here? How would you respond?

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Chapter 3: The Professional Doctor

For most of history, anyone could call himself a doctor. In Britain in the 1850s, a patient had no reliable way to tell a trained physician from a confident impostor selling coloured water; the qualified and the quack advertised side by side. In 1858, Parliament passed the Medical Act, creating a single official register of recognised practitioners and a council empowered to strike off those who disgraced the profession. With it, medicine claimed something new: the right, and the duty, to regulate itself. That bargain — society grants the profession its autonomy, and in return the profession polices its own standards — is the essence of what it means to be a professional. This chapter examines the privileges, and the obligations, that come with the title.

Learning Objectives

By the end of this chapter, you should be able to:

1. Define the medical profession and explain the social contract it entails.
2. Describe the key attributes of a professional physician.

3. Explain the concept of e-professionalism and apply major guidelines governing social media use by doctors.
4. Identify common forms of professional misconduct and the disciplinary consequences that follow.
5. Describe the regulatory bodies that govern medical practice in Saudi Arabia and explain their respective roles.
6. Explain the principle of self-regulation and its importance to professional integrity.
7. Recognize Islam's contribution to the concept of medical vocation and its relevance to contemporary professionalism.

3.1 From Student to Doctor: A Threshold, not a Transformation

The transition from medical student to doctor is marked by a ceremony, a certificate, and a new title. It is not, however, a transformation of character. The physician you become is built from the student you are. The habits, values, and conduct you develop during your training follow you across that threshold and into every clinical encounter you will have for the next four decades.

3.2 The Medical Profession: Three Defining Features

1. Expert Knowledge Not Available to the Public

A profession is built on a body of specialized knowledge that the practitioner has earned through years of rigorous training — knowledge that the patient or client cannot independently verify. This knowledge asymmetry is the foundation of medical authority — and its most significant ethical vulnerability. The same expertise that allows physicians to help patients can be used to exploit, deceive, or neglect them. Professionalism is the set of commitments that ensures the knowledge is used for the patient's benefit.

2. Self-Regulation

Professions are granted the privilege of regulating their own members — setting entry standards, defining acceptable conduct, and disciplining those who fall short. In Saudi Arabia, this function is performed primarily by the SCFHS, which sets standards of training and competence, issues licenses to practice, and enforces the Code of Ethics for Healthcare Practitioners.

3. Service Before Self-Interest

The hallmark of a profession is the orientation of practice. A tradesperson serves the customer in exchange for payment; if the transaction is not profitable, the tradesperson may decline. A professional serves the patient even at personal cost, because the professional's primary duty is to the person in need, not to personal gain. This does not mean that doctors are expected to work without payment — it means that when professional obligation and self-interest conflict, the professional duty takes precedence.

3.3 Medical Professionalism: Formal Definition and Charter

The SCFHS Code of Ethics defines professionalism as: "A collection of values, attitudes, behaviors, and relationships that act as the foundation of the healthcare profession's contract with society."

The landmark ABIM Foundation Charter on Medical Professionalism (2002) articulates three fundamental principles: primacy of patient welfare; patient autonomy; and social justice. The Charter also identifies ten professional commitments: commitment to professional competence; honesty with patients; patient confidentiality; maintaining appropriate relations with patients; improving quality of care; improving access to care; a just distribution of finite resources; scientific knowledge; managing conflicts of interest; and professional responsibilities.

3.4 The Islamic Concept of Medical Vocation

Islam provides a distinct and powerful framework for understanding medicine as a calling rather than merely a profession. The Quran states: "Whoever saves one life, it is as if he has saved all of humanity." (Al-Ma'idah 5:32). For the Muslim physician, clinical practice is not merely the application of technical skill; it is a form of worship ('ibadah), a fulfillment of the Islamic duty of care to one's fellow human beings, and an expression of the divine attribute of mercy (rahmah).

Niyyah (intention) occupies a central place in Islamic professional ethics. The hadith "Verily, actions are by intentions" (Bukhari and Muslim) implies that the moral value of a clinical act is determined partly by the physician's motivation. A doctor who performs a procedure with sincere intent to help the patient, even if the outcome is poor, has fulfilled their moral obligation. A doctor who performs the same procedure for financial gain or professional advancement, regardless of outcome, has not.

3.5 Professional Attributes of the Physician

Clinical Competence

The first obligation of any doctor is to be good at their job. All the ethical commitments in the world cannot substitute for the knowledge and skill required to diagnose and treat disease. Competence is not static; it must be actively maintained through continuing medical education, engagement with current evidence, and honest recognition of one's limitations. A physician who continues to practice in an area where their skills have become inadequate is acting unethically, even if no individual patient has yet been harmed.

Honesty and Transparency

The SCFHS Code states: "The healthcare practitioner shall be honest and truthful in all professional interactions." This encompasses honesty with patients about diagnosis, prognosis, and treatment options; honesty with colleagues and supervisors about one's own errors and limitations; and honesty in clinical documentation. Particular attention should be paid to error disclosure — patients who have been harmed by medical error have a right to know, both to seek appropriate redress and to make informed decisions about their ongoing care.

Compassion

Compassion is not sentimentality. It is the capacity to be moved by the suffering of another and to be motivated by that response to act — while maintaining the clinical judgment that emotion alone cannot provide. The Prophet (peace be upon him) said: "Verily, Allah is gentle and loves gentleness in all things." (Muslim). Gentleness in clinical practice — in how you examine, how you explain, how you break bad news — is not merely a communication technique; in Islamic ethics it is a moral obligation.

3.6 Professional Misconduct: Recognizing the Boundaries

Professional misconduct refers to conduct that falls below the standards expected of a registered healthcare practitioner. The SCFHS identifies the following as actionable forms of misconduct:

Clinical Misconduct

- Practicing outside the scope of competence or license
- Abandoning a patient under one's care without adequate alternative arrangement
- Falsifying medical records or documentation
- Failure to obtain informed consent for procedures

Integrity Violations

- Fraud: billing for services not rendered, falsifying credentials
- Misrepresentation: claiming qualifications, experience, or outcomes that are not accurate
- Conflicts of interest: undisclosed financial relationships with pharmaceutical companies or other commercial entities

Disciplinary Procedures

When a complaint of professional misconduct is received by the SCFHS or by a hospital, a formal process is initiated: investigation (review of the facts, interview of the practitioner and witnesses); fitness to practice assessment; and outcome — ranging from no further action, to remediation requirements, to suspension, to revocation of license. Disciplinary proceedings are primarily about patient protection, not punishment.

3.7 E-Professionalism: The Physician Online

You Are Always a doctor

When you graduate, your professional identity does not switch off at the end of the working day. A post made on a Saturday evening, on a personal account, under your real name — or under an anonymous name that can be traced — is a professional act. The AMA guidance states it plainly: "You're always a doctor." This does not mean that physicians have no private life. It means that the professional standards that govern your clinical conduct also govern your public behavior, including online behavior.

Confidentiality in the Digital Age

Patient confidentiality extends fully to the digital environment. Never post patient information on social media regardless of whether you use the patient's name. A combination of diagnosis, age, hospital, and approximate date is often enough to identify an individual. Never photograph patients, their records, their imaging, or their clinical environment without explicit consent and institutional approval. Never discuss cases in identifiable terms in public online forums, including WhatsApp groups that include non-clinical members.

Positive Professional Uses of Social Media

Used well, social media is a powerful tool for continuing education; professional networking; public health communication; health advocacy; and creating educational content for students and trainees. The physician who uses social media thoughtfully and ethically is not merely avoiding harm — they are contributing to a better-informed public and a more connected profession.

3.8 Self-Regulation: The Hardest Professional Duty

Physicians are at significantly elevated risk for burnout, depression, substance misuse, and compassion fatigue compared to the general population. The SCFHS Code states that practitioners have a responsibility to "seek help when their health or capacity to practice may be impaired." This is not weakness; it is a professional obligation. A physician who practices while impaired — whether by illness, exhaustion, or substance use — poses a risk to patients.

When you observe a colleague whose practice appears impaired or unsafe, the appropriate response is calibrated to severity: for mild concerns, address directly with the colleague, privately and respectfully; for persistent or serious concerns, escalate to a clinical lead, department head, or relevant hospital committee; for immediate patient safety risks, intervene directly and report immediately. Using these mechanisms is not a betrayal of collegiality; it is a fulfillment of professional duty.

Key Terms

Term	Definition
Social contract	The implicit agreement between medicine and society — privileges granted in exchange for service to the public interest
Self-regulation	The profession's responsibility to set and enforce its own standards of conduct and competence
Professional misconduct	Conduct that falls below the standards expected of a registered healthcare practitioner
SCFHS	Saudi Commission for Health Specialties — the regulatory body for healthcare practice in Saudi Arabia
ABIM Charter	The Physician Charter on Medical Professionalism (2002) — three principles and ten commitments
E-professionalism	The application of professional standards to online and digital behavior
Niyah (نية)	Intention — the Islamic concept that motivation contributes to the moral value of an act
Ihsan (إحسان)	Excellence — doing one's work to the highest standard as if in the presence of Allah
Amanah (أمانة)	Trustworthiness — the obligation to discharge responsibilities faithfully
Conflict of interest	A situation in which personal interests may compromise or appear to compromise professional judgment

Case Vignettes for Discussion

Case 3.1 — The Impaired Colleague

You are a junior doctor on a busy medical ward. A colleague arrives for a night shift having been on call for the previous 30 hours with no sleep. You notice their eyes are bloodshot, their responses slow, and they appear unable to focus on the handover notes. They twice misread a drug chart during the briefing. When you mention your concern, they insist they are fine and ask you not to make a scene. There are four patients who will need review overnight. What do you do? What professional obligations apply?

Case 3.2 — The Pharmaceutical Gift

A pharmaceutical company representative visits your department and leaves behind branded pens, notebooks, and a voucher for a "sponsored dinner" where a presentation on their new antibiotic will be given. Several colleagues accept the dinner voucher. Is this a professionalism issue? What does the SCFHS Code of Ethics say? What are the risks, and how should you respond?

Case 3.3 — The Social Media Post

A physician posts on social media: "Third patient today who refused to vaccinate their child. Some people don't deserve to be parents." The post receives hundreds of shares. The physician is identifiable from their profile. (a) Is this a professionalism violation? (b) What are the specific concerns? (c) What should the physician do? (d) What should the hospital do if the post comes to their attention?

Case 3.4 — The Second Opinion Request

A patient asks for a second opinion because she is not satisfied with the diagnosis her previous physician gave her. When you review the case, you believe the previous physician made a significant diagnostic error that delayed treatment by six weeks. The previous physician is a senior colleague and well-respected in your department. How do you proceed? What are your obligations to the patient, to your colleague, and to the profession?

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PART TWO — THE DOCTOR-PATIENT RELATIONSHIP

Chapter 4: Patient Rights

Through most of medical history, the patient's role was to obey. The good patient was compliant, trusting, and silent; the doctor decided, and the patient consented by not objecting. As late as the mid-twentieth century, hospitals rarely supposed that patients had “rights” at all. Then, in 1973 — driven by a rising tide of consumer and civil-rights activism — the American Hospital Association issued the first Patient's Bill of Rights, declaring that patients were entitled to information, to respectful care, to refuse treatment, and to the truth about their condition. It was a quiet revolution: the patient had become a person with standing, not merely a body to be treated. This chapter sets out the rights that patients hold today, including under Saudi law.

Learning Objectives

By the end of this chapter, you should be able to:

1. Define patient rights and explain their ethical, legal, and Islamic foundations.
2. Describe the international and Saudi frameworks governing patient rights.
3. Apply the four bioethical principles to the doctor-patient relationship.
4. Explain the ethical limits of medical paternalism.
5. Use the four-topic clinical ethics framework to analyze real patient cases.
6. Identify the specific rights of vulnerable patient groups.
7. Describe the responsibilities that patients bear alongside their rights.

4.1 Why Patient Rights Matter

For most of the history of medicine, the doctor decided and the patient complied. The physician's authority derived from expertise, and the patient's role was largely passive — to present symptoms, receive a diagnosis, and follow the prescribed treatment. This model was called medical paternalism, and it was widely accepted as both natural and benevolent.

The shift away from paternalism toward patient-centered care is one of the most significant ethical transformations in the history of medicine. It was driven by several forces: the western civil rights movement; the exposure of abuses in which patients were treated as subjects rather than persons; the growth of bioethics as an academic discipline; and the recognition that patients who are active participants in their care have better outcomes than those who are merely passive recipients of it.

Today, patient rights are enshrined in international declarations, national laws, hospital policies, and professional codes. In Saudi Arabia, the Ministry of Health's Patient Bill of Rights and Responsibilities gives legal force to these protections. Understanding these rights — not merely as abstract principles but as practical obligations that govern every clinical encounter — is a core competency for every physician.

4.2 Foundations of Patient Rights

Ethical Foundation

The ethical case for patient rights flows directly from the four principles. Autonomy holds that competent persons have the right to make decisions about their own bodies and lives — implying the right to information, the right to consent or refuse, and the right to have those decisions respected. Beneficence requires acting in the patient's best interest — but crucially, the patient's own conception of their best interest. Non-maleficence grounds the right to protection from harm. Justice grounds the right to equal and equitable access to care.

Legal Foundation

Internationally, patient rights are grounded in the Universal Declaration of Human Rights (1948) and the World Medical Association Declaration on the Rights of the Patient (Lisbon, 1981; revised 2015). In Saudi Arabia, the MOH Patient Bill of Rights and Responsibilities provides the operative legal framework, covering rights at every stage of the healthcare encounter and specifying additional rights for vulnerable groups: children, the elderly, patients with disabilities, cancer patients, patients with HIV/AIDS, psychiatric patients, and women.

Islamic Foundation

Islam's contribution to patient rights is grounded in the Quranic principle of *karama* (كرامة) — the inherent dignity of every human being — and in the *maqasid al-shari'ah*. Patient rights are not, in the Islamic framework, concessions granted by the healthcare system; they are expressions of the Allah-given dignity that every human being possesses and that no institution has the authority to strip away.

4.3 The Saudi Patient Bill of Rights: Core Categories

Right to Dignity and Respect

Every patient has the right to be treated with respect for their human dignity, regardless of their medical condition, nationality, religion, age, gender, disability, or social status. In practice: use the patient's name and appropriate title; do not discuss patient information in corridors or in the presence of other patients; ensure privacy during examination and procedures; maintain respectful conduct even when a patient is unconscious, terminally ill, or cognitively impaired.

Right to Information

Patients have the right to receive clear, accurate, and comprehensible information about their diagnosis, the proposed treatment plan (including benefits, risks, and alternatives), the likely prognosis with and without treatment, and the names and roles of healthcare providers involved in their care. Information must be communicated in language the patient can understand — this may require interpreters, simplified language, or visual aids.

Right to Informed Consent

No medical examination, investigation, or treatment may be performed without the patient's informed consent, except in defined emergency circumstances. The right to consent encompasses the right to accept a proposed treatment, the right to refuse, the right to withdraw consent at any time, and the right to consent to or refuse participation in clinical teaching or research.

Right to a Second Opinion and to Complaint

Patients have the right to seek a second medical opinion without this being interpreted as a challenge to their physician's authority. Every patient also has the right to raise a complaint about the care they receive, to have it investigated fairly and transparently, and to receive a response. In Saudi Arabia, the MOH operates a patient complaint system accessible via 937. A complaint is an important source of information about care quality — not a personal attack.

4.4 The Doctor-Patient Relationship

Trust as the Foundation

The doctor-patient relationship is built on trust. The patient trusts the physician to be competent, to tell the truth, to act in their interest, and to keep their confidences. This trust is not automatic; it must be earned through consistent professional behavior and sustained through honest, respectful communication.

The Problem of Paternalism

Medical paternalism — the practice of overriding patient preferences on the grounds of acting for the patient's own good — is ethically problematic when applied to competent adults, even when the physician's motives are benevolent. The paternalistic model assumes that the physician knows better than the patient what is good for the patient. This is partially correct — the physician has clinical expertise the patient lacks — but it ignores the equally important truth that the patient knows their own values, priorities, and life circumstances in ways the physician does not. Soft paternalism (overriding a decision that is not truly autonomous due to confusion, coercion, or inadequate information) is generally ethically justified. Hard paternalism (overriding a fully informed, competent patient's autonomous decision) is ethically indefensible.

4.5 The Four-Topic Framework for Clinical Ethics

The four-topic framework developed by Jonsen, Siegler, and Winslade in *Clinical Ethics* organizes ethical considerations in any clinical case into four domains. It is the most widely used systematic tool in clinical ethics worldwide.

Topic 1: Medical Indications

This covers the clinical facts: diagnosis, prognosis, and proposed treatment options. Relevant principles: beneficence and non-maleficence. Key questions: What is the patient's medical problem? What are the goals of treatment (cure, palliation, rehabilitation, comfort)? What are the benefits and harms of each treatment option? Is there a point at which further treatment is futile?

Topic 2: Patient Preferences

This covers the patient's values, wishes, and choices. Relevant principle: autonomy. Key questions: Has the patient been informed? Does the patient have capacity? What are their expressed preferences? Has the patient made advance directives? If lacking capacity, who is the appropriate surrogate decision-maker?

Topic 3: Quality of Life

This covers the patient's subjective experience. Relevant principles: beneficence and autonomy. Key questions: What are the prospects for returning to the patient's normal life? What burdens does the

proposed treatment impose? How does the patient define quality of life for themselves? Physicians must guard against substituting their own QoL assessment for the patient's — studies consistently show patients with severe disabilities rate their QoL higher than physicians rate it for them.

Topic 4: Contextual Features

This covers broader circumstances: family dynamics, institutional factors, legal obligations, cultural context, financial pressures. Relevant principle: justice. Key questions: Are there family members whose interests bear on the decision? Are there institutional policies, legal requirements, or resource constraints that affect the options? Are there conflicts of interest?

4.6 Patient Responsibilities

Rights do not exist in isolation. The Saudi Patient Bill of Rights explicitly addresses the responsibilities that patients bear alongside their rights. Patient responsibilities include: providing accurate information about their medical history, symptoms, medications, and relevant lifestyle factors; following agreed treatment plans; treating healthcare staff with respect; and communicating honestly about limitations (financial, logistical, religious objections) so that alternative arrangements can be made.

It is important to note that patient responsibilities do not serve as justification for withholding care. A patient who behaves badly does not forfeit their right to treatment. The responsibilities are ethical obligations in a partnership, not conditions for access to healthcare.

Key Terms

Term	Definition
Patient rights	The ethical and legal entitlements of patients in interactions with the healthcare system
Paternalism	Overriding a patient's preferences on the grounds of acting in their best interest
Informed consent	A patient's voluntary, informed agreement to a medical procedure or treatment
Capacity	The ability of a patient to understand information, appreciate implications, reason, and communicate a decision
Surrogate decision-maker	A person authorized to make healthcare decisions on behalf of a patient who lacks capacity
Advance directive	A document in which a competent person specifies wishes for future medical care
Four-topic framework	A systematic tool: medical indications, patient preferences, quality of life, contextual features
Soft paternalism	Overriding decisions that are not truly autonomous due to impairment, coercion, or inadequate information
Hard paternalism	Overriding the fully informed, competent decision of an autonomous patient — ethically indefensible
Karama (كرامة)	The inherent Allah-given dignity of every human being in Islamic theology

Case Vignettes for Discussion

Case 4.1 — The Withheld Diagnosis

A 58-year-old man presents with weight loss and persistent cough. Investigations confirm stage III lung cancer. His son approaches you before the consultation and begs you not to tell him the diagnosis. "He has a weak heart," he says. "He will not survive the news." The patient himself is fully alert and has not made any request to limit his information. How do you proceed? Apply the four-topic framework. What does the Patient Bill of Rights say about this situation?

Case 4.2 — The Refused Operation

A 35-year-old woman is admitted with post-partum hemorrhage. She is conscious and lucid. She tells you clearly: "I understand I may die. I do not consent to a surgery that may result in total hysterectomy under any circumstances." Her husband standing beside her begs you to operate on her regardless. What are the ethical issues? What does Islamic jurisprudence say? What should the clinical team do?

Case 4.3 — The Demanding Family

An 80-year-old man with advanced dementia is admitted with aspiration pneumonia. His three adult children disagree: one wants full aggressive treatment including ICU; one wants comfort care only; one is abroad and unreachable. The patient made no advance directive. Who is the appropriate decision-maker? How do you proceed?

Case 4.4 — The Complaint

A patient complains that during a ward round her diagnosis was discussed out loud in a four-bed bay while the curtains were open, and that the resident physician referred to her as "the diabetic in bed 3." The ward team dismisses the complaint as trivial. What rights has the patient identified as violated? What should happen next?

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Chapter 5: Autonomy and Informed Consent

A woman named Mary Schloendorff agreed to let her doctors at a New York hospital examine a lump under anaesthesia — but she expressly forbade any operation. While she lay unconscious, the surgeon removed the tumour anyway. She developed gangrene, lost several fingers, and sued. In 1914, Judge Benjamin Cardozo answered with words that would anchor a century of medical ethics: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault.” The modern law of consent begins in that sentence. This chapter is about the patient’s right to choose.

Learning Objectives

By the end of this chapter, you should be able to:

1. Define patient autonomy and explain its ethical, legal, and Islamic foundations.
2. Describe the three essential elements of valid informed consent: information, understanding, and voluntariness.
3. Assess a patient's capacity to consent using a structured approach.
4. Distinguish between different types of consent and identify when each is appropriate.
5. Explain how to proceed when a patient lacks capacity.
6. Describe the ethics of treatment refusal by competent patients.
7. Apply the Saudi Guidelines for Informed Consent to real clinical scenarios.

5.1 The Centrality of Autonomy in Modern Medicine

Autonomy — from the Greek *autos* (self) and *nomos* (law) — means self-governance: the capacity and the right of a competent person to direct their own life according to their own values and choices. In clinical medicine, respecting autonomy means recognizing that the patient, not the physician, is the final authority on what happens to the patient's body.

The landmark American legal case *Schloendorff v. Society of New York Hospital* (1914) first articulated the modern legal foundation: "Every human being of adult years and sound mind has a right to determine what shall be done with his body." But it took decades of legal evolution, ethical argument, and documented abuses before this principle became routinely embedded in clinical practice. The concept of informed — as distinct from simple — consent emerged in the 1950s, when courts first required physicians to disclose material information about treatment risks.

5.2 The Three Elements of Valid Consent

Element 1: Adequate Information

The patient must receive sufficient information to make a meaningful decision. The Saudi Guidelines for Informed Consent (MOH, 2019) specify that this must include: the nature of the proposed procedure; its purpose and expected benefits; its material risks and potential complications; available alternatives including the option of no treatment; the likely consequences of refusing treatment; and the identity and qualifications of the person performing the procedure.

A risk is material if a reasonable patient would consider it significant in deciding whether to proceed — determined not by statistical probability alone, but by the patient's values and circumstances. The therapeutic privilege (withholding distressing information to prevent harm) has been progressively narrowed. While brief, carefully timed disclosure is appropriate, systematic withholding of material information is generally ethically indefensible.

Element 2: Understanding

Information received is not the same as information understood. The physician must not merely disclose but verify comprehension — using plain language free of jargon, visual aids where helpful, actively inviting questions, and using the teach-back method: asking the patient to explain in their own words what they

have understood. Understanding is also affected by emotional state — a patient who has just been told they have cancer is in acute distress and may need staged disclosure.

Element 3: Voluntariness

Consent must be free from coercion, manipulation, and undue influence. Several situations commonly compromise voluntariness: implicit pressure from the physician (the way options are presented powerfully shapes patient choice); family pressure (particularly in Arab cultural contexts where families play an active role in health decisions); and institutional pressure (patients may feel they have no real choice without reassurance that their care will not change regardless of their decision).

5.3 Types of Consent

Express Consent

Written consent is required in Saudi Arabia per the MOH Guidelines for: surgical and invasive procedures; procedures with significant potential side effects; administration of blood and blood products; anesthesia; clinical research; and photography and recording of patients. A signature on a consent form is evidence that the consent process occurred — it is not the consent itself. A patient who signs without receiving or understanding the relevant information has not given valid informed consent.

Implied Consent

Implied consent arises from the patient's behavior — a patient who rolls up their sleeve when a nurse approaches with a blood pressure cuff is implying consent to the measurement. Implied consent is appropriate for routine, low-risk clinical interactions. It does not extend to invasive procedures, significant interventions, or any situation where there is reason to believe the patient might not agree if explicitly asked.

Emergency Consent and Proxy Consent

When a patient presents in an emergency and is unable to consent, treatment may proceed on the basis of presumed consent — it is assumed that a reasonable person would want life-threatening conditions treated. The Islamic Charter states: "A patient should not be examined or treated without his consent, except in cases when emergency medical intervention is required and informed consent cannot be obtained for any particular reason."

When a patient lacks capacity, consent must be obtained from an authorized representative. Saudi law and Islamic jurisprudence both recognize a hierarchy of guardianship (wilayah): the legal guardian (wali) for minors; next of kin for adult patients lacking capacity; and in genuine emergencies with no proxy available, the treating physician acting in the patient's best interest.

5.4 Assessing Capacity

Capacity is the clinical and legal prerequisite for self-consent. It is distinct from competence (a legal determination made by a court). Capacity is a clinical assessment made by the treating physician, and it is decision-specific and time-specific — a patient may have capacity for simple decisions but not complex ones, and may regain capacity after an acute confusional episode resolves.

The Four Components of Capacity

1. Understanding: Can the patient understand the information that has been given?
2. Appreciation: Can the patient appreciate how this information applies to their own situation?
3. Reasoning: Can the patient reason about the options and arrive at a decision through a coherent rational process?
4. Communication: Can the patient communicate their decision in some form?

The threshold for capacity is appropriately calibrated to the stakes of the decision — a higher level of decision-making ability is required to refuse life-saving treatment than to accept a low-risk investigation. Formal capacity assessment is indicated when the patient is refusing significantly beneficial treatment, when cognitive impairment may be affecting decision-making, or when the consequences of the decision are severe or irreversible.

5.5 The Islamic Framework for Consent

The concept of informed consent in Islamic jurisprudence predates its formalization in Western medical law by centuries. Classical Islamic legal scholars discussed the conditions under which medical treatment could be administered. Al-idhn al-tibbi (الإذن الطبي — medical permission) is the Islamic concept that corresponds to informed consent. Treatment is permissible when: the patient has given permission (idhn); the physician is qualified (khibra); the treatment is likely to benefit the patient (ghalab al-zann bi-l-shifa'); and the expected benefit outweighs the anticipated harm.

The Islamic concept of shura (consultation) supports the shared decision-making model: the ideal clinical encounter is one in which the physician provides expert guidance and the patient (and their family, where appropriate) makes an informed choice. Neither pure paternalism nor pure patient autonomy captures this ideal — the Islamic model is one of collaborative deliberation grounded in mutual trust and transparency.

5.6 Refusal of Treatment

The right to refuse medical treatment is the logical corollary of the right to consent. Competent adults have the right to refuse any treatment, for any reason, as long as the decision does not harm third parties. When a patient refuses significantly beneficial treatment, the physician's obligations include: ensuring the refusal is informed (has the patient understood the consequences?); exploring the reasons (a refusal that seems irrational often reflects a fear, a misunderstanding, or a value that, when understood, changes the clinical picture); offering alternatives; documenting the process; and ultimately accepting the decision.

Islamic jurisprudence does not require a patient to seek or accept treatment in all circumstances. The obligation to treat (wujub al-tadawi) is generally classified as recommended (mustahabb) rather than obligatory (wajib), except where failure to treat would constitute self-harm through neglect. A competent adult Muslim who, after genuine deliberation, declines a treatment is not violating their religious obligations — though physicians may appropriately engage patients in reflection about the implications of their decision.

5.7 Advance Directives

An advance directive is a document in which a competent person specifies their wishes regarding future medical care, to take effect if they later lose capacity. Common forms include living wills (specifying treatment preferences), DNR orders, and durable power of attorney for healthcare (appointing a specific

person to make healthcare decisions). Advance directives extend autonomy into a future period when the patient can no longer exercise it directly. In clinical practice, they should be documented clearly in the medical record, reviewed periodically, and respected by the clinical team even when the team disagrees with the patient's stated preferences.

Key Terms

Term	Definition
Autonomy	The right of a competent person to make decisions about their own body and life
Informed consent	A patient's voluntary, adequately informed agreement to a proposed treatment or procedure
Capacity	The clinical ability to understand information, appreciate its relevance, reason about options, and communicate a decision
Therapeutic privilege	The doctrine that a physician may withhold distressing information to prevent harm; now substantially narrowed
Proxy consent	Consent given by an authorized representative on behalf of a patient who lacks capacity
Substituted judgment	The surrogate standard of deciding as the patient would decide, based on their known values
Best interest standard	The surrogate standard of deciding as a reasonable person in the patient's situation would want
Advance directive	A document specifying a person's treatment wishes for a future period when they lack capacity
Al-idhn al-tibbi (الإذن الطبي)	The Islamic concept of medical permission, analogous to informed consent
Wilayah (ولاية)	Guardianship in Islamic law — authority to make decisions on behalf of a minor or incapacitated person
Tamyiz (تمييز)	The Islamic age of discernment (~7 years) after which a child's developing autonomy begins to carry weight
Teach-back method	A communication technique in which the patient explains understanding in their own words, to verify comprehension

Case Vignettes for Discussion

Case 5.1 — The Pre-operative Consent

A 55-year-old woman requires a colonoscopy for investigation of rectal bleeding. She is seen in the pre-admission clinic on the morning of surgery, already in a hospital gown. The surgical resident hands her a consent form and says: "Just sign here — it's routine, nothing to worry about." She asks about risks and receives the reply: "Very small — just the usual surgical risks." She signs. Has valid informed consent been obtained? What are the ethical failures? What should the endoscopy team do?

Case 5.2 — The Refusing Patient

A 40-year-old woman with newly diagnosed breast cancer refuses the recommended mastectomy: "I would rather die than lose my breast." Her husband is distraught and urges you to operate without her consent. How do you assess her capacity? What are your obligations to her? To her husband? Can you operate without consent?

Case 5.3 — The Unconscious Patient

A 30-year-old man is brought to the emergency department unconscious following a road traffic accident. He requires emergency surgery to control intra-abdominal bleeding. His family has not yet arrived. Among his belongings is a handwritten, signed, and dated note stating that for personal religious reasons he does not consent to blood transfusions and requests that only blood-free alternatives be used. The surgeon estimates that without transfusion, the risk of intraoperative death rises from 5% to 40%. What is the ethical framework for this decision? How does the Islamic principle of necessity (darurah) apply when a patient's pre-stated refusal conflicts with preservation of life? What should the surgical team do?

Case 5.4 — The Teenage Refusal

A 15-year-old girl is admitted with a serious eating disorder. Her weight is critically low and she requires nasogastric feeding. She refuses: "It is my body and my choice." Her parents consent to the tube feeding. What is the ethical framework? Does her age matter? Does her capacity matter? Who has the authority to make this decision?

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Chapter 6: Privacy and Confidentiality

In 1969, a young man told his university psychologist that he intended to kill a woman who had rejected him. The therapist was alarmed but, believing himself bound by confidentiality, warned no one beyond a brief and failed attempt to have the man detained. Two months later he killed her. Her parents sued, and in 1976 the California Supreme Court delivered a principle that reshaped medical confidentiality: “the protective privilege ends where the public peril begins.” A clinician’s duty of secrecy, the court held, is not absolute — it yields when an identifiable life is at stake. This chapter examines the strong duty to keep patients’ confidences, and the narrow but serious exceptions that can require breaking them.

Learning Objectives

By the end of this chapter, you should be able to:

1. Define privacy and confidentiality and explain the ethical distinctions between them.
2. Describe the historical, ethical, and Islamic foundations of medical confidentiality.
3. Identify the practical demands of confidentiality in ward, clinic, and digital settings.
4. Recognize the legitimate exceptions to confidentiality and apply them appropriately.
5. Navigate the specific challenge of family requests to withhold information from patients.
6. Apply principles of confidentiality to electronic health records, messaging platforms, and social media.
7. Describe the legal framework governing confidentiality in Saudi healthcare practice.

6.1 The Circle of Confidence

Imagine a circle drawn around a physician and a patient at the moment of consultation. Inside that circle flows information that the patient would share with almost no one else: symptoms they are ashamed of, behaviors they have hidden from their family, fears they cannot name, secrets that have shaped their life. The patient shares these things not because they trust this particular individual as a person — they may have met minutes before — but because they trust the role. They trust that what enters the circle stays within it.

This is the foundation of medical confidentiality. It is not a bureaucratic rule, a legal technicality, or a courtesy. It is the condition that makes the doctor–patient relationship possible. Without the assurance of confidentiality, patients would withhold exactly the information that physicians most need.

6.2 Definitions: Privacy, Confidentiality, and Secrecy

Privacy is the broader concept: the right of a person to control access to information about themselves. In healthcare, privacy has both a physical dimension (the right to bodily privacy during examination) and an informational dimension (the right to control who knows what about one’s health).

Confidentiality is a specific application of the privacy principle to information disclosed within a relationship of trust. It refers to the obligation of the person who receives private information — the physician — to use it only for the purpose for which it was disclosed and not to share it without the patient's consent.

Confidentiality is relational: it arises because of the relationship, and it is the physician's obligation, not merely an option. Secrecy is the simple act of keeping information hidden — broader and more passive than confidentiality.

6.3 Ethical and Islamic Foundations

The Hippocratic Oath states: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about." The WMA Code gives the contemporary formulation: "It is ethical to disclose confidential information when the patient consents or when there is a real and imminent threat of harm that can only be removed by breach of confidentiality."

The Islamic ethical framework provides a robust foundation. The Quran explicitly prohibits spying: "Do not spy on one another." (Al-Hujurat 49:12). The Prophet (peace be upon him) said: "Whoever conceals [the faults of] a Muslim in this world, Allah will conceal his faults on the Day of Resurrection." (Muslim). The concept of amanah (أمانة — trust) is central: when a patient discloses information to a physician, they are placing a trust in their hands. Betraying that trust is not merely a professional failing; in Islamic ethics it is a moral failing of the gravest kind.

Three overlapping ethical values ground confidentiality: autonomy (personal information belongs to the patient; sharing it without authorization violates their right of control); respect for dignity (confidentiality protects a person from having their medical history define them socially); and trust (without confidentiality, patients will not disclose fully, and medicine practiced without complete information is both less effective and more dangerous).

6.4 Confidentiality in Practice

Ward Rounds and Teaching Sessions

The traditional medical ward round is an inherently privacy-compromising activity — a patient's diagnosis, test results, social history, and treatment plan may be audible to every other patient in the bay. The ethical obligation is to minimize this exposure: drawing curtains, speaking quietly, conducting sensitive discussions in a private room, and ensuring teaching at the bedside is conducted with the patient's explicit consent. A patient who consented to admission has not automatically consented to being a teaching case.

Medical Records and Documentation

The medical record is a confidential document. Access should be restricted to those involved in the patient's care. Unauthorized access — looking up a record out of curiosity, reviewing a colleague's or family member's record without clinical justification — is a serious breach of confidentiality even if the information is never shared further. In Saudi Arabia, the Executive Regulations of the Health Professions Practice Law require healthcare practitioners to maintain the confidentiality of patient records and to use patient information only for the purposes of their care.

Casual Conversation

Discussing patient cases in elevators, hospital canteens, corridors, or social settings — even without using the patient's name — constitutes a confidentiality breach if enough identifying information is included. The rule is simple and absolute: patient information is for clinical purposes only, and clinical discussion belongs in clinical spaces.

6.5 Exceptions to Confidentiality

Patient Consent

The clearest exception is when the patient consents to disclosure. Consent to disclosure should be explicit where possible, documented, and limited to the specific information and recipient authorized.

Duty to Protect Third Parties

The most significant exception is the obligation to breach confidentiality when a patient poses a clear, serious, and imminent risk to an identifiable third party. The foundational legal case is *Tarasoff v. Regents of the University of California* (1976): "The protective privilege ends where the public peril begins." Application requires that the threat is serious, credible, imminent; that disclosure is necessary and no less privacy-invasive alternative can prevent the harm; and that disclosure is proportionate.

Compulsory Notification and Court Orders

Certain diseases are subject to mandatory notification requirements: the physician is legally obliged to report them to the appropriate public health authority regardless of patient consent. Saudi Arabia's MOH regulations specify a list of notifiable diseases including tuberculosis, meningococcal disease, and cholera. A physician may also be required by a court order to disclose confidential patient information in legal proceedings — a legal compulsion that overrides the ethical obligation of confidentiality.

6.6 The Family, Culture, and Confidentiality

In many Arab and Muslim cultural contexts, the family plays a central and active role in healthcare. This cultural reality does not alter the fundamental ethical principle: the right to confidentiality belongs to the patient, not to the family. The family's love, concern, and emotional investment do not entitle them to information the patient has not authorized them to receive.

A specific and ethically charged scenario: the family's request that the physician not disclose a serious diagnosis (most commonly cancer) to the patient. The ethical problems are several: it violates patient autonomy; it is usually based on a false premise (research consistently shows most patients want to know their diagnosis); it damages trust when the patient eventually learns they were deceived; and it impedes appropriate care. The culturally sensitive path involves meeting with the family first, acknowledging their concern, then assessing the patient's own preferences privately, and disclosing at the patient's pace.

6.7 Confidentiality in the Digital Age

Electronic Health Records

Electronic health records create new confidentiality vulnerabilities: the same accessibility that benefits clinical care means a single security breach can expose thousands of patients' records simultaneously. Obligations include: accessing only the records of patients under your care; using only authorized, secure

platforms; logging out of systems when not in use; reporting unauthorized access or security breaches immediately; and never photographing or screenshotting patient records.

Messaging Applications: WhatsApp and Clinical Communication

The use of consumer messaging applications — particularly WhatsApp — for clinical communication is widespread but ethically problematic. These platforms are stored on personal devices that may be lost, stolen, or accessed by others. Group chats routinely include forwarding of patient information and clinical photographs, often without patient consent. The ethical framework: patient information should be transmitted only through approved, encrypted, institutionally governed platforms. Where clinical necessity requires unofficial platforms, information should be maximally anonymized and explicit patient consent obtained for identifying clinical images.

Key Terms

Term	Definition
Privacy	The right of a person to control access to information about themselves
Confidentiality	The physician's obligation to use patient-disclosed information only for the purpose for which it was shared
Secrecy	The act of keeping information hidden — broader and more passive than confidentiality
Notifiable disease	A disease that must be reported to public health authorities regardless of patient consent
Tarasoff duty	The legal and ethical obligation to warn an identifiable third party of a credible, serious, imminent threat
Family collusion	The scenario in which family members ask the physician to withhold a serious diagnosis from the patient
Amanah (أمانة)	Trustworthiness — the Islamic concept framing confidentiality as a sacred trust
Ghaybah (غيبية)	Backbiting — the unauthorized disclosure of a person's private affairs, prohibited in Islam
Anonymization	The removal of identifying information from clinical data to protect patient privacy

Case Vignettes for Discussion

Case 6.1 — The WhatsApp Ward Round

A junior doctor photographs the chest X-ray of a patient with an unusual finding and shares it on the department WhatsApp group, which includes twelve colleagues. The image includes the patient's name, hospital number, and date of birth visible in the corner. The patient later complains that they did not consent to this. The doctor argues that the purpose was educational and no harm was caused. Evaluate the ethical issues. What should happen next?

Case 6.2 — The Concerned Employer

A 35-year-old bus driver is diagnosed with epilepsy. He is started on medication and counseled that he must not drive until he has been seizure-free for one year. Two weeks later he calls to say he is still driving — he cannot afford to lose his job. His employer calls the hospital asking for information about why the driver has been absent. What are your obligations? To the patient? To the employer? To the public?

Case 6.3 — The Spouse's Request

A 40-year-old woman attends a gynaecology outpatient clinic and is found to have a sexually transmitted infection. Her husband is in the waiting room and approaches the nurse, asking what the problem is. The patient had made no mention of her husband during the consultation. How should the nurse respond? What should happen next in the patient's care?

Case 6.4 — The Family Veto

The family of a 62-year-old man newly diagnosed with advanced colon cancer begs you: "Do not tell him. He has a heart condition. The shock will kill him." The patient has not been informed of the reason for his investigation. When you enter the room alone with him, he says: "Doctor, I need you to be straight with me. What did you find?" How do you proceed? What ethical principles apply?

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Chapter 7: Truth-Telling and Communication

In 1961, a researcher asked American physicians a simple question: would you tell a patient he had cancer? Ninety percent said no — convinced that the truth would crush hope and do more harm than good, so the

diagnosis was buried in euphemism and silence. Eighteen years later, researchers put the very same question to a new generation of doctors. This time, ninety-seven percent said yes. In under two decades the profession had completely reversed one of its most basic habits — and what had changed was not the disease, but the ethics of honesty. This chapter asks what we owe our patients in the way of truth, and how to tell it.

Learning Objectives

By the end of this chapter, you should be able to:

1. Explain the ethical and Islamic foundations of truth-telling in medicine.
2. Describe the main barriers to honest communication in clinical practice.
3. Apply a structured framework — the SPIKES protocol — for breaking bad news.
4. Navigate the culturally specific challenges of disclosure in the Saudi and Arab clinical context.
5. Recognize when withholding information may be ethically permissible and when it is not.
6. Manage disagreements between the physician's view and the views of the patient, family, or colleagues.
7. Apply principles of cultural, gender, religious, and generational sensitivity to clinical communication.

7.1 The Moral Weight of a Word

What is said to patients — and what is withheld — is not merely a communication style preference. It is a moral act. Words open or close possibilities: the possibility of decision-making, of preparation, of reconciliation, of dignity in facing illness. Silence, euphemism, and deliberate deception do not protect patients from suffering; they relocate that suffering, often making it worse, and they do so at the cost of the patient's autonomy and the physician's integrity.

7.2 The Ethical Obligation to Tell the Truth

In deontological ethics, Kant argued that lying is intrinsically wrong because it treats the person being deceived as a means to an end. A patient who is deceived about their diagnosis is not being protected; they are being denied the right to be an agent in their own life. In virtue ethics, honesty is a core medical virtue. The physician who tells the truth even when it is difficult exercises the virtue of courage. In consequentialist terms, the evidence strongly supports truthful disclosure: patients who are honestly informed cope better, engage more constructively with treatment, and do not die sooner. The fear that "the truth will kill them" is not supported by research.

Islam places truthfulness (sidq, صدق) among the most fundamental moral obligations. The Quran commands: "O you who believe! Be mindful of Allah, and be with the truthful." (Al-Tawbah 9:119). The Prophet (peace be upon him) said: "Truthfulness leads to righteousness, and righteousness leads to Paradise." (Bukhari and Muslim). In the medical context, the obligation of truthfulness is grounded in the concept of amanah — the patient who asks their physician about their condition has placed a trust in them, and that trust is betrayed by deception.

7.3 What Truth-Telling Requires in Practice

Completeness Without Overwhelm

The patient has a right to complete information, but that information need not be delivered all at once. For patients with serious diagnoses, a staged approach — providing the most important information first, then allowing time for questions, then returning to fill in details — is both ethically sound and clinically effective.

Truthfulness Within Uncertainty

Medicine involves uncertainty, and honest communication must acknowledge it. Saying "your prognosis is six months" when the honest answer is "most patients with this condition survive between three and twelve months, but individual variation is significant" is a form of false precision that can cause as much distress as underdisclosure.

The Right Not to Know

Autonomy includes the right not to receive information. A patient who says "I don't want the details — I trust you to decide" is exercising a legitimate autonomous choice. This preference should be documented, and its limits clarified: the patient may not want diagnostic details but may need information about treatment in order to consent to it.

7.4 Breaking Bad News: The SPIKES Protocol

Breaking bad news is among the most demanding communication tasks in medicine. The SPIKES protocol — developed by Buckman and Baile — provides a structured framework validated across multiple clinical contexts.

S — Setting Up the Interview

Arrange a private room; close the door. Ensure the patient is comfortable and clothed. Sit down — sitting at eye level signals that you are present and not rushing. Minimize interruptions. Ask the patient if they would like someone with them — but ensure the patient themselves makes this choice.

P — Assessing the Patient's Perception

Before disclosing, establish what the patient already knows or suspects. Ask: "What have you been told about your condition so far?" A patient who says "I think it might be cancer" requires a different opening than a patient who says "I just thought it was a routine check-up."

I — Obtaining the Patient's Invitation

Before disclosing, explicitly check how the patient wants to receive information. Ask: "Some patients want all the details about their diagnosis, and others prefer to take it step by step. What would work best for you?" This operationalizes the right not to know while ensuring that patients who want information receive it fully.

P — Giving Knowledge and Information

Use a warning shot: "I'm afraid I have some serious news to share with you." Use plain language — "tumor" rather than "malignant neoplasm." Deliver information in manageable pieces; pause after each. Do not fill

silence — the patient needs a moment to register what they have been told. Do not give false hope.

E — Addressing Emotions with Empathy

Use the NURSE framework for empathic responses: Naming ("It sounds like you are feeling overwhelmed"); Understanding ("This makes complete sense given what you have just been told"); Respecting ("You have handled an incredibly difficult situation with remarkable courage"); Supporting ("I want you to know that we are going to be with you through this"); Exploring ("Can you tell me more about what you are most worried about?").

S — Strategy and Summary

The consultation should not end with the disclosure alone. The patient needs a clear sense of what happens next: investigations planned, who will be involved in their care, when the next appointment will be, who they can call. A written summary of key information given to the patient at the end is extremely valuable — patients in acute distress retain very little of what they are told verbally.

7.5 Disclosure in the Saudi and Arab Clinical Context

Saudi oncologist Aljubran (2013) notes that attitudes toward disclosure in the Arab world have been changing significantly, driven by increased patient education, greater awareness of patient rights, and recognition that non-disclosure causes harm. Surveys of Saudi cancer patients consistently show that the majority want to know their diagnosis — including terminal diagnoses — when asked directly and without family pressure.

Cultural Sensitivity vs. Cultural Capitulation

Respecting cultural context means adapting the how of disclosure — the timing, the pace, the language, the role of the family — not the whether. The obligation to disclose is not culturally relative; what is culturally variable is the style in which disclosure is most effectively and compassionately conducted. The assumption that "Arab patients don't want to know" is a stereotype that harms patients by denying them the opportunity to express their actual preferences.

The Role of Hope

The cultural resistance to disclosure often stems from a genuine belief that removing hope is harmful. This concern deserves serious engagement. The physician can and should communicate hope — but hope that is grounded in reality: hope for effective symptom control, hope for meaningful time, hope for dignity, hope for the support of the healthcare team. False hope is not compassion; it is a deception that forecloses the real preparation and reconciliation that honest knowledge enables.

7.6 Managing Disagreement

Physician-Patient Disagreement

When a patient's choice conflicts with the physician's clinical recommendation, the starting point is genuine curiosity: why does the patient see things differently? The disagreement may reflect a difference in values, a misunderstanding, a fear, or a practical barrier — each calling for a different response. The physician's role is to understand the patient's reasoning, address modifiable barriers, ensure the patient is fully informed, and ultimately accept a competent patient's autonomous decision even when the physician disagrees.

Intra-professional Conflict

Disagreements within the clinical team require structured, respectful communication. The SBAR framework (Situation, Background, Assessment, Recommendation) provides a structured approach to clinical escalation equally applicable to ethical concerns. When a trainee observes conduct they believe is ethically problematic, the appropriate response is structured escalation through legitimate channels — the clinical supervisor, the course coordinator, or the hospital ethics committee.

7.7 Cultural, Gender, and Religious Sensitivity

Cultural sensitivity is not stereotyping patients by national origin; it is remaining genuinely curious about the individual patient's values and preferences. In the Saudi clinical context, relevant cultural dimensions include the importance of family involvement in healthcare decisions; the significance of religious faith in making sense of illness; norms around gender and physical examination; and communication styles that may be more indirect or hierarchical than those familiar from Western medical education.

For Muslim patients, religious faith is often the primary framework through which illness is understood and interpreted — through the lens of *sabr* (patient endurance), *tawakkul* (trust in Allah), and the conviction that suffering carries spiritual meaning and reward. The physician who engages with this dimension — who acknowledges the patient's faith, who does not pathologize religious responses to illness, who involves the hospital chaplain where appropriate — is practicing medicine that is holistic in the fullest sense.

Key Terms

Term	Definition
SPIKES protocol	Setting, Perception, Invitation, Knowledge, Emotions, Strategy — a framework for breaking bad news
NURSE framework	Name, Understand, Respect, Support, Explore — an empathic response framework
Sidq (صدق)	Truthfulness — a foundational Islamic moral virtue
Therapeutic privilege	The doctrine permitting withholding of distressing information; now substantially narrowed
Staged disclosure	A graduated approach to delivering difficult information in manageable portions over time
Family collusion	A scenario in which family members ask the physician to withhold diagnosis from the patient
Sabr (صبر)	Patient endurance — the Islamic virtue of bearing suffering with faith and trust in Allah
Tawakkul (توكل)	Trust in Allah — the Islamic disposition of reliance on divine providence alongside use of appropriate means
SBAR	Situation, Background, Assessment, Recommendation — a structured clinical and ethical escalation framework

Case Vignettes for Discussion

Case 7.1 — The Son's Request

You are seeing a 67-year-old man with newly diagnosed metastatic colon cancer. His son meets you before the consultation and asks you not to tell his father the diagnosis. You respectfully explain the ethical framework and your obligation to your patient. You enter the room alone. Within the first two minutes, the patient looks at you and says: "Doctor, my son told me this morning that I have cancer. I know what is happening. I just need you to tell me the truth about how long I have." Walk through how you would approach the rest of this consultation using SPIKES.

Case 7.2 — The Prognosis Question

A 55-year-old woman with advanced ovarian cancer, receiving palliative chemotherapy for eight months, asks you directly: "Am I going to die from this?" The treatment has not been working and her last scan showed significant progression. Her performance status is declining. How do you respond? Is it ever acceptable to say "I don't know" in this context? How do you balance honesty with the maintenance of appropriate hope?

Case 7.3 — The Disagreeing Resident

During a ward round, you observe the attending physician tell a patient with a new diagnosis of type 2 diabetes that their condition is "just a bit of sugar in the blood — nothing serious." You know this significantly understates the condition and its complications. The patient has not been counseled about lifestyle modification, medication, or the risk of end-organ damage. After the round, what do you do? Who do you speak to? What do you say?

Case 7.4 — The Physician Patient

A 42-year-old man is admitted for investigation of weight loss and is found to have inoperable pancreatic cancer. He is a physician himself and asks you to "give it to him straight — all of it, including the prognosis statistics." His wife, present in the room, begins to cry and shakes her head at you. How do you navigate between the patient's explicit request and his wife's visible distress?

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PART THREE — SPECIAL CLINICAL TOPICS

Chapter 8: Women's Health and Reproductive Ethics

Shortly before midnight on 25 July 1978, in a hospital in the north of England, a baby girl named Louise Brown was born. She looked entirely ordinary — and she changed the world. Louise was the first human being conceived outside the body, through in-vitro fertilisation, after years of work by Robert Edwards and Patrick Steptoe. Her birth was met with wonder and with alarm: religious leaders, scientists, and ethicists asked whether a sacred boundary had been crossed, and what it meant to create life in glass. Those questions — about the status of the embryo, the limits of reproductive technology, and the meaning of parenthood — are still debated. This chapter takes them up, including from within the Islamic tradition.

Learning Objectives

By the end of this chapter, you should be able to:

1. Describe the Islamic framework for understanding the moral status of the embryo and fetus at successive stages of development.
2. Explain the ethical and jurisprudential conditions under which termination of pregnancy is permissible in Islam.
3. Discuss the ethical issues raised by assisted reproductive technologies (ART), including IVF and surrogacy.
4. Analyze the ethical and Islamic dimensions of contraception and permanent methods of family planning.
5. Describe the ethical framework for prenatal and postnatal screening and testing.
6. Apply the four principles of biomedical ethics to reproductive health scenarios.
7. Navigate clinical scenarios involving reproductive ethics with sensitivity to Islamic values and patient autonomy.

8.1 Why Reproductive Ethics Demands Special Attention

Reproductive medicine occupies a uniquely sensitive position in clinical ethics. It deals simultaneously with the most intimate aspects of human life — sexuality, fertility, pregnancy, birth — and with some of the most contested questions in moral philosophy: when does life begin? Who has the right to make decisions about reproduction? What obligations do we owe to future persons who do not yet exist?

For Muslim physicians practicing in Saudi Arabia, these questions have an additional dimension: Islamic jurisprudence has developed highly refined positions on many reproductive ethics issues, positions that are both internally sophisticated and sometimes at variance with secular bioethical frameworks. Navigating this terrain requires fluency in both frameworks.

8.2 The Moral and Legal Status of the Embryo and Fetus

The Islamic Framework: Stages of Fetal Development

Islamic jurisprudence does not treat fetal moral status as binary. Rather, classical scholars articulated a developmental framework rooted in Quranic and Prophetic sources. The most important reference is the hadith reported in Bukhari and Muslim: "Each of you is constituted in your mother's womb for forty days as a nutfah (drop), then it becomes an 'alaqah (clot) for a similar period, then a mudghah (morsel of flesh) for a similar period, after which the angel is sent and breathes the ruh (soul) into it."

Based on this, classical scholars identified a critical threshold at 120 days after conception — the moment of nafkh al-ruh (نفخ الروح — the breathing of the soul). Before this point, the fetus has life (hayah) but not the full status of a person with an ensouled existence. After this point, the fetus is treated for most legal purposes as a person, and termination becomes categorically prohibited except to save the mother's life. Some Hanafi scholars distinguished a secondary threshold at 40 days, holding that restrictions before 40 days are less stringent.

8.3 Abortion: The Islamic Jurisprudential Framework

Before 40 Days

The majority of Hanafi scholars and a significant minority in other schools permit termination before 40 days if there is a valid reason ('udhr). This includes: serious medical risk to the mother; confirmed severe fetal abnormality incompatible with life; pregnancy resulting from rape (accepted by many contemporary scholars); and significant hardship meeting the jurisprudential threshold. The Maliki school is stricter, generally prohibiting abortion from the moment of conception except in cases of necessity.

Between 40 and 120 Days

Between 40 and 120 days, termination is permissible only for more serious reasons: confirmed severe fetal abnormality incompatible with life or associated with severe suffering; serious threat to maternal health that substantially worsens with the continuation of pregnancy; or pregnancy from rape (accepted by many contemporary scholars as a valid basis for termination up to 120 days).

After 120 Days (Ensoulment)

After ensoulment, the fetus is treated as a person with full legal protection. Termination is prohibited except when the mother's life is in direct, immediate danger from the continuation of the pregnancy, and there is no alternative means of saving her. The principle of tarjih al-maslaha al-ra'jiha (preferring the greater

interest) applies: the certain, present life of the mother takes precedence over the potential future life of the fetus.

8.4 Assisted Reproductive Technologies

IVF: The Basic Framework

The dominant scholarly consensus — endorsed by the Islamic Fiqh Council of the OIC — permits IVF under the following conditions: the egg and sperm must come from the legally married couple; the embryo must be transferred to the wife's uterus; the procedure is carried out only for medically indicated infertility; and excess embryos are handled with appropriate care.

Third-Party Reproduction: Sperm Donation, Egg Donation, and Surrogacy

The introduction of a third party's genetic material is prohibited under the dominant scholarly consensus in Islam. The reasons are grounded in the imperative to preserve lineage (*nasl* — one of the five *maqasid*): donor sperm from a man outside the marriage introduces a child whose biological paternity differs from their legal paternity — a confusion of lineage (*ikhtilat al-ansab*) that Islamic law regards as a serious harm to the child and to the social order. Surrogacy is similarly prohibited.

Pre-implantation Genetic Diagnosis (PGD)

Islamic scholars have generally permitted PGD for: serious genetic diseases that cause significant suffering; conditions incompatible with life; and sex-linked disorders where only male embryos carry the disease. PGD for sex selection for non-medical reasons is more contested; many scholars prohibit it as a form of selective discrimination against embryos on the basis of sex.

8.5 Contraception

The ethics of contraception is significantly less contested in Islamic jurisprudence than abortion or ART. The classical position, based on the practice of *'azl* (عزل — coitus interruptus), is that contraception is generally permissible within marriage, for legitimate reasons, with the agreement of both spouses.

Contemporary Islamic scholarly consensus generally permits barrier methods, hormonal contraception, IUDs, and emergency contraception (before confirmed implantation). Permanent contraception — vasectomy and tubal ligation — is generally prohibited (*haram*) in the absence of medical necessity, on the grounds that it permanently eliminates a Allah-given function and forecloses future reproduction. Exceptions are recognized when pregnancy would pose a serious, documented threat to the woman's life or health.

8.6 Prenatal and Postnatal Screening

The Ethics of Prenatal Screening

Prenatal screening programs raise ethical issues that intersect the Islamic framework on fetal status with questions of autonomy, disability rights, and obligations to future children. Women must have genuinely informed, non-directive counseling before and after prenatal testing. The purpose is to inform the woman's own decision-making — not to direct her toward termination. The right not to know must be respected — a woman who, after full information, declines a screening test is exercising a legitimate autonomous choice.

Genetic Counseling and Consanguineous Marriage

Saudi Arabia has among the highest rates of consanguineous (first-cousin) marriage in the world, which elevates the prevalence of autosomal recessive conditions. Preconception genetic counseling for consanguineous couples is an important clinical service carrying significant ethical obligations around non-directiveness, cultural sensitivity, and respect for autonomous reproductive choices. A specific challenge: if one partner has genetic test results relevant to the other partner's reproductive decisions but does not consent to disclosure, the physician faces a tension between the confidentiality owed to one patient and the potential harm to the other.

8.7 Maternal-Fetal Conflict

When a pregnant woman's autonomous choices conflict with the welfare of the fetus, the ethical framework is clear on one dimension: the pregnant woman is a patient with full moral and legal rights. Her autonomous decisions about her body and her pregnancy must be respected. The fetus does not have legal personhood before birth, and the physician cannot treat the fetus as a second patient with competing rights that override the mother's autonomy.

The appropriate clinical response to a woman making choices the physician believes may harm the fetus is: ensure she is fully informed of the risks; explore the reasons for her choices (which often reflect fear, practical barriers, or misunderstanding); engage with religious and cultural frameworks; accept her decision while maintaining the therapeutic relationship; and never coerce, deceive, or threaten the patient into compliance.

8.8 Sexually Transmitted Infections: Ethical Dimensions

Islam regards sexual virtue ('iffah) as a fundamental value, but the clinical obligation is the same regardless of the circumstances of acquisition: the patient with an STI is entitled to full, non-judgmental care, confidentiality, and honest information. Key ethical issues include partner notification (encouraging the patient to notify their partner and facilitating this through counseling); non-judgmental care (moral judgment about behavior has no place in clinical care); and confidentiality — the physician's role is to counsel strongly in favor of disclosure while maintaining the patient's confidentiality pending their own decision.

Key Terms

Term	Definition
Nafkh al-ruh (نفخ الروح)	The breathing of the soul at 120 days — in Islamic jurisprudence, the threshold for full fetal moral status
Nutfah (نطفة)	The first stage of fetal development (0–40 days) — a drop or zygote
'Alaqah (علقة)	The second stage of fetal development (40–80 days) — a clinging clot
Mudghah (مضغة)	The third stage of fetal development (80–120 days) — a morsel of chewed flesh
Al-ijhad (الإجهاض)	Abortion — termination of pregnancy
Ikhtilat al-ansab (اختلاط الأنساب)	Confusion of lineage — the primary reason Islamic scholars prohibit third-party reproduction
'Azl (عزل)	Coitus interruptus — the classical Islamic method of contraception, establishing general permissibility of family planning
Nasl (نسل)	Lineage or progeny — one of the five objectives of Islamic law (maqasid al-shari'ah)
ART	Assisted Reproductive Technologies — medical procedures used to address infertility, including IVF
PGD	Pre-implantation Genetic Diagnosis — genetic testing of IVF embryos before transfer
Maternal-fetal conflict	The ethical tension arising when a pregnant woman's autonomous choices may harm the fetus

Case Vignettes for Discussion

Case 8.1 — The Fetal Anomaly

A 30-year-old woman at 18 weeks gestation is told that her fetus has been diagnosed with anencephaly — a condition incompatible with survival after birth. She and her husband are devout Muslims and request guidance on whether termination is permissible. How do you counsel them? What are the relevant Islamic jurisprudential considerations? What is the role of gestational age in this case?

Case 8.2 — The Infertility Consultation

A married couple presents to a fertility clinic. The husband's sperm analysis shows azoospermia. The wife's investigations are normal. The fertility specialist informs them that IVF with donor sperm would give them an excellent chance of pregnancy. The husband asks you privately whether this is permitted in Islam. How do you respond?

Case 8.3 — The Sterilization Request

A 38-year-old woman with five children, whose last delivery was complicated by severe postpartum hemorrhage requiring emergency hysterectomy, presents requesting tubal ligation before her sixth pregnancy. Her husband opposes the procedure on religious grounds. She states clearly: "I nearly died last time. I want this operation." What are the ethical issues? Who has the authority to make this decision?

Case 8.4 — The Positive STI Test

A 32-year-old married man is diagnosed with gonorrhoea at a sexual health clinic. He discloses that he has had a sexual encounter outside his marriage and is terrified his wife will find out. He refuses to notify her. His wife is also your patient and is due for a routine check-up next week. What are your ethical and clinical obligations?

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Chapter 9: Surgical Ethics

During the First World War, a new weapon — high-velocity shrapnel — returned thousands of young soldiers from the trenches with their faces torn away. A surgeon named Harold Gillies set out to rebuild them, founding at a hospital near London the modern art of reconstructive surgery, operating not to save life but to restore identity and dignity. From the same techniques would later grow cosmetic surgery — the reshaping of healthy bodies for the sake of appearance. That lineage poses the central question of surgical ethics: when is it right to take a knife to a person who is not sick? This chapter examines consent, necessity, and the difference between healing the body and altering it.

Learning Objectives

By the end of this chapter, you should be able to:

1. Apply the four bioethical principles to surgical decision-making.
2. Describe the specific ethical obligations that arise in obtaining informed consent for surgery.
3. Distinguish between medically necessary surgery and elective cosmetic surgery from both ethical and Islamic perspectives.
4. Apply the Islamic concept of fitrah to analyze the ethics of body modification.
5. Discuss the ethical and jurisprudential framework for cosmetic surgery in Islam.
6. Analyze the ethics of gender reassignment surgery from Islamic and bioethical perspectives.
7. Recognize the ethical obligations arising at each stage of the surgical encounter.

9.1 Surgery as an Ethical Act

Surgery is among the most morally loaded acts in medicine. In no other clinical domain does the physician so directly and irreversibly alter the patient's body. The patient, rendered unconscious and entirely vulnerable, can neither consent nor withdraw consent in the operating theatre. The outcomes — when things go well — can be transformative. When things go wrong, the harm may be permanent. These features give surgical practice a distinctive ethical weight.

From the standpoint of both ethics and Islamic law, surgery represents one of the most significant forms of bodily intervention. The human body is described in the Quran as an amanah (trust) from Allah. Classical Islamic scholars classified surgery as permissible — indeed obligatory in cases of necessity — because the higher objective of preserving life (hifz al-nafs) overrides the general prohibition on bodily harm. But this permissibility is conditional: the intervention must be necessary, conducted with skill, and oriented toward the patient's genuine welfare.

9.2 Informed Consent for Surgery: Specific Obligations

Scope of Disclosure

For surgical procedures, the Saudi Guidelines for Informed Consent require that patients be informed of: the nature of the procedure and what it involves anatomically; its intended benefits and the probability of achieving them; all material risks — including rare but serious risks such as nerve damage, major hemorrhage, anaesthetic death, and organ injury; alternative treatments including non-surgical management and watchful waiting; the consequences of declining surgery; and what will happen during and after the procedure including recovery time.

Timing and Context of Consent

Surgical consent must be obtained before the patient enters the operative environment — not in the anaesthetic room, not while the patient is already sedated. The practice of obtaining consent on the morning of surgery while the patient is already in a hospital gown represents procedural compliance while violating the ethical substance of consent. Genuine consent requires time for reflection and questions.

The Intra-operative Discovery

A surgeon who discovers unexpected pathology during an operation faces a specific ethical dilemma: address it now, or close and discuss with the awake patient? The general ethical principle is that the surgeon's authority extends to what was consented to, not to what turns out to be discoverable. Urgent life-threatening conditions found intra-operatively may justify emergency treatment; non-urgent findings should wait for patient discussion.

Consent and the Surgical Trainee

The patient who consents to surgery has the right to know who will perform the operation. The practice of obtaining consent for a procedure that will in fact be performed in whole or in part by a trainee, without the patient's specific knowledge, is ethically problematic. Patients should be told when trainees will be involved and to what degree, and should have the opportunity to decline.

9.3 Cosmetic Surgery: Ethical Foundations

Cosmetic surgery — surgery performed primarily to alter appearance rather than to treat disease or restore function — presents ethical questions that do not arise in the same form in therapeutic surgery. The fundamental question is: is it ethically legitimate to subject a patient to the risks of surgery when there is no disease to treat?

From a secular autonomy-based perspective, the ethical case is straightforward: competent adults have the right to make decisions about their own bodies, and if they judge that altering their appearance will enhance their quality of life, their autonomous choice should be respected. Many cosmetic procedures genuinely improve patients' psychological wellbeing: rhinoplasty for a person who has experienced lifelong self-consciousness, breast reconstruction after mastectomy, scar revision after disfiguring injury.

9.4 The Islamic Framework: Fitrah and the Body

Islamic jurisprudence engages with cosmetic surgery through the concept of fitrah (فطرة). Fitrah refers to the natural disposition with which Allah has created human beings. The Quran states: "So set your face toward the religion of pure natural disposition — the fitrah of Allah upon which He created people." (Al-Rum 30:30). The Prophet (peace be upon him) cursed those who perform tattoos, remove eyebrow hair for beautification, file teeth for aesthetic purposes, and alter the body for beauty — taghyir khalq Allah (changing Allah's creation). This hadith, recorded in Bukhari and Muslim, forms the scriptural basis for restrictions on elective cosmetic modification.

9.5 The Islamic Classification of Cosmetic Procedures

Category 1: Medically or Functionally Indicated — Permitted

Procedures that restore normal function, correct genuine deformity, or relieve demonstrable suffering are permitted — and in some cases obligatory — in Islamic jurisprudence. Examples include: reconstructive surgery (repair of cleft palate, correction of deformities from burns or accidents, reconstruction after cancer surgery); functional restoration (procedures that restore sight, hearing, mobility); correction of congenital abnormalities causing functional impairment; and rhinoplasty for breathing obstruction. Islamic scholars have also recognized the psychological dimension of wellbeing: a disfigurement causing genuine, significant psychological suffering may justify corrective surgery even when physical function is intact.

Category 2: Pure Beautification Without Medical Need — Prohibited

Procedures motivated solely by a desire to enhance beauty or conform to cultural standards of attractiveness are generally prohibited as *taghyir khalq Allah*. Examples include: rhinoplasty for purely cosmetic reasons in a person with normal nasal function; lip augmentation and cheek fillers; elective breast augmentation (distinguished from breast reconstruction); and surgical removal of healthy tissue for aesthetic purposes. The underlying principle is not hostility to beauty — Islam celebrates beauty and permits adornment (*zeenat*) within defined limits — it is the distinction between enhancing what Allah has given versus altering it out of dissatisfaction with divine creation.

9.6 Body Dysmorphic Disorder and the Ethics of Cosmetic Surgery

Body dysmorphic disorder (BDD) is a psychiatric condition in which a person has an obsessive preoccupation with a perceived flaw in their appearance that is absent or barely noticeable to others. Studies suggest that between 5% and 15% of patients presenting for cosmetic surgery have BDD. Surgery does not improve BDD — patients typically shift their obsession to a different body part or develop new concerns.

The ethical obligations of the cosmetic surgeon include: screening for BDD before any procedure using validated tools; declining to operate when BDD is identified regardless of the patient's insistence (this is not a violation of autonomy but a recognition that surgery will cause harm rather than benefit); and referring to psychiatric care when psychological rather than surgical treatment is indicated.

9.7 Gender Reassignment Surgery: Ethical and Islamic Analysis

The Islamic Jurisprudential Position

Islamic jurisprudence draws a critical distinction between two scenarios. For intersex conditions (*khuntha*, خنثى) — a person born with ambiguous biological sex characteristics — Islamic scholars permit medical treatment including surgery to clarify and establish a clear biological sex. This is viewed not as *taghyir khalq Allah* but as correction of an ambiguity in the original creation, aimed at establishing the person in one of the two Allah-ordained sexes.

For transsexualism (psychological gender dysphoria in a person with unambiguous biological sex), the dominant scholarly consensus in Sunni Islam prohibits gender reassignment surgery. The reasoning is grounded in: the human body being created by Allah with a specific known biological sex; the concept of *fitrah* including one's biological sex as part of natural constitution; and the *maqasid al-shari'ah* not including accommodation of subjective identity at the cost of irreversible physical alteration. GRS is not legally available in Saudi Arabia in the transsexualism context.

The Physician's Ethical Obligations

The Muslim physician encountering a patient requesting GRS must: provide non-abandonment (compassionate, non-judgmental clinical care regardless of personal position); engage honestly with the patient about the Islamic scholarly position and the legal context; ensure comprehensive psychological assessment and support; and refer to appropriate psychiatric and multidisciplinary care, not simply dismiss the patient.

Key Terms

Term	Definition
Fitrah (فطرة)	The natural human constitution with which Allah created human beings — grounds Islamic limits on cosmetic modification
Taghyir khalq Allah (تغيير خلق الله)	Changing Allah's creation — the Quranic and Prophetic basis for prohibitions on certain forms of body modification
Reconstructive surgery	Surgery that restores normal form and function following disease, injury, or congenital abnormality — generally permitted
Cosmetic surgery	Surgery performed primarily to enhance appearance without a medical indication — ethically and Islamically more restricted
BDD	Body dysmorphic disorder — a psychiatric condition characterized by obsessive preoccupation with perceived appearance flaws; a contraindication to cosmetic surgery
Gender dysphoria	A persistent, clinically significant distress arising from incongruence between gender identity and assigned sex
Khuntha (خنثى)	A person with intersex characteristics — surgical clarification of biological sex is permitted in Islamic jurisprudence
Intra-operative discovery	Unexpected pathology found during a surgical procedure — raises specific consent and scope-of-practice issues
WHO Surgical Safety Checklist	A structured communication tool used before, during, and after surgery to reduce preventable adverse events

Case Vignettes for Discussion

Case 9.1 — The Pre-operative Consent

A 45-year-old woman is scheduled for an elective laparoscopic cholecystectomy. She is seen in the pre-admission clinic on the morning of surgery, already in a hospital gown. The surgical resident hands her a consent form and says: "Just sign here — it's a routine operation, nothing to worry about." She asks about risks and the resident replies: "Very small — just the usual surgical risks." She signs. Is this valid informed consent? What are the ethical failures? What should have happened?

Case 9.2 — The Rhinoplasty Request

A 22-year-old woman presents to a cosmetic surgery clinic requesting rhinoplasty. She has no nasal obstruction and her nose is within normal anatomical variation. She has felt self-conscious about her nose since childhood, has researched the procedure extensively, has realistic expectations, and understands all risks. She is clearly competent and freely choosing. How do you apply the Islamic framework? Does the secular autonomy argument override Islamic restrictions? How do you counsel her?

Case 9.3 — The Intra-operative Finding

A 55-year-old man consents to a laparoscopic appendicectomy. During the operation, the surgeon notices an incidental finding: a mass on the right colon that looks suspicious for carcinoma. The appendicectomy is complete. Should the surgeon proceed to biopsy the mass now, or close and discuss with the patient? What does informed consent doctrine require?

Case 9.4 — The Gender Dysphoria Presentation

A 25-year-old biologically male patient presents in significant distress, describing long-standing gender dysphoria and requesting referral for gender reassignment surgery. The attending physician is a devout Muslim with sincere personal and religious objections to GRS. What are the physician's ethical obligations in this consultation? What must they not do? What must they do?

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Chapter 10: End-of-Life Care and Elderly Patients

In 1975, a twenty-one-year-old woman named Karen Ann Quinlan stopped breathing for long enough to leave her in a permanent coma, kept alive on a mechanical ventilator. Her parents, convinced she would never recover, asked the doctors to switch it off. The doctors refused, fearing prosecution. The case reached the New Jersey Supreme Court, which in 1976 ruled that the family could withdraw the ventilator — one of the first times a court recognised a right to let a patient die. (Remarkably, once weaned, Karen breathed on her own and lived nine more years.) This chapter confronts the hardest questions in medicine: when treatment should stop, and who decides.

Learning Objectives

By the end of this chapter, you should be able to:

1. Define palliative care and explain its ethical foundations.
2. Describe the ethical distinction between withholding and withdrawing life-sustaining treatment.
3. Explain the concept of medical futility and apply it to clinical decision-making.
4. Define brain death and describe the Islamic scholarly position on its legal and ethical significance.
5. Explain DNR orders, advance directives, and the principles governing their use.
6. Describe the Islamic position on euthanasia and physician-assisted dying.
7. Apply the four bioethical principles and the Islamic framework to end-of-life clinical scenarios.
8. Recognize the specific ethical obligations arising in the care of elderly patients.

10.1 The Ethics of Dying

Death is not a medical failure; it is a biological certainty. The physician's obligation at the end of life is not to prevent death indefinitely but to ensure that the dying patient receives care that is compassionate, dignified, and consistent with their values; that suffering is minimized; and that the patient and their family are supported through one of the most profound experiences in human life.

The Islamic tradition approaches death not as a failure but as a transition — the return of the soul to its Creator, the culmination of earthly life. The Quran states: "Every soul shall taste death." (Al-Imran 3:185). This universal truth frames the Islamic approach to end-of-life care: neither life should be prolonged beyond its natural course by extraordinary means, nor death hastened. The physician's role is to accompany the dying patient with compassion, to relieve suffering, and to facilitate a death that honors the patient's dignity and faith.

10.2 Palliative Care: The Ethical Foundation

Palliative care is the active, total care of patients whose disease is no longer responsive to curative treatment. The WHO defines it as "an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual."

Palliative care is not the withdrawal of medicine; it is the redirection of medicine. The shift from curative to palliative intent does not mean abandoning the patient; it means reorienting the goals of care from cure to comfort, from length of life to quality of life. Palliative care attends to the whole person — not only physical symptoms but psychological distress, social needs, and spiritual concerns.

The Doctrine of Double Effect

This doctrine holds that an action with both a good effect and a harmful side effect is morally permissible if: the action itself is not inherently wrong; the good effect is genuinely intended; the harmful effect is not the

means to the good effect; and the good effect proportionately outweighs the harmful effect. In palliative care, this justifies adequate doses of opioids for pain control even in the theoretical scenario where they might hasten death — the physician's intention is pain relief; death, if it occurred, would be an unintended side effect. This principle is accepted in both secular ethics and Islamic jurisprudence.

10.3 Quality of Life vs. Sanctity of Life

The sanctity of life position holds that human life must be preserved under all conditions — evaluations of quality of life are irrelevant. Its secular counterpart — vitalism — holds that organic life must be preserved even when all distinctly human functions are lost. The quality of life position holds that the goal of medicine is not mere biological survival but a life characterized by function, consciousness, relationship, and the fulfillment of personal values.

The Islamic framework does not endorse either extreme. Islam affirms the sanctity of human life (hifz al-nafs) but does not endorse vitalism. Classical Islamic scholars distinguished between al-'ilaj al-wajib (obligatory treatment, required when it offers genuine prospect of benefit) and al-'ilaj al-ja'iz (permissible but not obligatory treatment). Life-prolonging treatment that only prolongs suffering without hope of recovery falls outside the category of obligatory care. The Islamic Fiqh Council has affirmed that it is permissible to withhold or withdraw life-sustaining treatment when three specialist physicians agree the condition is beyond cure and treatment merely prolongs the dying process without benefit to the patient.

10.4 Brain Death: Medical Definition and Islamic Ruling

Brain death is defined as the irreversible cessation of all functions of the entire brain, including the brainstem. It is characterized by: absent brainstem reflexes; apnoea (inability to breathe without mechanical ventilation); and irreversibility confirmed by the absence of any known reversible cause. A patient who meets clinical criteria for brain death is biologically dead — the brain has permanently ceased to function. The continued movement of blood and breath in a brain-dead patient on a ventilator is a product of the machine, not of life.

The dominant scholarly position — affirmed by the Islamic Fiqh Council of the Muslim World League, the OIC Fiqh Academy, and the Saudi Council of Senior Scholars — holds that brain death constitutes legal death in Islamic jurisprudence. The brain is the seat of consciousness, perception, and voluntary function — the faculties most distinctly human. Brainstem function is the ultimate regulator of autonomous life; its permanent cessation is equivalent to the irreversible departure of the capacity for life. On the basis of this ruling, a brain-dead patient may have life support withdrawn, may be declared dead for legal purposes, and may have their organs donated. A minority of scholars disagree, maintaining that death is established only by cessation of heartbeat and breathing.

10.5 Withholding and Withdrawing Life-Sustaining Treatment

Withholding treatment means deciding not to initiate an intervention. Withdrawing treatment means stopping an intervention that has been started. The dominant ethical position — and the position of most professional bodies and Islamic scholars — is that withholding and withdrawing are morally equivalent when the clinical circumstances are the same. Recognizing this equivalence supports rather than undermines appropriate clinical trial of treatment: if physicians believe starting a treatment creates an irreversible obligation to continue it, they will be less willing to initiate trials of potentially beneficial treatment.

Medical Futility

Medical futility refers to treatment that cannot achieve its intended clinical goal. Two forms: quantitative futility (extremely low probability of achieving the goal — CPR in metastatic cancer with multi-organ failure approaches zero survival-to-discharge); and qualitative futility (treatment achieves its physiological goal but provides no quality of benefit that makes it worthwhile from the patient's perspective). Futility determination should involve the multidisciplinary team, clear documentation, communication with the patient and family, and ethics committee involvement when there is disagreement.

10.6 DNR Orders and Advance Directives

A DNR (Do-Not-Resuscitate) order is a clinical instruction that CPR should not be attempted if the patient suffers a cardiac arrest. It is not an instruction to reduce the quality of care in any other way. The Islamic position supports DNR orders when CPR is clearly futile — when it cannot restore life but only prolongs the dying process. The Prophet (peace be upon him) said: "Make use of medical treatment, for Allah has not made a disease without appointing a remedy for it." (Abu Dawud). This establishes the obligation to seek treatment — but treatment, not futile intervention.

Advance directives extend autonomy into a future period when the patient can no longer exercise it directly. In clinical practice, they should be discussed with patients who have serious or progressive illness before the point of crisis; documented clearly in the medical record; reviewed periodically as values and circumstances change; and respected by the clinical team even when the team disagrees with the patient's stated preferences.

10.7 Euthanasia: The Islamic Prohibition

The Islamic scholarly consensus on euthanasia is unanimous and unambiguous: both active euthanasia and physician-assisted suicide are prohibited (haram), regardless of the patient's consent, the degree of suffering, or the apparent hopelessness of the prognosis. The reasoning rests on: the sanctity of life (the Quran states: "Do not kill yourselves — indeed Allah is to you ever Merciful." Al-Nisa 4:29); the prohibition on despair of Allah's mercy (qunoot); the sufficiency of palliative care (Islam does not require the prolongation of suffering — it provides a full toolkit of legitimate end-of-life care, making euthanasia ethically unnecessary); and the physician's role (to heal, to relieve suffering, and to accompany the dying — not to kill).

The Muslim physician who encounters a patient requesting euthanasia must: acknowledge the patient's suffering with genuine compassion; explore what is driving the request (inadequately controlled pain, fear, depression, social isolation, spiritual distress — each is addressable); ensure comprehensive palliative care is in place; offer spiritual support; clearly explain the Islamic position without judgment; and not abandon the patient because of the request.

10.8 Care of the Dying Patient and Death Certification

Adequate management of pain, dyspnea, nausea, and psychological distress is both a clinical obligation and an ethical imperative. The physician who allows a dying patient to suffer from controllable symptoms has failed in their most fundamental obligation. The dying patient deserves honest, compassionate communication about their prognosis, their options, and what they can expect. The temptation to maintain false hope — "we'll keep trying" when curative treatment is exhausted — deprives the patient of the opportunity to complete unfinished business, make peace, say what needs to be said, and engage in spiritual preparation.

Islam places great emphasis on preparation for death. The talqeen (تلقين — prompting the dying person to say the Shahada) is a Sunnah practice; the presence of family reciting Quran, particularly Surah Yasin, is widely practiced. Death certification must accurately record the cause of death — falsification of a death certificate, whether to conceal a medical error or for any other reason, is a serious criminal offence and a profound ethical violation. The human body retains dignity after death and should be treated with respect.

10.9 Ethics of Elderly Care

Ageism — discrimination or bias based on age — is documented in healthcare settings and affects clinical decision-making in ways that harm elderly patients. Studies show that elderly patients are less likely to receive certain investigations, less likely to be referred for surgical interventions, and more likely to have DNR orders placed without adequate discussion, compared to younger patients with equivalent clinical profiles. The ethical obligation: each patient's clinical circumstances and personal values must be assessed individually. Age alone is not a basis for limiting care.

When capacity is absent, the surrogate decision-making framework applies. For elderly patients who have lived long, value-rich lives, the emphasis should be on substituted judgment — deciding as the patient would decide, based on their known values and preferences. Elder abuse — physical, psychological, financial — is a significant clinical and ethical concern. The physician's obligations include documenting clinical findings carefully, speaking with the patient privately without the suspected abuser, and reporting concerns to the appropriate authorities.

Key Terms

Term	Definition
Palliative care	Active total care of patients with life-limiting illness, focused on quality of life and relief of suffering
Doctrine of double effect	Permits an action with both a good and harmful effect when the good is intended and proportionate
Medical futility	Treatment that cannot achieve a clinically meaningful goal or provides no benefit to the patient as a person
Brain death	Irreversible cessation of all brain function including the brainstem; constitutes legal death in Islamic jurisprudence
Withholding treatment	Deciding not to initiate a life-sustaining intervention
Withdrawing treatment	Discontinuing a life-sustaining intervention that has been started — morally equivalent to withholding
DNR order	Do-Not-Resuscitate order — a clinical instruction that CPR should not be attempted
Advance directive	A document specifying a patient's wishes for future care in the event they lose capacity
Active euthanasia	The deliberate administration of a lethal agent by a physician to end a patient's life — prohibited in Islam
Talqeen (تلقين)	The Islamic practice of prompting the dying person to say the Shahada
Sabr (صبر)	Patient endurance — the Islamic virtue of bearing suffering with faith and trust in Allah
Hifz al-nafs (حفظ النفس)	Preservation of life — one of the five objectives of Islamic law

Case Vignettes for Discussion

Case 10.1 — The Ventilator Decision

An 82-year-old man with end-stage COPD and heart failure is admitted in acute respiratory failure. He is hypoxic and confused. His daughter, who holds power of attorney for health decisions, says her father "always said he never wanted to be on machines." No written advance directive exists. The medical team believes without intubation he is likely to die within hours, but even with intubation his prognosis is extremely poor. How do you proceed? What ethical frameworks apply? What role does the daughter's account play?

Case 10.2 — The DNR Conflict

A 55-year-old woman with metastatic breast cancer has a DNR order documented after a conversation with the patient, who agreed. Her husband arrives and demands the order be removed: "I don't accept this. We are Muslims — Allah gives life and only Allah takes it. You must do everything." How do you respond to the

husband? What are the ethical obligations? What does the Islamic framework say about the patient's own expressed wish?

Case 10.3 — The Euthanasia Request

A 45-year-old man with inoperable pancreatic cancer is in severe pain despite current analgesia. He says: "Doctor, I can't live like this. Please end it for me. I've heard this is available in other countries." You are a Muslim physician in Saudi Arabia. How do you respond? What specific steps do you take? What does compassionate, ethically grounded care look like in this moment?

Case 10.4 — The Brain-Dead Patient

A 28-year-old man is brought to the emergency department following a severe road traffic accident. Over 48 hours, all clinical tests confirm brain death. His family refuses to accept the diagnosis: "As long as the heart is beating, he is alive. You cannot remove the machine." How do you engage with the family? What does the dominant Islamic scholarly position say? How do you balance respect for the family's distress with your clinical and ethical obligations?

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Chapter 11: Organ Donation and Transplantation Ethics

On a December day in 1954, in a Boston hospital, a surgeon named Joseph Murray did something that had never before succeeded: he removed a healthy kidney from one young man and placed it into the body of his dying identical twin. The transplant worked, and the recipient lived for years. But it forced a question medicine had never had to face: is it right to perform a major operation on a perfectly healthy person — to wound him — purely for the benefit of someone else? Every act of living donation since has rested on the answer. This chapter examines the ethics of giving and receiving organs, including the rulings of Islamic jurisprudence on donation and on the definition of death.

Learning Objectives

By the end of this chapter, you should be able to:

1. Describe the major types of organ donation and transplantation and explain their clinical significance.
2. Apply the four bioethical principles to organ donation and transplantation scenarios.
3. Explain the Islamic scholarly consensus on organ donation and the Saudi Grand Ulama Fatwa.
4. Describe the ethics of living donor donation, including special obligations arising from related and unrelated donation.
5. Analyze the ethical framework for deceased donor donation, including the role of brain death.
6. Describe the principles governing fair organ allocation.
7. Identify the ethical problems posed by organ trafficking and commercial organ trade.
8. Navigate clinical conversations about organ donation with patients, families, and the clinical team.

11.1 The Organ Shortage: A Permanent Ethical Crisis

Every day, patients die waiting for an organ transplant that never arrives. The gap between patients on transplant waiting lists and available organs is one of the most persistent ethical shortages in modern medicine. In Saudi Arabia, as across most of the Arab world, the transplantation rate from deceased donors remains significantly lower than clinical need — a disparity driven by infrastructure limitations, workforce constraints, legal frameworks, cultural attitudes, and, in some cases, misunderstanding of the Islamic position on donation.

This shortage is not merely a logistical problem. It is an ethical emergency: a predictable, preventable injustice in which people die from organ failure not because no treatment exists, but because the social, institutional, and cultural conditions required to make that treatment available have not been adequately established.

11.2 Types of Organ Donation

Living Donor Transplantation

Living donation involves the voluntary donation of an organ or part of an organ by a living person. The kidneys (one of two) and partial liver are the most commonly transplanted organs from living donors. Related living donation (a family member donating to a relative) is the most common form and the least ethically contested, provided donation is genuinely voluntary. Unrelated living donation raises more complex questions about motivation, voluntariness, and the risk of subtle coercion. Paired exchange programs allow incompatible donor-recipient pairs to exchange donors to achieve compatible transplants, significantly increasing the number of living donor transplants.

Deceased Donor Transplantation

Donation after Brain Death (DBD): The body remains on ventilatory support until organs are retrieved after confirmed brain death. This is the major source of deceased donor organs. Donation after Circulatory Death (DCD): Organs are retrieved after cessation of cardiorespiratory function, following a decision to withdraw life-sustaining treatment. DCD is more complex ethically because of the proximity between the decision to withdraw treatment and organ retrieval — a separation that must be scrupulously maintained to prevent any conflict of interest.

11.3 The Islamic Framework for Organ Donation

The Islamic case for organ donation rests on one of the most powerful moral principles in the Quran: "Whoever saves the life of one person, it is as if he has saved the life of all mankind." (Al-Ma'idah 5:32). The Islamic principle of *maslaha* (المصلحة — public interest or benefit) further supports organ donation: when the benefit to society is clear and substantial, actions that might otherwise be restricted become permissible.

The Saudi Grand Ulama Fatwa (1982)

Fatwa No. 99 of the Council of Senior Scholars, issued in 1982, unanimously sanctioned autografts; sanctioned by majority donation of organs by living donors; and sanctioned by majority donation of organs from the deceased, either through the donor's prior testament or through the consent of relatives. This fatwa established the Islamic legitimacy of organ donation in Saudi Arabia.

Conditions for Permissibility

Islamic scholarly consensus identifies the following conditions: no harm to the donor that outweighs the benefit to the recipient; genuine voluntariness without coercion; no commercialization (the organ must not be sold — organ sale is categorically prohibited as it violates the dignity of the human person); confirmed death of the deceased donor; and medical necessity (transplantation as the treatment of last resort).

Organs That May Not Be Donated

Reproductive organs (gonads — ovaries and testes) — prohibited because donation would transfer reproductive capacity and create confusion of lineage. Organs from living donors that would cause the donor's death — a living person may not donate their heart or both kidneys (this would constitute suicide). Organs procured through wrongdoing — organs obtained through murder, coercion, or trafficking are categorically prohibited.

11.4 Ethics of Living Donor Transplantation

Living donor transplantation involves deliberately subjecting a healthy person to surgical risk for the benefit of another — an ethically unusual act. The justification lies in the autonomy of the donor (who freely chooses to accept risk for an altruistic purpose) and the magnitude of benefit to the recipient. The ethical acceptability therefore depends entirely on the quality of the consent process and the genuine voluntariness of the donation.

Voluntariness and Family Pressure

In close-knit Arab family cultures, a relative with organ failure creates an implicit pressure on family members to offer donation. The family member who does not offer may feel they are letting the patient down. This pressure may never be expressed explicitly — it operates entirely through guilt and expectation. The clinical team's obligation is to create a protected space in which the potential donor's genuine wishes can be explored away from family dynamics. The assessment process must include consultation with the donor alone, without the recipient present; explicit exploration of whether the offer is freely chosen; clear communication that declining is entirely acceptable; a genuine opt-out pathway; and psychological assessment.

Medical Risks to the Living Donor

Living kidney donation carries a small but real long-term risk — approximately 0.3% absolute lifetime increase in the risk of end-stage renal disease — alongside the immediate surgical risks of donor nephrectomy (approximately 0.03% mortality). These risks must be fully disclosed. The principle of non-maleficence requires that the medical team advocates for the donor's welfare, not only the recipient's. A donor who is medically suboptimal should not be approved for donation even if they are willing and the recipient is in urgent need.

Consents for Minors and Those Without Decision-Making Capacity

Donating an organ: A person must be at least 18 years old and have the capacity to make their own decision before they can consent to living organ donation. Parents or guardians cannot consent to organ donation on behalf of a child or a person who lacks decision-making capacity, because donation is not considered part of that person's own medical treatment. One exception is bone marrow or stem cell donation between siblings, when the recipient is expected to benefit and the risk to the donor is minimal. If a child dies and organ donation is being considered, the parents or legal guardians may provide consent.

Receiving an organ: Receiving a transplant is considered a medical treatment. Therefore, if a patient cannot make their own medical decisions, a parent or legal guardian may give consent on their behalf because transplantation is in their best interest.

11.5 Ethics of Deceased Donor Transplantation

The Dead Donor Rule

The dead donor rule is the foundational ethical principle of deceased donor transplantation: vital organs may only be retrieved after the donor is dead, and the retrieval itself must not cause the donor's death. This maintains the absolute prohibition on killing one person to save another — a prohibition grounded in both secular ethics and Islamic jurisprudence.

The Separation of Death Determination and Donation

A critical structural requirement of the transplantation system is that the clinical team responsible for declaring a patient brain dead must be completely independent of the transplantation team. This prevents any conflict of interest — the possibility that a patient might be declared dead prematurely in order to facilitate organ retrieval.

Supporting Families in the Donation Conversation

The conversation asking a family to consider organ donation from their brain-dead relative is among the most delicate in clinical medicine. It occurs at a moment of acute grief. Best practice: separate the notification of death from the donation request; use a trained donation coordinator; provide honest, accurate information about brain death and the donation process; acknowledge the family's grief and their right to say no without judgment; present donation as a meaningful gift — a final act of generosity by their loved one; and involve an Islamic scholar or chaplain if the family wishes religious guidance.

Registration as an Organ Donor:

Saudi Arabia operates an opt-in system administered by the Saudi Center for Organ Transplantation (SCOT). Individuals can register their wish to donate through the Athar platform (athar.scot.gov.sa) or the Tawakkalna application. Registration is voluntary and records the individual's preference for donation upon death.

However, registration alone is not sufficient to authorize organ retrieval. Under SCOT regulations, the written consent of the legal heirs (الورثة الشرعيون) must be obtained at the time of death, unless the deceased had made a formal legal will (wasiya — وصية) during their lifetime explicitly consenting to donation. This means that a registered donor's organs cannot be retrieved if the family refuses, unless a wasiya exists. For unregistered donors, the family's written consent is the sole pathway to donation.

11.6 Organ Allocation: The Justice Dimension

Allocation systems aim to balance: medical urgency (patients who will die soonest without transplantation); probability of benefit (patients most likely to survive and benefit); waiting time (first-come, first-served principles); and compatibility (biological compatibility directly affects transplant success). What must not drive allocation: ability to pay; social worth judgments; racial or ethnic discrimination; and corruption or favoritism.

11.7 Organ Trafficking

Organ trafficking — the illegal commercial trade in organs — is prohibited for multiple reasons: it exploits the poor (organ sellers are almost invariably in financial desperation — their "consent" is not genuinely autonomous); it violates human dignity (the human body is not a commodity — treating organs as products to be bought and sold reduces the human person to a collection of spare parts, violating the Islamic principle of karama); it produces poor outcomes for both donors and recipients; and it undermines the altruistic donation system.

The Declaration of Istanbul on Organ Trafficking and Transplant Tourism (2008) categorically prohibits organ trafficking and transplant tourism and calls on all countries to develop self-sufficient national deceased donation programs. The Islamic position, grounded in the prohibition on selling the human body and in the principle of la darar, is unambiguous: commercial organ trading is prohibited.

Key Terms

Term	Definition
Living donor	A person who donates an organ or part of an organ while alive
Deceased (cadaveric) donor	A person from whom organs are retrieved after death
Brain death (DBD)	Donation after irreversible cessation of all brain function
Dead donor rule	Vital organs may only be retrieved after confirmed death
Opt-in consent	Donation requires the donor's prior explicit agreement — the model used in Saudi Arabia
Paired exchange	A program in which incompatible donor-recipient pairs exchange donors to achieve compatible transplants
Organ trafficking	The illegal commercial trade in human organs — categorically prohibited
Declaration of Istanbul	International declaration (2008) prohibiting organ trafficking and transplant tourism
Maslaha (مصلحة)	Public interest or benefit — the Islamic principle supporting organ donation
Saudi Grand Ulama Fatwa	Fatwa No. 99 (1982) — the landmark Islamic endorsement of organ donation in Saudi Arabia

Case Vignettes for Discussion

Case 11.1 — The Reluctant Family

A 42-year-old man is declared brain dead following a subarachnoid haemorrhage. He had no registered organ donor status. His wife, clearly in shock, is approached by the transplant coordinator for a discussion about donation. She says: "I don't know if Islam allows this. I don't want him cut up." How do you engage with her? What specific Islamic information is relevant? What happens if she declines?

Case 11.2 — The Living Donor Under Pressure

A 35-year-old man comes to the living donor assessment clinic as a potential kidney donor for his older brother who has end-stage renal disease. During the assessment alone with the clinician, he says: "To be honest, I'm scared. But my family would never forgive me if I said no. My brother has three kids." How do you proceed? What are your ethical obligations? What specific steps must the assessment process include?

Case 11.3 — The Commercial Offer

A 50-year-old woman with end-stage liver disease has been on the transplant waiting list for two years. Her son approaches you and says: "I've found a clinic in another country that says they can get a liver within two weeks. We just need to pay. Can you help us arrange the medical records?" What are your ethical and legal obligations? What do you say to the family?

Case 11.4 — The Allocation Dilemma

Two patients on the liver transplant waiting list are compatible with a newly available liver: Patient A is a 48-year-old woman with autoimmune liver disease, stable condition, waiting two years; Patient B is a 35-year-old man with alcohol-related cirrhosis, acute-on-chronic liver failure, likely to die within days without transplant, alcohol-free for six months. What ethical principles apply? Does the cause of the liver failure influence the decision?

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Chapter 12: Patients with Special Needs

In 1982, in Bloomington, Indiana, a baby boy was born with Down syndrome and a blockage of the oesophagus that surgery could easily have repaired. Because the child had a disability, his parents and doctors chose not to operate, and within days he died — a death that would have been unthinkable for an otherwise healthy newborn. The case, known only as “Baby Doe,” provoked national outrage and new laws protecting infants with disabilities from being denied ordinary care. It crystallised a duty that runs through this chapter: that patients who cannot speak for themselves — the disabled, the very young, those who cannot communicate — are owed not less protection, but more. This chapter is about caring for them justly.

Learning Objectives

By the end of this chapter, you should be able to:

1. Define the concept of “patients with special needs” and explain why they require heightened ethical attention.

2. Apply the ethical framework for treating children, including assent, parental authority, and best interests.
3. Describe the ethical principles governing the care of patients with mental illness, including involuntary treatment.
4. Explain the ethics of treating patients with intellectual or physical disabilities.
5. Apply the principles of resource allocation ethics to scenarios involving limited healthcare resources.
6. Describe the Islamic framework for the care of vulnerable patients.
7. Recognize and respond to abuse and neglect in vulnerable patient populations.

12.1 Vulnerability and the Ethics of Special Obligation

The Saudi Patient Bill of Rights defines people with special needs as "the elderly, chronically ill, physically or mentally disabled, and all those who are unable to help themselves." Vulnerability in healthcare arises from many sources: developmental stage (children who cannot yet exercise full autonomous decision-making), psychiatric illness (which may temporarily or chronically impair judgment), physical disability (which may create communication barriers), cognitive impairment (which affects capacity across a spectrum), and social marginalization.

The Islamic tradition gives particular emphasis to the care of those who cannot care for themselves. The Prophet (peace be upon him) said: "The best of you are those who are best to the weak." And: "Allah is in the aid of the servant as long as the servant is in the aid of his brother." (Muslim). These teachings establish a positive duty of care toward vulnerable persons that goes beyond the minimum obligations owed to all patients.

12.2 Children and Pediatric Ethics

Parental Authority and Its Limits

In Islamic law and in the law of most jurisdictions, parents hold guardianship (*wilayah*) over their minor children and are authorized to make healthcare decisions on their behalf. This authority is extensive but not absolute — it is bounded by the child's best interests. A parent who makes a medical decision clearly contrary to their child's welfare — refusing life-saving treatment, for example — has exceeded the limits of legitimate guardianship. The threshold for overriding parental decisions rises with the severity of the potential harm and the strength of the medical case for intervention.

The Child's Voice: Assent and Emerging Autonomy

As children develop cognitive and moral capacity, their own preferences increasingly deserve weight — even before they reach the legal threshold for autonomous consent. Assent is the child's agreement to a medical procedure, sought in addition to parental consent. A child who clearly refuses a procedure — who says "no" with evident understanding and distress — is communicating something the clinical team has a moral obligation to attend to. Islamic jurisprudence identifies the age of *tamyiz* (تمييز — discernment, approximately 7 years) as the threshold at which a child's expressed preferences begin to carry moral weight.

Child Abuse and Neglect

Healthcare professionals are among the few adults who regularly have access to children outside the family home. Signs of child abuse must trigger a structured clinical and safeguarding response: documenting clinical findings carefully; speaking with the child privately, separately from the parents; and reporting concerns to the hospital child protection team and relevant authorities. The confidentiality owed to parents does not extend to protecting abusive behaviour toward a child.

12.3 Patients with Mental Illness

The Dual Ethical Challenge

Psychiatric illness creates a dual ethical challenge: on one hand, mental illness can impair the very capacity on which the ethics of autonomy depends; on the other hand, psychiatric patients have historically been among the most abused of all patient populations, subjected to non-consensual treatment and denied the rights that other patients receive. The ethical framework must navigate between paternalistic overriding of genuine autonomous choices and harmful permissiveness toward decisions that are the product of illness rather than genuine self-determination.

Involuntary Treatment

Involuntary psychiatric treatment represents the most significant departure from the autonomy principle in all of medicine. It is ethically justified only when: the patient lacks capacity for the specific decision; the risk of harm is serious; the treatment has a reasonable prospect of benefit; less restrictive alternatives have been considered and are insufficient; and the treatment is consistent with the patient's best interests. Involuntary treatment is not ethically equivalent to punitive detention — the treating team's obligation remains fully intact to provide the highest standard of care, minimize restriction, treat the patient with dignity, and restore voluntary status as soon as safely possible.

Stigma and Non-Discrimination

Psychiatric patients experience pervasive stigma — documented in healthcare settings and affecting clinical decision-making. Patients with psychiatric diagnoses receive less thorough physical healthcare investigation for the same symptoms, are more likely to have physical complaints attributed to their psychiatric condition, and are more likely to have expressed preferences dismissed. This represents a form of discrimination that the physician has an obligation to resist.

12.4 Patients with Physical and Intellectual Disabilities

The Disability Rights Perspective

Research consistently shows that people with disabilities — including severe disabilities — rate their own quality of life significantly higher than non-disabled people and healthcare providers rate it for them. The physician who assumes that a patient with paraplegia, Down syndrome, or profound deafness has a poor quality of life is making a judgment based on their own imagined response to the disability, not on the patient's actual experience. Treatment decisions for patients with disabilities must be based on the patient's own values and preferences — not on the physician's assessment of how the disability affects quality of life.

Patients with communication impairments — those who are deaf, non-verbal, aphasic, or who communicate through assistive technology — have full cognitive and moral status. The physician's obligation is to ensure adequate communication support — interpreters, speech and language therapists, communication aids — not to proceed without meaningful communication because it is more convenient.

12.5 Resource Allocation in Healthcare

Resource allocation decisions occur at three levels: macro-allocation (national-level decisions about how much of the public budget is devoted to healthcare); meso-allocation (institutional decisions about which services a hospital provides); and micro-allocation (bedside decisions about which individual patient receives a scarce resource when not all who need it can receive it — the last ICU bed, the last unit of a scarce blood product). Micro-allocation is the most ethically immediate level for the bedside clinician.

Ethical Frameworks for Allocation

Utilitarian allocation: maximize overall benefit — allocate resources to patients who will derive the greatest benefit. Egalitarian allocation: treat all patients equally — first-come, first-served. Prioritarian allocation: give priority to the worst-off patients — the sickest, the most disadvantaged, those with the most urgent need. Fair innings: each person is entitled to a "fair innings" of life — those who have already had a full life have a weaker claim on scarce resources than those who have not. In practice, most allocation frameworks combine these considerations.

The Islamic Framework for Resource Allocation

Islamic jurisprudence approaches resource allocation through 'adl (عدل — justice) and maslaha (public benefit). Key principles: every person has an equal claim to be treated with dignity regardless of age, wealth, social status, or disability; preventing serious, irreversible harm takes priority; the approach that saves the most lives or prevents the most serious harm is generally preferred; and no allocation based on social worth — the physician and the street cleaner are equal before Allah and before the hospital.

Key Terms

Term	Definition
Vulnerability	A heightened susceptibility to harm arising from developmental stage, illness, disability, or social circumstances
Best interests standard	The decision-making standard for patients without capacity — what promotes the patient's overall welfare
Assent	A child's agreement to a medical procedure, sought alongside parental consent
Tamyiz (تميز)	The Islamic age of discernment (~7 years) after which a child's expressed preferences begin to carry moral weight
Wilayah (ولاية)	Guardianship in Islamic law — authority of parents to make decisions on behalf of minor children
Involuntary treatment	Treatment administered without consent, when specific ethical conditions are met
Resource allocation	The distribution of finite healthcare resources among competing needs
Micro-allocation	Bedside decisions about which specific patient receives a scarce resource
Triage	Systematic prioritization of patients for treatment based on urgency and probability of benefit
'Adl (عدل)	Justice — a core Islamic principle governing fair treatment of all persons
Al-tibb al-nabawi (الطب النبوي)	Prophetic medicine — health practices endorsed by Hadith literature

Case Vignettes for Discussion

Case 12.1 — The Refusing Child

A 10-year-old girl with acute leukaemia requires a bone marrow biopsy to assess treatment response. She is fully aware of her diagnosis. She says clearly: "I don't want the biopsy. I've had too many of them and they hurt too much. I want a break." Her parents insist she should have it. The biopsy is clinically important but not immediately life-threatening to delay. How do you weigh the girl's expressed refusal? What ethical principles apply?

Case 12.2 — The Refusing Psychiatric Patient

A 35-year-old man with schizophrenia is admitted acutely confused and thought-disordered following medication non-compliance. He is refusing insulin for his diabetes, saying the nurses are trying to poison him. His blood glucose is 28 mmol/L. Is this a competent refusal? What capacity assessment is required? Under what conditions may insulin be administered without consent?

Case 12.3 — The Last ICU Bed

Your hospital has one remaining ICU bed. Two patients need it: a 72-year-old man with community-acquired pneumonia, previously well, good prognosis with ICU-level care; and a 45-year-old woman with metastatic breast cancer in acute respiratory failure, whose oncologist estimates she has 2–3 months to live even if she recovers. Both patients are competent and want aggressive treatment. How do you apply the allocation frameworks? What ethical principles govern the decision?

Case 12.4 — The Alternative Medicine Patient

A 55-year-old man with Type 2 diabetes and hypertension tells you he has stopped his medications for the past three months and has been treating his conditions with black seed oil, honey, and dietary changes recommended by a herbalist. His HbA1c has risen from 7.2% to 9.8% and his blood pressure is 165/100. He is committed to this approach and becomes defensive when you raise concerns. How do you engage with him? What are your ethical obligations?

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PART FOUR — RESEARCH AND PUBLICATION

Chapter 13: Research Ethics

In 1966, a young investigator for the U.S. Public Health Service named Peter Buxtun filed a formal protest about a study he had stumbled upon: for decades, hundreds of poor Black men in Alabama with syphilis had been left deliberately untreated so that doctors could watch the disease run its course. His complaints went nowhere. Frustrated, in 1972 he handed the file to a journalist, and the story broke across the front pages of America. Public revulsion forced the study to close after forty years — and led directly to the law that now

requires an ethics committee to approve research before a single patient is enrolled. This chapter is about the safeguards that one whistle-blower made unavoidable.

Learning Objectives

By the end of this chapter, you should be able to:

1. Distinguish medical research from medical care and explain why research requires a separate ethical framework.
2. Describe the historical abuses that drove the development of modern research ethics regulations.
3. Explain the core principles of the Belmont Report and their application to human subjects research.
4. Describe the Declaration of Helsinki and its key provisions.
5. Explain the role and function of Institutional Review Boards (IRBs) and Research Ethics Committees (RECs).
6. Apply the ethical framework for informed consent in research, including special provisions for vulnerable populations.
7. Identify common forms of research misconduct and explain their ethical and professional consequences.
8. Describe the Islamic framework for research ethics and the Saudi national regulatory structure.

13.1 Research and Medical Care: A Fundamental Distinction

The primary role of the physician is to care for the patient before them. Medical research serves a different purpose: it is a systematic investigation designed to develop generalizable knowledge — knowledge that will benefit future patients, not necessarily the present participant. This difference in purpose has profound ethical consequences.

In clinical care, the physician does what is believed to be best for this patient. In research, the investigator does what is necessary to answer a scientific question — which may involve randomizing patients to a treatment they might personally prefer not to receive, administering a placebo instead of active treatment, or subjecting participants to procedures that carry risk without direct therapeutic benefit. Research participants therefore need additional protections: specific disclosure of the research nature of the activity, voluntary consent to participate, independent review of the risk-benefit balance, and the right to withdraw at any time.

13.2 Historical Background: Abuses That Built Modern Research Ethics

Nazi Medical Experiments (1939-1945)

The experiments conducted by German physicians on concentration camp prisoners represent the most systematic and brutal violation of research ethics in recorded history. Prisoners were subjected without consent to high-altitude and hypothermia experiments, deliberate infection with typhus and malaria,

surgical amputations without anaesthesia, and injection with gasoline, sea water, and toxic substances. The Nuremberg Doctors' Trial (1946–47) resulted in convictions of 23 physicians and produced the Nuremberg Code (1947): the first international document establishing binding ethical principles for human subjects research.

The Tuskegee Syphilis Study (1932-1972)

Forty years after the Nuremberg Code, the United States Public Health Service was still running a study that violated its principles. The Tuskegee study enrolled 399 African American men with syphilis in rural Alabama, promising them free medical care. What they received was deliberate observation without treatment — maintained even after penicillin became the standard of care in 1947. The participants were never told they had syphilis. At least 28 men died directly from syphilis, 100 from complications; 40 wives were infected; 19 children were born with congenital syphilis. The public exposure of Tuskegee directly drove the creation of the Belmont Report (1979).

13.3 The Belmont Report (1979): Three Foundational Principles

1. **Respect for Persons (Autonomy):** People should be treated as autonomous agents — their choices should be respected, and their right to decide whether to participate in research must be genuinely protected. Persons with diminished autonomy are entitled to special protection. This principle grounds the requirement for voluntary informed consent.
2. **Beneficence:** Do not harm; maximize possible benefits and minimize possible harms. This grounds the requirement for scientific validity — research that cannot answer a meaningful scientific question has no ethical justification for the risks it imposes on participants.
3. **Justice:** The benefits and burdens of research should be distributed fairly. Historically, research burdens were disproportionately imposed on vulnerable, disadvantaged populations while the benefits accrued primarily to more advantaged groups. Justice requires both that no group be unfairly burdened and that no group be unfairly excluded from research benefits.

13.4 The Declaration of Helsinki (1964, revised multiple times)

The WMA Declaration of Helsinki is the most influential international document governing medical research involving human subjects. Key provisions include: the distinction between research and care (participants must understand which components are research and which are treatment); independent ethics committee review (every research study must be reviewed and approved before commencement); informed consent (fully detailed, with specific requirements for vulnerable populations); the therapeutic misconception (investigators must actively correct participants' mistaken belief that experimental treatment is personally tailored care); post-trial obligations (obligations to participants after the research ends); restrictions on placebo use (a placebo control is only ethical when no proven intervention exists); and publication ethics (results must be published — positive and negative).

13.5 The Saudi Regulatory Framework

The National Committee of Bioethics (NCBE) was established by Royal Decree No. 7/B/9512 (1422H) and affiliated with KACST (King Abdulaziz City for Science and Technology). The NCBE provides national oversight of bioethics, sets standards for IRBs, and offers online training and certification for researchers at ncbe.kacst.edu.sa. All Saudi researchers conducting human subjects research are expected to complete the NCBE training course.

Institutional IRBs/RECs: KKU has its own Research Ethics Committee, accessible through an online portal (forms.kku.edu.sa). The MOH maintains RECs for health facilities under its jurisdiction. For studies involving new drugs, devices, or biological products, SFDA approval is required in addition to IRB approval. Medical students at KKU are not permitted to serve as Principal Investigators (PIs) for studies involving human subjects — they may participate as co-investigators under the supervision of a faculty PI.

13.6 Informed Consent in Research

In addition to the standard elements of clinical consent, research consent must disclose: that the activity is research, not standard medical care; the purpose of the research; that participation is voluntary and that refusal or withdrawal will not affect the quality of clinical care received; that the research may involve randomization; the expected duration of participation; any compensation provided and any costs incurred; how confidentiality will be protected; who to contact with questions; and the IRB that approved the study. The treating physician and the researcher role must be clearly distinguished where possible, and sufficient time must be provided for reflection before consent is sought.

13.7 Research Misconduct: FFP

Fabrication

Fabricating data means inventing results that were not actually observed — creating observations, measurements, or participant responses that did not occur. This is the most serious form of misconduct because it introduces false information into the scientific record that may influence clinical practice, pharmaceutical licensing, and public health policy.

Falsification

Falsification involves manipulating research materials, equipment, or processes, or altering or omitting data so that the research findings no longer accurately represent what was observed. This includes selectively removing outlier data points to improve statistical significance, altering the scale on a graph to make a small effect appear large, or reporting only the time points that support the hypothesis. Image manipulation — digitally altering scientific images (Western blots, microscopy, radiological images) — is a form of falsification actively detected by publishers and ethics bodies.

Plagiarism

Plagiarism in research includes appropriating another researcher's ideas, methods, results, or words without proper attribution — presenting them as one's own. This extends to self-plagiarism (republishing one's own previously published work without disclosure) and data plagiarism (presenting another researcher's unpublished data as one's own).

Why Research Misconduct Matters

The consequences of research misconduct extend far beyond the dishonest researcher: patients may be harmed by treatments licensed on the basis of fabricated efficacy data; resources are wasted on follow-up studies of fabricated findings; public trust in science is corroded; and careers of honest researchers are damaged when they cannot replicate fabricated results. High-profile examples — including the Wakefield MMR-autism fabrication (retracted 2010) — demonstrate that the consequences of medical research misconduct are not academic; they directly affect clinical practice and patient care across the world.

13.8 Animal Research Ethics and the Three Rs

The ethical framework for animal research is built around the Three Rs: Replace (use non-animal alternatives — cell cultures, computer models, organoids — where scientifically valid); Reduce (minimize the number of animals used to the minimum necessary to answer the scientific question); and Refine (minimize pain, suffering, distress, and lasting harm to the animals used — through anaesthesia, analgesics, humane endpoints, and improved housing). Islamic jurisprudence permits the use of animals in medical research that is necessary and that minimizes suffering — grounded in the principle that necessity permits what is otherwise prohibited and in the Islamic ethic of responsible stewardship of animals. The Prophet (peace be upon him) said: "Allah has prescribed proficiency in all things. Thus, if you kill, kill well; and if you slaughter, slaughter well." (Muslim). This principle of *ihsan* (excellence and care) extends to the treatment of research animals.

13.9 The Islamic Framework for Research Ethics

Islamic jurisprudence approaches research ethics through several foundational principles: the obligation to seek knowledge (*talab al-'ilm*) — pursuit of medical knowledge that alleviates suffering is a form of *fard kifayah* (collective duty); the conditions of *maslaha* — research is ethically permissible when it serves genuine public benefit and the risk to participants does not outweigh the expected benefit; informed consent as *amanah* — the researcher's obligation of truthful disclosure, protection of privacy, and honoring the terms of the consent agreement; and protection of the vulnerable — Islam's strong ethic of care for the weak applies directly to research.

Key Terms

Term	Definition
Belmont Report	1979 US document establishing respect for persons, beneficence, and justice as foundational research ethics principles
Declaration of Helsinki	WMA document (1964, revised 2013) governing medical research with human subjects
NCBE	National Committee of Bioethics — Saudi Arabia's national research ethics oversight body, affiliated with KACST
IRB / REC	Institutional Review Board / Research Ethics Committee — independent body reviewing research proposals
Therapeutic misconception	A participant's mistaken belief that research procedures are individually tailored clinical care
Fabrication	Inventing research data that was not actually observed
Falsification	Manipulating research data to misrepresent actual observations
Plagiarism	Presenting another's ideas, methods, or words as one's own
The Three Rs	Replace, Reduce, Refine — the ethical framework for animal research
FFP	Fabrication, Falsification, Plagiarism — the three core categories of research misconduct
Incidental findings	Clinically significant findings discovered in research that are not the study's primary objective

Case Vignettes for Discussion

Case 13.1 — The Retrospective Study

A medical student wants to conduct a research project comparing outcomes in two groups of patients who received different surgical approaches for appendicitis over the past five years. The data already exists in hospital records. A fellow student tells him: "You don't need IRB approval — it's just a chart review, and the patients are already treated." Is this correct? What ethical and regulatory obligations apply? What specific steps must the student take before beginning data collection?

Case 13.2 — The Pressured Enrollment

A consultant physician conducting a clinical trial of a new antihypertensive approaches each hypertensive patient in his clinic and says: "I want to add you to my research study — it's an important study and I think you'd benefit from the new medication. Can you sign here?" Is this appropriate research consent? What are the specific ethical problems? How should research enrollment be conducted differently from routine clinical care?

Case 13.3 — The Suspicious Data

A junior researcher notices that her supervisor's published paper reports results that appear inconsistent with the raw data she helped collect — the published paper reports outcomes for 200 patients, but the researcher can only account for 147 patients in the database. When she raises this, the supervisor dismisses her: "You don't have the full picture — trust the analysis." What are her ethical obligations? Who should she contact?

Case 13.4 — The Genetics Incidental Finding

A 35-year-old woman participates in a genome-wide association study of diabetes. During data analysis, a researcher discovers she carries a BRCA1 mutation associated with dramatically elevated lifetime risk of breast and ovarian cancer. This was not part of the study's aims. What are the researcher's obligations? Does the woman have a right to this information? Does she have a right not to receive it?

Further Reading

- National Commission for the Protection of Human Subjects. The Belmont Report. US DHHS; 1979.
- World Medical Association. Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. Revised 2013.
- National Committee of Bioethics (NCBE), KACST. Bioethics Online Training Course. ncbe.kacst.edu.sa
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Chapter 14: Scientific Publication Ethics

In 1998, a respected British medical journal published a study suggesting that a common childhood vaccine might cause autism. The paper described only twelve children, but its effect was vast: frightened parents stopped vaccinating, and preventable diseases returned. Years of investigation revealed that the lead author had manipulated the data, that undisclosed payments had compromised his work, and that the findings were simply false. In 2010 the journal retracted the paper and the author was struck off the medical register — but the damage to public trust outlived the correction. The episode is a warning that a single dishonest publication can cost lives. This chapter examines honesty, authorship, and integrity in scientific writing.

Learning Objectives

By the end of this chapter, you should be able to:

1. Explain the fundamental principles of publication ethics: honesty, transparency, accountability, and reproducibility.
2. Define and identify all major forms of publication misconduct.
3. Apply the ICMJE criteria for authorship and explain the ethical problems of ghost, guest, and gift authorship.
4. Describe the roles and responsibilities of authors, co-authors, peer reviewers, and editors.
5. Define conflict of interest and describe appropriate disclosure practices.
6. Explain the consequences of publication misconduct, including retraction, sanctions, and loss of credibility.
7. Describe the role of international standards bodies — COPE, ICMJE, WAME — in governing publication ethics.
8. Apply Islamic values of *sidq*, *amanah*, and *ihsan* to scientific publication.

14.1 Why Publication Ethics Matters

Every clinical decision you will make as a physician will be informed — directly or indirectly — by published research. The drug doses you prescribe, the screening intervals you recommend, the surgical techniques you employ, the guidelines you follow: all are built upon a foundation of published evidence. If that foundation is contaminated by fabricated data, distorted by suppressed negative results, or misrepresented through ghost authorship and plagiarism, the clinical decisions built upon it will be less safe. Publication ethics is not an abstract academic concern. It is a patient safety issue.

The stakes became viscerally clear in 1998, when Andrew Wakefield published a paper in *The Lancet* claiming a link between the MMR vaccine and autism. The paper was fabricated — the data manipulated, the conflicts of interest undisclosed. By the time it was retracted in 2010, it had triggered a global decline in MMR vaccination rates and a resurgence of measles in countries that had all but eliminated it. Children died from a preventable disease because a paper should never have been published.

14.2 Foundational Principles of Publication Ethics

1. **Honesty:** All aspects of the research process must be reported truthfully. This means reporting results as they were actually found, reporting negative results with the same care as positive ones, and acknowledging limitations clearly.
2. **Transparency:** The research process must be open to scrutiny — registering clinical trials before commencement, sharing data and methods in sufficient detail for replication, disclosing all conflicts of interest, and identifying all contributors.
3. **Accountability:** Researchers are accountable to their participants, the scientific community, and the patients who will ultimately be affected. Each author who signs their name to a paper accepts

responsibility for the integrity of its content.

4. Fairness: Credit must be attributed fairly — to all who contributed substantively, and to those whose prior work is built upon.
5. Reproducibility: Science advances through replication. Research that cannot be replicated — because methods are insufficiently described or data are unavailable — blocks rather than advances knowledge.
6. Integrity toward Patients: Research participants trusted the investigator with their time, their bodies, and sometimes their lives. The minimum return on that trust is honest, complete, accurately reported knowledge.

14.3 Forms of Publication Misconduct

Plagiarism and Its Forms

Verbatim plagiarism: copying text directly without quotation marks and citation. Paraphrasing plagiarism: rewording another's ideas without credit. Idea plagiarism: appropriating a conceptual framework without acknowledging its origin. Data plagiarism: using another researcher's unpublished data without authorization. Image plagiarism: using figures, photographs, or tables without attribution and permission.

Self-Plagiarism

Duplicate publication: submitting identical or near-identical work to two journals simultaneously without disclosure. Text recycling: reusing substantial portions of methods, results, or discussion from a previous paper without acknowledgment. Salami publication (salami slicing): dividing the results of a single study into multiple small papers, each reporting a slice of the dataset, to maximize publication count. Each paper implies a complete study; together they misrepresent the scope and significance of the research.

Fabrication, Falsification, and Image Manipulation

As discussed in Chapter 13, fabrication (inventing data) and falsification (manipulating data) in the context of publication mean that the published literature contains false information with potentially serious clinical consequences. Digital image processing has made it trivially easy to alter scientific images in ways that support a desired result. Most journals now have specific image integrity policies, and image manipulation is actively detected by publishers and ethics bodies.

14.4 Authorship: Criteria, Problems, and Obligations

The ICMJE Criteria

The ICMJE defines authorship by four criteria, all of which must be met: (1) substantial contribution to the conception or design of the work, or to the acquisition, analysis, or interpretation of data; (2) drafting the work or critically revising it for important intellectual content; (3) final approval of the version to be published; and (4) agreement to be accountable for all aspects of the work. An individual who meets all four criteria should be listed as an author. An individual who does not meet all four should not — regardless of their status, their funding, or their relationship to the research team.

Ghost, Guest, and Gift Authorship

Ghost authorship: failure to list someone who has made substantial contributions to the work — most commonly involves professional medical writers employed by pharmaceutical companies. When the person who drafted the paper is not accountable for its content, the accountability structure of authorship breaks down. Guest (honorary) authorship: listing someone who did not meet the ICMJE criteria because of their seniority or prestige. Gift authorship: listing a colleague as an author in exchange for a favor — future authorship on their papers, help with grants, or social goodwill.

Contributor Statements and the Corresponding Author

Most journals now require a contributor statement — a specific description of each author's contribution. The corresponding author bears primary responsibility for: ensuring all listed authors meet the ICMJE criteria; managing communication with the journal; ensuring all authors have seen, approved, and agreed to submit the final manuscript; disclosing all conflicts of interest; and responding to post-publication queries.

14.5 Peer Review Ethics

A reviewer who accepts an invitation to review a manuscript incurs obligations: honesty (provide a thorough, honest evaluation of scientific merit); confidentiality (the manuscript is privileged information — must not be shared or used for any purpose outside the review); timeliness (respond promptly — late reviews delay publication of potentially important work); impartiality (review based on scientific merit, not the identity of the authors); and conflict of interest disclosure (declare any personal, professional, or financial relationship with the authors and decline if it would compromise objectivity).

Reviewer misconduct includes: using unpublished ideas from a reviewed manuscript in one's own work (intellectual theft made possible by privileged access); delaying review to gain competitive advantage; recommending rejection of a competitor's valid work; and revealing the identity of authors in a blinded review. Editors bear responsibility for: selecting qualified, unbiased reviewers; making editorial decisions based on scientific merit; acting on concerns about research integrity promptly; and maintaining records of decisions and reasoning.

14.6 Conflicts of Interest and Consequences

The most extensively documented conflicts of interest in medical publishing are financial — specifically, the influence of pharmaceutical and medical device industry funding on research outcomes. Studies consistently show that industry-funded clinical trials produce more favorable outcomes for the sponsor's product than independently funded trials of the same interventions. The disclosure obligation: all financial relationships relevant to the research must be disclosed to the journal at submission. Disclosure does not eliminate the conflict; it makes it transparent, allowing readers to factor it into their interpretation of the findings.

A retraction is the formal withdrawal of a published paper following a determination that it contains major errors or misconduct that invalidate its conclusions. Retracted papers continue to be cited at alarming rates — studies suggest a significant proportion of retractions are cited positively by authors who appear unaware of or indifferent to the retraction. For individual researchers, publication misconduct can result in: termination of employment; loss of research funding; loss of professional license; requirement to complete additional training; criminal prosecution (in cases of fraud involving grant money); and civil liability (in cases where patients were harmed).

14.7 International Standards Bodies

COPE (Committee on Publication Ethics): Founded in 1997, COPE provides guidelines, case discussions, and training resources on all aspects of publication ethics. Journals that are COPE members commit to upholding its guidelines. ICMJE (International Committee of Medical Journal Editors): The ICMJE Recommendations — informally known as the Vancouver Guidelines — define standards for authorship, reporting, conflicts of interest, and research ethics that govern the major international medical journals. WAME (World Association of Medical Editors): provides guidance and training for medical journal editors with a focus on ethics education and peer review quality. EQUATOR Network: provides reporting guidelines for different types of studies (CONSORT for randomized trials, STROBE for observational studies, PRISMA for systematic reviews, CARE for case reports).

14.8 The Islamic Framework for Publication Ethics

Sidq (صدق — truthfulness) is the first obligation: reporting results honestly, acknowledging uncertainty, not overstating findings or suppressing inconvenient data. Amanah (أمانة — trustworthiness) governs the researcher's relationship with participants, the scientific community, and future patients. Ihsan (إحسان — excellence) demands that researchers design rigorous studies, collect data carefully, analyze honestly, and report completely. The Prophet (peace be upon him) said: "Allah loves that when any of you does a task, they do it with excellence." (Tabarani). The prohibition on riya' (رياء — ostentation) warns against the pursuit of publication for professional advancement or personal recognition rather than the genuine advancement of knowledge.

Key Terms

Term	Definition
ICMJE criteria	Four criteria that must all be met for authorship to be attributed
Ghost authorship	Failure to list a substantial contributor as an author
Guest authorship	Listing someone as an author who did not meet the ICMJE criteria
Gift authorship	Exchanging authorship credits as professional favors
Salami publication	Dividing a single study's findings into multiple publications to maximize publication count
Retraction	Formal withdrawal of a published paper due to errors or misconduct
COPE	Committee on Publication Ethics — provides guidelines and case resources for publication ethics
ICMJE	International Committee of Medical Journal Editors — authors the Vancouver Guidelines
EQUATOR	Network providing reporting guidelines for different study types
Conflict of interest	A secondary interest that may compromise or appear to compromise research objectivity
Riya' (رياء)	Ostentation — doing good deeds for recognition rather than genuine purpose; prohibited in Islam

Case Vignettes for Discussion

Case 14.1 — The Authorship Dispute

A junior resident conducts a retrospective chart review and writes the manuscript entirely. Her supervisor — who suggested the research question at a departmental meeting but had no further involvement — insists on being listed as first author. The department chairman, who reviewed the manuscript once before submission, expects to be listed as last author. Apply the ICMJE criteria. Who qualifies as an author? What should the junior resident do?

Case 14.2 — The Selective Reporting

A pharmaceutical company sponsors a multi-centre trial of a new antibiotic. The trial shows the drug is effective for one of its two primary endpoints but not the other. The company's publication team suggests writing the paper as if the effective endpoint was always the primary one, and relegating the ineffective endpoint to a supplementary table. Is this fabrication, falsification, or neither? What are the ethical obligations of the named academic authors?

Case 14.3 — The Peer Review Opportunity

A researcher is asked to review a manuscript describing a clinical trial on a topic closely related to his own unpublished research. He realizes one of the methods described is similar to an approach he has been developing independently. He completes the review fairly and recommends major revisions. Six months later, he incorporates the same methodological approach into his own paper without citing the reviewed manuscript. Is this a publication ethics violation?

Case 14.4 — The Retracted Citation

During preparation of a systematic review, a medical student discovers that one of three key papers supporting a widely used clinical guideline was retracted two years ago due to data fabrication. The guideline committee has not updated the guideline. The student's supervisor suggests "quietly leaving out" the retracted paper and continuing. What are the ethical obligations? To whom, and through what channels, should the concern be raised?

Further Reading

- International Committee of Medical Journal Editors (ICMJE). Recommendations for the Conduct, Reporting, Editing and Publication of Scholarly Work in Medical Journals. icmje.org
- Committee on Publication Ethics (COPE). Principles of Transparency and Best Practice in Scholarly Publishing. publicationethics.org
- World Association of Medical Editors (WAME). Publication Ethics Policies for Medical Journals. wame.org
- EQUATOR Network. Reporting Guidelines for Health Research. equator-network.org
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Chapter 15: Ethics of Artificial Intelligence in Medicine and Academia

In 1966, a computer scientist at MIT named Joseph Weizenbaum wrote a simple program called ELIZA that imitated a psychotherapist, echoing the user's words back as questions. It understood nothing. Yet Weizenbaum was unsettled to find that people — including his own secretary, who asked him to leave the room — quickly came to believe the program cared about them, and confided their most private troubles to it. He spent the rest of his life warning that we are dangerously willing to trust a machine that merely sounds

as though it understands. Sixty years on, far more capable programs now suggest diagnoses and draft our notes. This chapter asks how to use them wisely — without repeating Weizenbaum's lesson.

Learning Objectives

By the end of this chapter, you should be able to:

1. Explain the fundamental concepts of AI and describe its major applications in medicine and healthcare education.
2. Define algorithmic bias and explain how it arises and why it matters for health equity.
3. Apply the principles of academic integrity to the use of AI tools in assignments, research, and examinations.
4. Describe the data privacy and patient confidentiality obligations that apply when AI systems use patient data.
5. Analyze the ethical risks of over-reliance on AI in clinical decision-making.
6. Discuss authorship and transparency obligations arising from AI-assisted research and writing.
7. Recognize the ethical obligations of the human-centered clinician in an increasingly automated healthcare environment.
8. Apply Islamic ethical principles to AI in medicine: amanah, sidq, ihsan, and human karama.

15.1 A Technology That Arrived Before the Ethics

AI is not coming to medicine; it is already here. Large language models generate clinical documentation, draft referral letters, and answer patient queries. Diagnostic algorithms analyze radiology images, pathology slides, and ECGs. Predictive models stratify patients by risk and flag potential drug interactions. Students use generative AI to write assignments, summarize literature, and prepare for examinations. None of these applications is inherently wrong. Many are genuinely beneficial. All require ethical frameworks that medicine has only begun to develop.

15.2 What AI Is and How It Works in Medicine

Machine learning (ML): Systems that learn patterns from large datasets without being explicitly programmed with rules. A ML model trained on thousands of chest X-rays labeled as normal or abnormal learns to identify features associated with each category. Deep learning: A subset of ML using neural networks with many layers, particularly powerful for image recognition. Most high-performing medical imaging AI tools — in radiology, pathology, dermatology, and ophthalmology — are deep learning systems.

Natural language processing (NLP): AI that understands, generates, and transforms human language. Large language models (LLMs) such as ChatGPT and others are NLP systems capable of producing coherent, contextually appropriate text across a wide range of topics. Predictive analytics: Systems that use patient data to predict future events such as hospital readmission, sepsis onset, or deterioration.

15.3 Algorithmic Bias and Health Equity

Algorithmic bias — the production of systematically discriminatory outputs arising from training data that does not adequately represent the full population — is one of the most serious ethical problems with AI in medicine. If a model is trained primarily on data from one demographic group, it will perform less well on groups underrepresented in the training set. The dermatology example is well documented: dermatology AI tools trained predominantly on lighter skin tones have been shown to perform less accurately on darker skin tones, with potentially fatal consequences. Similar patterns exist in pulse oximetry algorithms, cardiovascular risk calculators, and natural language models.

Algorithmic bias in medical AI is not merely a technical problem; it is a justice problem. When AI tools systematically perform less well for patients from ethnic minorities, lower socioeconomic groups, or underrepresented populations, they exacerbate existing health inequities. The Islamic principle of 'adl (justice) requires that AI systems be tested for bias across all relevant population subgroups before clinical deployment. The physician who uses an AI diagnostic tool is not absolved of responsibility for its outputs — they must know the population on which the tool was validated and whether it is appropriate for the patients they serve.

15.4 AI in Clinical Decision-Making: Ethical Opportunities and Risks

The Benefits

Improved diagnostic accuracy in defined settings; extended access (AI-assisted diagnostic tools can bring specialist-level pattern recognition to healthcare settings that cannot recruit specialist physicians); error reduction (AI systems do not fatigue or develop cognitive biases from a long shift); and earlier detection (predictive models can identify patients at risk of deterioration hours before clinical signs become apparent, enabling earlier intervention).

The Risks

Over-reliance (automation bias): the human tendency to over-trust automated systems — to accept their outputs uncritically — is well documented. A physician who accepts an AI diagnosis without clinical judgment is not practicing medicine; they are operating a machine. The AI output is a prior probability, not a clinical conclusion. The black box problem: many high-performance AI systems are not interpretable — the physician cannot understand why the system reached a particular conclusion, creating a specific informed consent problem. Deskilling: physicians may lose the ability to perform tasks that AI routinely performs for them. Privacy erosion: clinical AI systems require access to large quantities of patient data, creating risks that extend beyond the individual clinical encounter.

The Human-Centered Care Imperative

Technology has not changed the fundamental nature of the clinical encounter. A patient who comes to a physician is not coming for an algorithm; they are coming for a person — someone who will listen, understand, communicate, make judgments that integrate clinical evidence with the patient's individual values, and bear responsibility for those judgments. No AI system can provide the human quality of compassionate presence. The ethical imperative is not to resist AI but to ensure that its deployment enhances rather than replaces the human dimensions of care.

15.5 Academic Integrity in the Age of Generative AI

Large language model tools can produce coherent, academically formatted text on almost any medical topic in response to a simple prompt. They can draft assignments, summarize literature, generate case discussions, and produce content superficially indistinguishable from a student's own work.

Prohibited Uses

Submitting AI-generated text as one's own original work without disclosure; using AI to generate answers to examination questions; using AI to fabricate clinical case data or patient interactions in assignments; and allowing AI to perform the substantive intellectual work that an assignment is designed to develop.

The Deeper Problem: Learning vs. Appearing to Learn

The most serious concern about AI use in medical education is not dishonesty but bypassed learning. The physician who used AI to pass their medical education without developing genuine clinical reasoning will face a patient whose presentation does not match any template the AI provides — and will be dangerous. Medical education is not credential accumulation; it is the development of clinical competence. AI that bypasses the learning process bypasses the competence, while producing the credential.

The Obligation of Disclosure and Critical Appraisal

When AI tools are used legitimately in academic work, disclosure obligations apply. Students should follow their institution's AI use policy; disclose AI use in any work where it is relevant; and critically appraise AI outputs before incorporating them — LLMs generate plausible-sounding text that may be factually incorrect, poorly evidenced, or culturally inappropriate. The Islamic obligation of critical appraisal (tathabbut, تثبیت) is directly relevant: the Quran commands: "O you who believe, if a wicked person brings you any news, verify it." (Al-Hujurat 49:6). AI-generated text must be verified before acting on it.

15.6 Data Privacy and AI-Assisted Research

Patient data used to train AI models may be de-identified at the time of use but remain potentially re-identifiable. Research has shown that combining seemingly innocuous data points — age, diagnosis, hospital, date of admission — can re-identify individuals even from anonymized datasets. When hospitals partner with technology companies to develop AI tools, patient data may be transferred to commercial entities without patients' knowledge. The principle: the primary purpose for which patients share their health data is their own care. Any secondary use requires explicit, specific consent or a robust legal and ethical framework.

COPE and the AMA have both issued guidance on AI tools in research and publication. The consensus position: AI tools cannot be listed as authors (authorship requires the ability to take responsibility for the work — AI cannot do this); use of AI in generating text, analyzing data, or creating figures must be disclosed in the methods section and acknowledgments; and the authors are fully responsible for all AI-assisted content.

15.7 The Islamic Framework for AI Ethics

Human dignity (karama) and the non-negotiability of human value: The Quran establishes that Allah has honored the children of Adam (Al-Isra 17:70). AI systems that reduce human beings to data points must be governed by human oversight that ensures the patient's dignity and individuality are never lost in the

computation. Amanah (trustworthiness): When a patient submits to an AI-assisted diagnostic process, they place a trust in the healthcare system that the tools being used are fit for purpose, appropriately validated, and deployed with their interest at heart. Sidq (truthfulness) requires that every communication sent in the physician's name reflects their own honest assessment, not merely the output of a tool they have not critically evaluated. Tawadu' (تواضع — humility): The Islamic virtue of recognizing one's own limitations applies directly to AI — an AI system trained on historical data does not know what it does not know, and the clinician who uses AI as a tool rather than an oracle is practicing intellectual humility that is both ethically sound and clinically safer.

Key Terms

Term	Definition
Artificial Intelligence (AI)	Computational systems that perform tasks ordinarily requiring human intelligence
Machine learning	AI that learns patterns from data without explicit programming
Deep learning	A subset of machine learning using multi-layer neural networks — powers most medical imaging AI
Large language model (LLM)	AI trained on large text corpora to generate, understand, and transform human language
Algorithmic bias	Systematic discrimination in AI outputs arising from biased or unrepresentative training data
Automation bias	The human tendency to over-trust automated systems and accept their outputs uncritically
Black box problem	The inability to understand or explain the internal reasoning of complex AI models
Deskilling	The erosion of human skills through over-reliance on automated tools
Re-identification	Recovery of individual identity from supposedly anonymized data through data linkage
Tathabbut (تثبت)	Critical verification — the Islamic obligation to check information before acting on it
Tawadu' (تواضع)	Humility — the Islamic virtue of recognizing one's own limitations; applicable to AI as a tool

Case Vignettes for Discussion

Case 15.1 — The AI Diagnosis

A 55-year-old woman presents to a primary care clinic with a skin lesion on her forearm. The clinic has recently deployed an AI-assisted dermatology tool. The tool reports: "99% confidence — benign seborrheic keratosis." The physician, trusting the AI, reassures the patient without performing a clinical examination of

the lesion itself. Six months later, the lesion is biopsied at a specialist clinic and found to be an early melanoma. What are the ethical failures in this scenario?

Case 15.2 — The AI Assignment

A fourth-year medical student uses a large language model AI tool to draft a 2,000-word essay on informed consent for the first assignment of MED 431. She reads the essay, finds it broadly accurate, makes minor edits, and submits it under her name without disclosure. The course policy states: "AI tools may be used to support learning but all submitted work must represent the student's own intellectual effort." Has she violated academic integrity? What are the ethical issues?

Case 15.3 — The Patient Data Request

A technology company approaches your hospital with a proposal to develop an AI system for predicting sepsis onset. In exchange for access to five years of de-identified inpatient records, the company will provide the hospital with a licence to use the resulting algorithm. The ethics committee asks you to review the proposal. What ethical issues does it raise? What conditions would need to be met for the data sharing to be ethically acceptable?

Case 15.4 — The LLM Co-Author

A junior researcher writes a paper using an AI tool to draft the introduction and discussion sections, which she then significantly revised. She discloses the AI use in the methods section. Her supervisor insists this disclosure will harm the paper's chances of acceptance and demands she remove it. What are the ethical obligations? What should the junior researcher do?

Further Reading

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PART FIVE — PUBLIC HEALTH AND SYSTEMS ETHICS

Chapter 16: Public Health and Preventive Medicine Ethics

In the early 1900s, a cook named Mary Mallon moved from household to household in New York, and wherever she worked, people fell ill with typhoid fever. Mary felt perfectly healthy and angrily denied being the cause — yet she was an unwitting carrier, spreading the disease through the food she prepared. In 1907 the health authorities seized her and confined her to an island, where, with one brief interruption, she would spend most of the rest of her life in isolation. Her case poses the defining dilemma of public-health ethics: how far may a society go in restricting one person's liberty to protect the health of the many? This chapter weighs the good of the community against the rights of the individual.

Learning Objectives

By the end of this chapter, you should be able to:

1. Define public health and preventive medicine and explain how their ethical frameworks differ from individual clinical ethics.
2. Describe the core values of the Public Health Code of Ethics.
3. Analyze the fundamental tension between individual autonomy and collective benefit in public health practice.
4. Apply utilitarian, deontological, and Islamic ethical frameworks to public health dilemmas.
5. Evaluate the ethical dimensions of vaccination, disease screening, quarantine, and health promotion programs.
6. Describe the Islamic foundations for preventive medicine and public health obligations.
7. Apply the concepts of equity and social justice to healthcare resource distribution.
8. Recognize the physician's advocacy role in population health.

16.1 The Shift from Individual to Population

For most of this book, the ethical focus has been on the individual patient. Public health ethics requires a different lens. When a public health official decides whether to mandate a vaccine, when a policymaker designs a tobacco control law, when a clinician considers whether to report a communicable disease — they are making decisions that affect not one person but thousands, or millions. The ethical frameworks that govern individual clinical care are necessary but insufficient for these population-level decisions.

Public health and preventive medicine are, as defined by the American Board of Preventive Medicine, "that specialty of medical practice which focuses on the health of individuals and defined populations in order to protect, promote, and maintain health and well-being and prevent disease, disability, and premature death."

They are concerned with the upstream determinants of health — the social, environmental, behavioral, and biological conditions that produce or prevent illness before it reaches the clinic.

16.2 The Public Health Code of Ethics: Core Values

1. Professionalism and Trust

Public health effectiveness depends on public trust. Populations who received honest, complete information — including acknowledgment of uncertainty — are more compliant with public health measures than those who received oversimplified or politicized messaging. Public health practitioners and organizations promote competence, honesty, and accuracy and ensure that their work is not unduly influenced by secondary interests.

2. Health and Safety

Health and safety are essential conditions for human flourishing. Public health practitioners have an ethical responsibility to prevent, minimize, and mitigate health harms — not only through direct clinical intervention but through advocacy, policy, and structural change.

3. Health Justice and Equity

Human flourishing requires that all people have equal opportunities to achieve health. Health equity requires attention to the social determinants of health — income, education, housing, food security, occupation — that systematically produce health disparities across population groups. The public health professional has an ethical obligation to address these disparities: not only to measure them, but to use their knowledge, skills, and professional influence to advocate for the conditions that make health possible for all.

4. Inclusivity and Stewardship

Public health decisions that affect communities should be made with the genuine participation of those communities — not imposed upon them by experts who believe they know best. Public health professionals are also custodians of public funds and public trust. Resources must be used efficiently, fairly, and for their designated purposes.

16.3 The Central Tension: Individual Autonomy vs. Collective Benefit

The most fundamental ethical tension in public health is the conflict between individual autonomy — the right of persons to make their own choices — and the collective benefit that may require restricting those choices for the good of the whole. This tension manifests in virtually every domain of public health: a person who chooses not to vaccinate exercises autonomy, but potentially exposes others who cannot be vaccinated; a person who refuses quarantine during an infectious disease outbreak exercises autonomy, but may transmit a serious illness to others.

Utilitarianism provides a clear answer: the action that maximizes overall welfare is the right one. If mandatory vaccination produces enough collective benefit to outweigh the individual autonomy cost, it is ethically justified. The harm principle (John Stuart Mill) offers a middle path: individual liberty may be restricted only to prevent harm to others. The Islamic framework is not individualistic — Islam describes the community (ummah) as a body: "The believers in their mutual kindness, compassion, and sympathy are just like one body. When one of the limbs suffers, the whole body responds to it with wakefulness and fever."

(Bukhari and Muslim). This framing explicitly supports collective action to prevent harm spreading through the community.

16.4 Vaccination Ethics

Vaccination is the most cost-effective public health intervention in history. Smallpox has been eradicated; polio is on the verge of eradication; measles, diphtheria, whooping cough, and dozens of other once-devastating diseases have been dramatically reduced. These achievements required that a sufficiently high proportion of the population be vaccinated to achieve herd immunity — the threshold above which transmission cannot be sustained even among unvaccinated individuals.

The ethical case for vaccination rests on: beneficence (vaccination protects the individual recipient from serious illness); non-maleficence toward third parties (by reducing transmission, vaccination protects those who cannot protect themselves — newborns, immunocompromised individuals, infants too young to be vaccinated); justice (herd immunity is a collective good produced by collective action — free-riding is unfair to those who bear the cost of maintaining the protection from which all benefit); and the Islamic perspective (Islamic jurisprudence supports vaccination under the principles of *la darar wa la dirar* and *hifz al-nafs* — several contemporary Islamic scholars have issued fatwas explicitly supporting vaccination as a religious obligation of health preservation).

Vaccine Hesitancy

Vaccine hesitancy — the delay or refusal of vaccination despite availability — is driven by a complex mix of safety concerns, misinformation, distrust of healthcare systems, and religious misunderstanding. The ethical response is engagement: addressing safety concerns with accurate evidence-based information; acknowledging and investigating genuine adverse events; building trust; engaging religious and community leaders as partners; and providing vaccination services in culturally acceptable settings.

16.5 Disease Screening Ethics

The Wilson-Jungner Criteria

The internationally accepted criteria for a population screening program (WHO, 1968) require that: the condition is an important health problem; there is an accepted treatment; facilities for diagnosis and treatment are available; there is a recognizable latent or early symptomatic stage; a suitable test is available; the test is acceptable to the population; the natural history is adequately understood; there is an agreed policy on whom to treat; the cost is economically balanced; and case-finding is a continuing process.

The Harm Side of Screening

Screening is not without harm. False positives generate anxiety and may lead to unnecessary investigations and treatment. In cancer screening, overdiagnosis — the detection of cancers that would never have caused symptoms in the patient's lifetime — is a recognized harm of significant population impact. False negatives may falsely reassure a person who does have early disease. The right not to be screened must be respected: a person who, after full information, declines a screening test is exercising a legitimate autonomous choice.

16.6 Communicable Disease Control and the Ethics of Quarantine

Isolation separates sick individuals from healthy ones to prevent transmission. Quarantine separates and restricts the movement of individuals who have been exposed but are not yet symptomatic. Both represent restrictions on individual liberty for the protection of others. Their ethical justification requires: the disease poses a serious risk to others; restriction is necessary and less restrictive measures are insufficient; restriction is proportionate; due process protections exist; and basic rights are maintained during restriction (adequate food, shelter, healthcare, communication).

The Islamic tradition explicitly supports quarantine through the Prophetic hadith: "If you hear of an outbreak of plague in a land, do not enter it; but if the plague breaks out in a place while you are in it, do not leave that place." (Bukhari). In Islamic jurisprudence, the obligation to prevent harm to others (la darar) justifies restrictions on individual freedom of movement when communicable disease risk is genuine and serious.

16.7 Health Promotion and Social Determinants

The Ethics of Nudging

A nudge is a policy intervention that alters the choice environment in ways that predictably influence behavior without restricting options or changing incentives significantly. Classic examples: placing fruit at eye level in a school cafeteria; making organ donation the default requiring opt-out rather than opt-in; printing calorie counts on menus. Nudging is ethically less intrusive than mandates but not ethically neutral — it is not fully transparent, and it can be used to serve commercial interests as well as public health interests. The ethical use of nudging requires transparency about the nudge, direction toward genuine population benefit, and preservation of real choice.

Addressing Social Determinants

The most powerful determinants of population health are social: income inequality, educational attainment, housing quality, food security, occupational safety, and social cohesion. The physician who treats one diabetic patient but does not engage with the social conditions that produce diabetes across a community is addressing the symptom while ignoring the cause. The Islamic concept of fard kifayah (collective duty) is relevant: when a community need exists that no one is meeting, the obligation to meet it falls on every capable member until it is met.

16.8 The Physician as Advocate

Every physician is both a clinician and a participant in the social systems that produce or prevent health. The physician's unique combination of scientific expertise, social trust, and proximity to the consequences of policy gives them a special standing to advocate for conditions that support population health. Advocacy takes several forms: clinical advocacy (addressing social determinants of health in the clinical encounter — asking about food security, housing stability, domestic safety); institutional advocacy (participating in hospital governance to promote patient rights and equity of access); policy advocacy (using clinical expertise to contribute to public debates on health policy); and community advocacy (engaging with the communities physicians serve, particularly underserved communities).

The Islamic concept of amr bil ma'ruf wa nahy 'an al-munkar (الأمر بالمعروف والنهي عن المنكر — commanding good and forbidding evil) provides an explicit religious mandate for advocacy: the Muslim physician is obligated not only to treat disease but to work toward the social conditions that prevent it.

16.9 Islamic Foundations of Public Health Ethics

Islam has a rich tradition of public health practice. Prophetic quarantine: The Prophet's guidance on quarantine during plague established one of the earliest and most effective public health protocols in history — anticipating by fourteen centuries the modern epidemiological understanding of communicable disease control. Environmental health: The Prophet commanded cleanliness (al-nazafah min al-iman — "Cleanliness is part of faith") and prohibited practices that contaminate shared resources — polluting water sources, leaving waste in public places.

Preventive medicine as religious duty: The Prophetic hadith "Take advantage of five before five: your youth before your old age, your health before your illness..." (al-Hakim) and "There is no disease Allah has created, except that He also has created its treatment" (Bukhari) together establish both the obligation to maintain health and the legitimacy of preventive medicine as a religious practice. Collective responsibility: The Quranic injunction to "cooperate in righteousness and piety" (Al-Ma'idah 5:2) provides the foundation for the collective action that public health requires.

Key Terms

Term	Definition
Public health	The science and art of improving population health through organized societal efforts
Preventive medicine	Medical specialty focused on protecting and promoting the health of individuals and defined populations
Herd immunity	The indirect protection of unvaccinated individuals when a sufficient population proportion is immune
Vaccine hesitancy	Delay or refusal of vaccination despite its availability
Quarantine	Restriction of movement for individuals exposed to communicable disease but not yet symptomatic
Isolation	Separation of confirmed infectious individuals from others
Harm principle	Individual liberty may only be restricted to prevent harm to others (Mill)
Nudge	A policy intervention that influences behavior through choice architecture without restricting options
Overdiagnosis	Detection through screening of conditions that would never have caused symptoms in a patient's lifetime
Social determinants of health	Social, economic, and environmental conditions that shape health outcomes
Fard kifayah (فرض كفاية)	Collective duty — a religious obligation that falls on all community members until it is fulfilled
Amr bil ma'ruf (الأمر بالمعروف)	Commanding good — the Islamic mandate for advocacy against harmful social conditions
Wilson-Jungner criteria	Ten internationally accepted criteria for the ethical introduction of a population screening program

Case Vignettes for Discussion

Case 16.1 — The Unvaccinated Child

A 7-year-old child is brought to the emergency department with measles. Her parents, citing religious concerns, have refused all vaccinations since birth. The child is severely ill. During admission, the ward nurse informs you that three other children in the same ward are immunocompromised and unable to be vaccinated. What public health obligations arise? How do you engage with the parents? What are the obligations to the other vulnerable children?

Case 16.2 — The Contact Tracing Refusal

During a tuberculosis outbreak, a patient with active pulmonary TB refuses to provide the names of his close contacts, citing privacy concerns. Contact tracing is essential to prevent further transmission. What ethical principles are in conflict? What legal and public health obligations apply in Saudi Arabia? How do you proceed?

Case 16.3 — The Screening Dilemma

A primary care clinic is considering introducing routine PSA screening for all male patients over 50. Evidence shows that PSA screening reduces prostate cancer mortality in some populations but leads to significant overdiagnosis, unnecessary biopsies, and treatment of cancers that would never have caused symptoms. Apply the Wilson-Jungner criteria. Is this screening program ethically justified? What information must patients receive before consenting to screening?

Case 16.4 — The Social Determinant

A 45-year-old woman presents with poorly controlled type 2 diabetes. Her HbA1c has risen despite medication compliance. Further questioning reveals she has recently lost her job, is food insecure, and cannot afford the fresh vegetables recommended in her dietary plan. Apply the social determinants framework. What clinical actions are appropriate? What advocacy obligations does this encounter create?

Further Reading

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Chapter 17: Rules, Laws, and Regulations

For most of medical history, a physician's conduct in the Muslim world was governed by two things: his conscience and the teachings of the Sharia. There was no statute book to consult. As modern medicine grew more powerful and more complex, the Kingdom of Saudi Arabia, like every modern state, found that conscience alone was not enough. In 2005, the Law of Practising Healthcare Professions was enacted by royal decree, making it unlawful to practise without a licence and setting out in formal statute the duties, liabilities, and discipline of every practitioner — building on the Saudi Commission for Health Specialties established in 1992. This chapter introduces the rules, laws, and regulations that bind the physician working in Saudi Arabia today.

Learning Objectives

By the end of this chapter, you should be able to:

1. Explain the relationship between law and ethics in medical practice.
2. Describe the regulatory structure governing healthcare practice in Saudi Arabia — MOH, SCFHS, and SFDA.
3. Outline the key provisions of the Law of Practicing Healthcare Professions (Royal Decree M/59).
4. Describe the conditions for obtaining and maintaining a license to practice medicine in Saudi Arabia.
5. Explain the SCFHS Code of Ethics and its practical implications for daily practice.
6. Describe the rights and obligations of medical students and interns under Saudi regulations.
7. Explain the university and college conduct regulations that govern student behavior at KKU.
8. Recognize the legal consequences of professional misconduct, including SCFHS disciplinary procedures.

17.1 Why Regulations Matter: The Link Between Law and Ethics

Throughout this book, the distinction between law and ethics has been maintained: ethics sets the standard for what ought to be done; law enforces a minimum standard of what must not be done. Ethics often demands more than law requires, and occasionally ethics requires deviation from law when the law demands unethical conduct. Yet this distinction should not obscure the profound interdependence of law and ethics in medical practice. Laws governing healthcare are, in their best form, the codification of ethical principles — the translation of values like patient autonomy, non-maleficence, and professional accountability into enforceable obligations.

17.2 The Regulatory Ecosystem: Key Bodies in Saudi Healthcare

The Ministry of Health (MOH)

The Ministry of Health is the primary governmental body responsible for healthcare policy, planning, and delivery across Saudi Arabia. Its regulatory functions include: issuing licenses to practice healthcare professions through regional health directorates; establishing and enforcing standards for healthcare facilities; publishing the Saudi Patient Bill of Rights and Responsibilities; operating the national system of public health surveillance and communicable disease control; and managing the majority of public hospitals and primary healthcare centers. The MOH complaint hotline (937) provides a mechanism through which patients and practitioners can report concerns.

The Saudi Commission for Health Specialties (SCFHS)

Established in 1992, the SCFHS is the independent body responsible for regulating and developing healthcare specialties in Saudi Arabia. Its functions include: licensing and registration (all healthcare practitioners must be registered before practicing); classification (practitioners are classified at different levels — residency, fellow, consultant — based on qualifications and experience); Continuing Medical Education (CME) requirements for maintaining registration; publishing and enforcing the Code of Ethics for Healthcare Practitioners; disciplinary procedures (the SCFHS can suspend or revoke registration); and administering Saudi Board programs across all specialties.

The Saudi Food and Drug Authority (SFDA)

The SFDA regulates drugs, food, biological products, medical devices, and cosmetics. Its functions include: licensing new pharmaceutical products; pharmacovigilance (post-market surveillance of drug safety); and regulation of clinical trials involving new therapeutic agents.

17.3 The Law of Practicing Healthcare Professions (Royal Decree M/59)

Royal Decree No. M/59, dated 04/11/1426H (2005) and its implementing regulations (Ministerial Resolution 4080489, 1439H/2018) constitute the primary legal framework for healthcare practice in Saudi Arabia. Article 2 specifies that practicing any healthcare profession without a license is strictly forbidden. The conditions for obtaining a license are: a recognized qualification from an accredited institution recognized by the SCFHS; completion of mandatory internship as prescribed by the SCFHS; medical fitness; a clean criminal record (no prior conviction for crimes against honor or honesty unless rehabilitated); and formal SCFHS registration.

Key Practitioner Obligations

Practice within scope (practitioners must practice only within the scope of their qualifications and licensing — practicing outside one's licensed scope is both illegal and unethical); maintain medical records (accurate, complete, and timely medical records must be kept for the minimum period specified); report serious adverse events; obtain informed consent before medical procedures; comply with CME requirements; and cooperate with regulatory oversight.

Disciplinary Provisions

Graduated disciplinary measures include: warning (for minor violations); temporary suspension of practice license; permanent revocation (for severe or repeated violations); financial penalties in defined circumstances; and referral to criminal prosecution where the violation constitutes a criminal offence. Disciplinary proceedings are primarily about patient protection, not punishment.

17.4 The SCFHS Code of Ethics: Key Chapters

The SCFHS Code of Ethics (2014) is a legally binding document grounding professional ethics in Islamic values. Chapter 1 (Healthcare Practitioner Ethics) covers: devotion and worship (the practitioner's work is an act of service to Allah — motivating the highest standard of conduct even in the absence of external oversight); best of manners (husn al-akhlaq in all professional interactions); self-accountability (muhasabah — reviewing one's own conduct and committing to continuous improvement).

Chapter 2 (Duties Towards Patients) establishes: good treatment and respect for patient dignity; achieving the patient's interests; honesty and truth-telling; maintaining confidentiality; respecting patient autonomy; proper consent and disclosure; non-abandonment of patients. Chapter 3 (Duties Towards Colleagues) includes: respectful professional relationships; supporting colleagues' development; and reporting unsafe or unethical conduct through appropriate channels. Chapter 4 (Duties Towards Society) includes: serving the community's health needs; contributing to public health; maintaining the honor of the profession in the public eye.

17.5 The Internship Year: Regulatory and Ethical Framework

The internship year is the mandatory practical training year following graduation with an MBBS degree — a period of transition during which the graduate gains supervised clinical experience across the major specialties before becoming fully licensed. Interns are graduates of medical school holding an MBBS degree but are not yet licensed by the SCFHS. They may perform clinical tasks under supervision; they may not practice independently without supervision; and they are not authorized to sign clinical documents as the responsible physician.

The ethical obligations of interns include: practicing within supervision (the willingness to say "I need supervision for this" is a mark of professional maturity, not weakness); honest documentation (clinical records must be accurate, complete, and honest — including documentation of uncertainty and of supervisor involvement); escalation (when an intern encounters a situation beyond their competence or recognizes a patient deteriorating, they must escalate promptly); and maintaining patient confidentiality (interns must sign a confidentiality agreement as part of the internship program).

17.6 KKU Student Conduct Regulations

The KKU Student Rights and Obligations Charter establishes student rights alongside their obligations: attendance (mandatory requirements apply to all lectures, tutorials, and clinical sessions — failure to meet minimum attendance results in academic consequences that may include exclusion from examinations); dress code (clinical environments require professional attire consistent with Islamic modesty standards and hospital requirements); academic integrity (violations carry consequences ranging from a grade of zero to expulsion); and examination regulations.

The university maintains a graduated disciplinary system: warning (informal or formal); recorded reprimand (documented in the student's academic file); suspension (from one or more examinations, courses, or a full semester); and expulsion (for serious or repeated violations). Medical students should understand that academic and professional misconduct during training can have consequences that extend beyond the university — the SCFHS may consider a history of documented academic misconduct when assessing fitness to practice.

17.7 Medical Malpractice: Legal and Ethical Dimensions

Medical malpractice is professional negligence — the failure of a healthcare practitioner to meet the standard of care, resulting in patient harm. For a successful malpractice claim, the plaintiff must establish the four Ds: Duty (a doctor-patient relationship existed, creating a duty of care); Deviation (the practitioner deviated from the accepted standard of care); Damage (the patient suffered harm); and Direct causation (the deviation directly caused the damage). All four elements must be present. A bad outcome does not constitute malpractice if the standard of care was met.

Ethical Response to Medical Error

Medical errors are inevitable in a complex system operating under time pressure with incomplete information. The ethical response to error is not concealment but: disclosure to the patient (patients who have been harmed by medical error have a right to honest information about what happened); apology (a genuine, compassionate apology is both ethically appropriate and often more important to patients than legal proceedings); reporting (significant adverse events should be reported through the hospital's incident reporting system to enable learning); and remediation (identifying and addressing the factors that contributed to the error).

Key Terms

Term	Definition
MOH	Ministry of Health — primary government body for healthcare policy and facility regulation in Saudi Arabia
SCFHS	Saudi Commission for Health Specialties — regulates training, licensing, and professional ethics for all healthcare practitioners
SFDA	Saudi Food and Drug Authority — regulates drugs, devices, and clinical trials
Practice license	The legal authorization to practice a healthcare profession, issued by the MOH following SCFHS registration
CME	Continuing Medical Education — required for maintenance of SCFHS registration
Scope of practice	The range of procedures, diagnoses, and treatments a practitioner is qualified and licensed to perform
Medical malpractice	Professional negligence — deviation from the standard of care causing patient harm
The 4 Ds	Duty, Deviation, Damage, Direct causation — the four elements required to establish malpractice
Standard of care	What a reasonably competent practitioner with equivalent training would have done in the same circumstances
Internship	The mandatory supervised clinical training year following MBBS graduation, prior to full SCFHS licensing
Muhasabah (محاسبة)	Self-accountability — the Islamic practice of regular self-examination of one's conduct
Royal Decree M/59	The Saudi Law of Practicing Healthcare Professions (2005) and its executive regulations

Case Vignettes for Discussion

Case 17.1 — The Unlicensed Practice

A newly graduated Saudi physician, awaiting his SCFHS registration to be processed, is approached by a relative who asks him to prescribe medication for a family member with a chronic condition. He has the clinical knowledge to manage the condition. Is he legally and ethically permitted to prescribe? What are the risks — clinical, legal, and professional? What should he do?

Case 17.2 — The Falsified Record

During a ward round, a consultant discovers that an intern has documented a neurological examination that — based on the clinical timeline — could not have been performed. When confronted, the intern admits that the examination was documented before it was performed because "it was going to be done anyway." What legal and ethical obligations have been violated? What should the consultant do? What consequences may the intern face?

Case 17.3 — The Complaint

A patient submits a formal complaint alleging that a physician refused to see her after she arrived late for an appointment, despite the fact that she had traveled two hours and was in pain. The physician argues that his clinic schedule does not permit late patients. What regulatory obligations apply? Through what process should the complaint be investigated? What are the potential outcomes?

Case 17.4 — The Scope Violation

A general practitioner working at a primary health center performs a joint injection — technically within his training but for which he is not specifically credentialed at this facility. The patient develops a complication. Analyze this scenario using the 4 Ds of malpractice. What ethical and legal obligations were involved in the initial decision? What should happen now?

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Chapter 18: The Pharmaceutical Industry, Private Sector, and Healthcare Ethics

In the late 1950s, a German company marketed a new sedative, sold as a safe remedy for the morning sickness of pregnancy. It was a catastrophe: thalidomide crossed the placenta and caused thousands of babies to be born with malformed or missing limbs. In the United States, the disaster was largely averted by a single official, Frances Oldham Kelsey, who — under heavy commercial pressure — refused to approve the drug without better evidence of its safety. The scandal transformed the law, requiring companies to prove that medicines are both safe and effective before sale. It exposed a permanent tension: the pharmaceutical industry does immense good, yet its commercial interests can collide with patients' welfare. This chapter examines how to manage that conflict honestly.

Learning Objectives

By the end of this chapter, you should be able to:

1. Explain the nature of the physician-industry relationship and why it creates ethical risks.
2. Describe the specific forms of industry influence on physician behavior and prescribing patterns.
3. Apply the SCFHS Code of Ethics provisions on gifts, advertisements, and pharmaceutical company relationships.
4. Discuss the ethical and Islamic framework for accepting gifts from pharmaceutical companies.
5. Explain the ethical issues arising when physicians work in both public and private sectors simultaneously.
6. Describe the ethics of healthcare advertising and media participation by physicians.
7. Apply the principles of conflict of interest to scenarios involving pharmaceutical industry relationships.
8. Explain the ethics of health insurance and patient access to private healthcare.

18.1 Medicine as Commerce: The Unavoidable Tension

Healthcare is not a normal commodity. The patient who needs treatment is not a customer with negotiating power; they are a person in need who must trust the practitioner to act in their interest regardless of financial incentive. The growth of the private healthcare sector in Saudi Arabia — parallel to the public MOH system — and the deep involvement of the pharmaceutical and medical device industry in clinical practice have created financial relationships that can, if unmanaged, compromise the primacy of patient welfare.

The SCFHS Code of Ethics addresses this directly: "With the increase in the growth of the private sector in the provision of health services, the general direction towards privatization and the application of health insurance along with the spread of health insurance companies; healthcare practitioners have become actively tangled in the for-profit health sector. This could be followed by commercial competition that could lead to attitudes that could breach the ethics of the healthcare profession."

18.2 How Industry Influences Physician Behavior

The mechanisms of pharmaceutical industry influence are multiple and mutually reinforcing: gifts and hospitality (branded promotional items, meals, sponsored educational events, travel to conferences — research consistently shows that physicians who receive such gifts are more likely to prescribe the promoted product even when they sincerely believe the gift has not influenced them); CME sponsorship (industry sponsors a significant proportion of CME programs globally — even when sponsors are prohibited from controlling content, the framing of educational events and the choice of topics favor the sponsor's therapeutic area); research funding and publication bias (as discussed in Chapter 13, industry-funded trials consistently produce more favorable outcomes for the sponsored product); and pharmaceutical detailing (one-on-one visits from sales representatives that significantly influence prescribing patterns).

Research demonstrates three consistent findings: (1) industry interactions influence physician prescribing in measurable ways; (2) physicians systematically underestimate the influence of industry on their own

behavior; and (3) the effects are present even for small, inexpensive gifts. The second finding is the most troubling: it means that subjective confidence that "I'm not influenced" is not a reliable guide to actual influence.

18.3 The SCFHS Code on Gifts and Benefits

Clearly Prohibited: Bribes

The SCFHS Code states: "Any form of bribe whose intention is to conceal truth or the realization of a void, should not be taken or given, whether in the form of financial, in-kind, loans, equipment and so forth, regardless whether they were cheap or expensive. Bribery is one of the major sins that the Islamic Sharia has prohibited." A bribe in the medical context is any benefit given or received with the expectation — explicit or implicit — of influencing a clinical decision for commercial rather than clinical reasons.

Prohibited in Practice: Expensive Gifts

"What is not apparently a bribe, but was in the form of expensive cash or in-kind gifts, should not be accepted, whatever the motives and justifications, as it would most probably be intended for illegitimate purposes." Expensive gifts from commercial entities — regardless of the giver's stated justification — are prohibited because their function is almost certainly to create obligation and influence.

Permissible with Conditions: Minor Items

"The inexpensive gifts that people usually exchange among themselves as an expression of passion and cordiality like pens, scientific books, medical journals, or similar are considered less strictly, unless the healthcare practitioner feels an effect on him/herself in relation to his/her attitudes and medical decisions towards the presenter of the gift." Even apparently minor gifts are prohibited if the practitioner notices they are affecting their clinical decisions.

Corporate Gifts: Stricter Standard

"It is not permissible for the healthcare practitioner, whether in the public or private sector, to accept gifts that are linked to the number of prescriptions that he/she prescribes or the number of equipments he/she advises his/her patients to have." This explicitly prohibits prescription-linked bonuses. "It is not permissible for the healthcare practitioner to accept gifts, loans, equipment, instruments, or cash paid directly to him/her personally from the commercial companies for whatever justification."

18.4 The Islamic Framework for Industry Ethics

The Prophet Muhammad (peace be upon him) said: "The curse of Allah be upon the one who gives a bribe and the one who receives it." (Ahmad, Abu Dawud). Rishwa (رشوة) encompasses any payment or benefit given to influence a judgment that should be made impartially. The physician who prescribes for financial benefit rather than clinical need is giving patients the judgment they paid for, not the judgment they need — a violation of both amanah (trust) and 'adl (justice).

Taghrir (غرر — deception in a transaction) is prohibited in Islamic commercial law. A physician who prescribes an expensive branded drug when a cheaper equivalent would be equally effective, without informing the patient, is engaging in a form of taghrir. Bara'a al-dhimma (براءة الذمة — freedom from obligation) is valued in Islam: when a physician accepts a gift from a commercial entity, they create an

obligation — even an unconscious one — toward the giver. The physician who is in no one's commercial debt is free to prescribe solely for the patient's benefit.

18.5 Ethics of Medical Advertising

The SCFHS Code prohibits: claims of superiority over other practitioners or demeaning of competitors' abilities; claiming skills, qualifications, or services for which the practitioner is not competent or authorized; adding false or unauthentic titles or qualifications; exploiting patients' lack of medical knowledge to make misleading claims; and guaranteeing cures for diseases. When participating in media, practitioners must: refrain from advertising oneself or one's workplace; provide only professionally authentic and scientifically acceptable information; and clearly identify personal opinions that differ from accepted professional standards.

18.6 Dual Practice: Public and Private Sector Ethics

Many Saudi physicians work in both the public (government) and private sectors simultaneously. This creates specific ethical risks: time and attention diversion; patient diversion (using the public sector position as a platform to attract patients to the private clinic); inequitable care (treating private patients more promptly or attentively than public patients); and conflict of interest in referrals (referring patients to one's own private facility).

The SCFHS Code specifies: "His/her work in the private sector does not affect his/her governmental work, and his/her basic governmental job should be given its due diligence." "His/her work in the public sector should not be used as a means/bridge to his/her private work, for example, by attracting patients to his/her private practice." "The healthcare practitioner should not under any circumstance give priority to his/her personal interests, financially or socially, above the interests of the patient."

18.7 Healthcare Fees, Insurance Ethics, and Financial Exploitation

The SCFHS Code establishes: practitioners are entitled to fair fees equivalent to the going rate; "It is not permissible to exaggerate in the set fees, or abuse the patient's condition to achieve material or moral benefit"; and "It is not permissible to expose the patient to investigations or medical procedures for the purpose of increasing the amount to be paid without a clear medical indication." This provision addresses one of the most common forms of financial exploitation in healthcare: ordering unnecessary tests, referrals, and procedures driven by financial incentive rather than clinical need.

Health insurance creates specific ethical obligations: the physician must not provide false information to insurance companies — either to secure unjustified coverage for patients or to falsely deny legitimate claims; must not inflate claims, fabricate diagnoses, or misrepresent services; and must not allow insurance coverage decisions to compromise the standard of care. The physician who participates in insurance fraud violates the law, their professional obligations, and the Islamic prohibition on deception (ghish, غش).

Key Terms

Term	Definition
Conflict of interest	A situation in which a secondary interest (financial, personal) may compromise professional judgment
Rishwa (رشوة)	Bribery — giving or receiving benefits to influence a judgment that should be made impartially; prohibited in Islam
Taghrir (غرر)	Deception or misleading uncertainty in a transaction; prohibited in Islamic commercial law
Pharmaceutical detailing	One-on-one marketing visits by pharmaceutical sales representatives to physicians
Prescription-linked bonus	Payment or benefit tied to the number of prescriptions written for a specific product; prohibited
Dual practice	Working simultaneously in the public and private healthcare sectors
Fee-for-service	A payment model in which providers are paid per service delivered, creating incentives for overtreatment
Insurance fraud	Submitting false claims, fabricating diagnoses, or misrepresenting services to obtain unjustified insurance payment
Ghish (غش)	Deception in commerce; prohibited in Islam — applicable to fraudulent billing and advertising
Bara'a al-dhimma (براءة الذمة)	Freedom from obligation — the Islamic value of maintaining independence from undue commercial debts

Case Vignettes for Discussion

Case 18.1 — The Conference Invitation

A pharmaceutical company invites you, as a specialist, to an international conference. They will cover all travel, accommodation, and conference fees. In exchange, they ask you to attend a symposium featuring their new drug and to "share your experience" with the drug at your institution. Is this an acceptable arrangement? What does the SCFHS Code say? What conditions, if any, would make acceptance ethical?

Case 18.2 — The Private Clinic Referral

A consultant physician who works full-time at a government hospital has a private clinic on Thursday afternoons. During a morning ward round at the hospital, he sees a patient who needs an elective procedure. He tells the patient: "You could wait four months for this here, or I can see you at my clinic this Thursday and we can schedule it much sooner." Is this ethically acceptable? What principles does it violate? What should the consultant do instead?

Case 18.3 — The Branded Prescription

A patient presents with hypertension. A well-established, inexpensive generic ACE inhibitor would be the evidence-based first-line treatment. However, the physician recently attended a dinner sponsored by a pharmaceutical company promoting a newer, more expensive branded ARB. The physician prescribes the branded ARB. The patient has no insurance and will pay out of pocket. What ethical issues arise? What should the physician have considered before prescribing?

Case 18.4 — The Insurance Claim

A patient presents with a condition that requires a specific investigation. The patient's insurance does not cover this investigation but does cover a more expensive alternative that provides similar information. The patient asks: "Can you put on the form that I need the expensive one? It's covered and it basically does the same thing." What are the physician's legal and ethical obligations? What should they say to the patient?

Further Reading

- Saudi Commission for Health Specialties. Code of Ethics for Healthcare Practitioners. 2014. Chapter 10: Ethics of Financial Affairs.
- Hussein GM, Alkabba AF, Kasule OH. Professionalism and Ethics Handbook for Residents. SCFHS; 2015. Module 10.
- American College of Physicians. ACP Ethics Manual. 7th ed. 2019. Sections on Conflicts of Interest.
- Ministry of Health, Kingdom of Saudi Arabia. Law of Practicing Healthcare Professions. Royal Decree M/59; 2005.
- Al-Jarallah J. Akhlaqiyyat al-Tibb (أخلاقيات الطب). 2021.
- Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 8th ed. Oxford University Press; 2019.

Appendix A: Key International Declarations and Codes

The Hippocratic Oath (Classical Version — Excerpt)

"I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I

suggest such a course... Whatever I see or hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one."

The Nuremberg Code (1947) — Ten Principles (Summary)

1. Voluntary consent of the human subject is absolutely essential.
2. The experiment should yield fruitful results for the good of society, unprocurable by other methods.
3. The experiment should be based on prior animal experimentation and knowledge of the disease under study.
4. All unnecessary physical and mental suffering and injury should be avoided.
5. No experiment should be conducted if there is reason to believe it will cause death or disabling injury.
6. The degree of risk should never exceed the humanitarian importance of the problem to be solved.
7. Proper preparations and facilities should be provided to protect the experimental subject.
8. Only scientifically qualified persons should conduct the experiment.
9. The human subject should be free to end their participation at any time.
10. The scientist in charge must be prepared to terminate the experiment at any stage if continuation appears likely to cause harm.

Declaration of Helsinki (2013) — Key Principles (Summary)

- Respect for the individual and their right to self-determination and to make informed decisions.
- The primary purpose of medical research involving human subjects is to understand the causes, development, and effects of diseases and improve preventive, diagnostic, and therapeutic interventions.
- While the primary purpose of medical research is to generate new knowledge, this goal can never take precedence over the rights and interests of individual research subjects.
- Independent ethics committee review before commencement of research is required.
- Risks and burdens to research subjects must be minimized, and benefits must clearly outweigh risks.
- Both positive and negative results must be published or otherwise made publicly available.

The Belmont Report (1979) — Three Principles

1. Respect for Persons: Individuals should be treated as autonomous agents; those with diminished autonomy are entitled to protection.
2. Beneficence: Do not harm; maximize possible benefits and minimize possible harms.
3. Justice: The benefits and burdens of research should be distributed fairly.

Declaration of Geneva (WMA, 2017 Revision) — Full Text

"AS A MEMBER OF THE MEDICAL PROFESSION: I SOLEMNLY PLEDGE to dedicate my life to the service of humanity; THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration; I WILL RESPECT the autonomy and dignity of my patient; I WILL MAINTAIN the utmost respect for human life; I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; I WILL RESPECT the secrets that are confided in me, even after the patient has died; I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice; I WILL FOSTER the honour and noble traditions of the medical profession; I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due; I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare; I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard; I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat; I MAKE THESE PROMISES solemnly, freely, and upon my honour."

Appendix B: SCFHS Code of Ethics — Summary

The Saudi Commission for Health Specialties Code of Ethics for Healthcare Practitioners (2014) is a legally binding document governing the conduct of all registered healthcare practitioners in Saudi Arabia. The following is a structured summary of its key provisions.

Chapter 1: Healthcare Practitioner Ethics

- Devotion and feeling the worship of Allah — the practitioner's work is an act of service and worship.
- Demonstration of the best of manners (husn al-akhlaq) in all professional interactions.

- Self-accountability (muhasabah) — regular review of one's own conduct and commitment to improvement.
- Avoidance of trivialities and conduct that demeans the dignity of the profession.

Chapter 2: Duties Towards Patients

- Good treatment and respect for patient dignity regardless of condition, nationality, religion, or social status.
- Acting in the patient's genuine interest — not influenced by financial or personal considerations.
- Obtaining proper informed consent before any procedure.
- Reassuring the patient and maintaining therapeutic hope without deception.
- Maintaining complete patient confidentiality — not disclosing information except with consent or as required by law.
- Not photographing patients or recording their voices without explicit consent.
- Respecting the patient's right to refuse treatment.
- Acknowledging the right to conscientious objection while ensuring continuity of patient care.

Chapter 3: Duties Towards Community

- Serving the health needs of the wider community, not only the individual patient.
- Contributing to health promotion, disease prevention, and health education.
- Reporting communicable diseases and public health hazards as required by law.
- Participating in the training of the next generation of healthcare professionals.

Chapter 4: Duties Towards Professional Colleagues

- Maintaining respectful, collegial, and professional relationships with all colleagues.
- Reporting unsafe or unethical conduct by a colleague to the responsible authority.
- Not undermining a colleague's professional reputation unfairly.
- Cooperating with consultations and referrals promptly and professionally.

Chapter 10: Ethics of Financial Affairs (Key Provisions)

- Practitioners are entitled to fair fees equivalent to the going rate; exaggeration of fees is prohibited.
 - Performing investigations or procedures for the purpose of increasing payment without medical indication is prohibited.
 - Bribes — in any form — are absolutely prohibited (one of the major sins in Islamic Sharia).
 - Expensive gifts from commercial entities are prohibited regardless of the justification given.
 - Prescription-linked bonuses from pharmaceutical companies are prohibited.
 - Direct personal gifts from commercial companies in any form are prohibited.
 - In dual practice, public sector obligations must be fully met and must not be used to attract patients to private practice.
 - Healthcare advertising must be accurate, must not demean competitors, and must not claim unauthorized skills or qualifications.
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Appendix C: Ethical Decision-Making Frameworks

The Four-Topic (Jonsen-Siegler-Winslade) Framework

The four-topic framework is the most widely used systematic approach to clinical ethics case analysis. Apply it in the following sequence:

Topic 1: Medical Indications (Beneficence and Non-maleficence)

- What is the patient's medical problem? Is it acute, chronic, critical, or reversible?
- What are the goals of treatment: cure, palliation, rehabilitation, or comfort?
- What are the benefits and harms of each treatment option?
- What happens if no treatment is given?
- Is there a point at which further treatment is futile?

Topic 2: Patient Preferences (Autonomy)

- Has the patient been informed about their condition and options in an understandable way?
- Does the patient have the capacity to make this decision?
- What are the patient's expressed preferences? What do they value most?
- Has the patient made any advance directives?
- If the patient lacks capacity, who is the appropriate surrogate decision-maker?

Topic 3: Quality of Life (Beneficence, Non-maleficence, and Autonomy)

- What are the prospects for returning to the patient's normal life with and without treatment?
- What physical, psychological, social, or spiritual burdens does the proposed treatment impose?
- How does the patient define quality of life for themselves?
- Are there biases that might affect the clinical team's assessment of the patient's quality of life?

Topic 4: Contextual Features (Justice)

- Are there family members whose interests or preferences bear on the decision?
- Are there institutional policies, legal requirements, or resource constraints that affect the options?
- Are there conflicts of interest — financial, professional, or personal — that might influence the clinical team's recommendations?
- Are there cultural or religious factors relevant to the clinical team or the patient?

The Islamic Ethics Supplement

After applying the four-topic framework, ask these additional questions:

1. Is there a relevant Quranic verse, Prophetic hadith, or established jurisprudential rule (qa'idah fiqhiyyah) that applies directly to this situation?
2. Does the Islamic framework converge with or diverge from the secular bioethical analysis? If it diverges, how should the divergence be navigated?
3. Does the principle of darura (necessity) apply — is there a genuine necessity that permits an otherwise restricted act?
4. Does the maqasid al-shari'ah framework (preservation of life, intellect, progeny, wealth, and religion) help clarify the priority of competing considerations?
5. Are there Islamic scholarly rulings (fatawa) from recognized authorities (such as the Islamic Fiqh Council, the Saudi Council of Senior Scholars, or the Islamic Organization of Medical Sciences) that

address this specific scenario?

Quick Reference: The Six-Step Process

1. Identify: What are the ethical issues in this case?
 2. Gather: What are the clinical facts, patient preferences, quality of life considerations, and contextual features?
 3. Analyze: What do the four principles say? What does the Islamic framework say? Where do they agree and disagree?
 4. Deliberate: What options are available? What are the consequences and moral implications of each?
 5. Decide: What is the most defensible course of action given all the considerations?
 6. Justify: Can you clearly articulate why this course of action is ethically preferable to the alternatives?
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Appendix D: Glossary of Key Terms

This glossary provides concise definitions of key terms used throughout this guide. Arabic terms are provided with transliteration and English translation. Entries are arranged alphabetically.

Term	Definition
Advance directive	A document in which a competent person specifies wishes for future medical care in the event they lose capacity.
Al-idhn al-tibbi (الإذن الطبي)	Medical permission — the Islamic concept analogous to informed consent.
Algorithmic bias	Systematic discrimination in AI outputs arising from unrepresentative training data.
Amanah (أمانة)	Trustworthiness — the Islamic obligation to discharge responsibilities faithfully; frames confidentiality as a sacred trust.
Autonomy	The right of a competent person to make informed decisions about their own care, free from coercion.
Beneficence	The duty to act in the patient's best interest — actively doing good.
Brain death	Irreversible cessation of all functions of the entire brain including the brainstem; constitutes legal death in Islamic jurisprudence.
Capacity	The clinical ability to understand information, appreciate its relevance, reason about options, and communicate a decision.
Confidentiality	The physician's obligation to use patient-disclosed information only for the purpose for which it was shared.
Conflict of interest	A situation in which a secondary interest may compromise or appear to compromise professional judgment.
Darura (ضرورة)	Necessity — the Islamic principle that may permit otherwise prohibited acts when genuinely required.
Deontology	Ethics based on duties and rules, regardless of consequences.
DNR order	Do-Not-Resuscitate order — a clinical instruction that CPR should not be attempted.
Fabrication (research)	Inventing research data that was not actually observed.
Falsification (research)	Manipulating research data to misrepresent actual observations.
Fitrah (فطرة)	The natural human constitution with which Allah created human beings; relevant to limits on cosmetic modification.
Four-topic framework	A systematic tool for analyzing clinical ethics cases: medical indications, patient preferences, quality of life, contextual features.
Futility (medical)	Treatment that cannot achieve a clinically meaningful goal or that provides no benefit to the patient as a person.
Hifz al-nafs (حفظ النفس)	Preservation of life — one of the five objectives of Islamic law (maqasid al-shari'ah).
Ihsan (إحسان)	Excellence — the Islamic obligation to perform one's work to the highest standard.

Informed consent	A patient's voluntary, adequately informed agreement to a proposed treatment or procedure.
Justice	The fair distribution of benefits and burdens in healthcare.
Karama (كرامة)	The inherent Allah-given dignity of every human being — a foundational concept in Islamic ethics.
La darar wa la dirar (لا ضرر ولا ضرار)	"Do no harm and cause no harm to others" — the Prophetic principle grounding non-maleficence in Islamic medicine.
Maqasid al-shari'ah (مقاصد الشريعة)	The five objectives of Islamic law: preserving life, intellect, progeny, wealth, and religion.
Medical malpractice	Professional negligence — deviation from the standard of care causing patient harm.
Non-maleficence	The duty to avoid causing harm — primum non nocere.
Palliative care	Active total care of patients with life-limiting illness, focused on quality of life and relief of suffering.
Paternalism	Overriding a patient's preferences on the grounds of acting in their best interest.
Plagiarism	Presenting another's words, ideas, data, or images as one's own without proper attribution.
Professionalism	The values, behaviors, and relationships that fulfill medicine's contract with society.
Proxy consent	Consent given by an authorized representative on behalf of a patient who lacks capacity.
Rishwa (رشوة)	Bribery — giving or receiving benefits to influence a judgment that should be made impartially; prohibited in Islam.
Sidq (صدق)	Truthfulness — a foundational Islamic moral virtue directly governing honest reporting.
SPIKES protocol	Setting, Perception, Invitation, Knowledge, Emotions, Strategy — a framework for breaking bad news.
Surrogate decision-maker	A person authorized to make healthcare decisions on behalf of a patient who lacks capacity.
Taghyir khalq Allah (تغيير خلق الله)	Changing Allah's creation — the Quranic basis for restrictions on certain forms of body modification.
Virtue ethics	Ethics focused on the character and moral dispositions of the agent rather than rules or outcomes.
Wilayah (ولاية)	Guardianship in Islamic law — authority to make decisions on behalf of a minor or incapacitated person.

Appendix E: List of Abbreviations

Abbreviation	Full Term
ABIM	American Board of Internal Medicine
ACP	American College of Physicians
AMA	American Medical Association
ART	Assisted Reproductive Technologies
BDD	Body Dysmorphic Disorder
BMA	British Medical Association
CME	Continuing Medical Education
COPE	Committee on Publication Ethics
CPR	Cardiopulmonary Resuscitation
DCD	Donation after Circulatory Death
DBD	Donation after Brain Death
DNR / DNAR	Do Not Resuscitate / Do Not Attempt Resuscitation
EHR	Electronic Health Record
EQUATOR	Enhancing the QUALity and Transparency Of health Research Network
GRS	Gender Reassignment Surgery
ICMJE	International Committee of Medical Journal Editors
IOMS	Islamic Organization of Medical Sciences
IRB	Institutional Review Board
IVF	In Vitro Fertilization
KKU	King Khalid University
LLM	Large Language Model
MBBS	Bachelor of Medicine, Bachelor of Surgery
MOH	Ministry of Health (Saudi Arabia)
NCBE	National Committee of Bioethics (Saudi Arabia)
NLP	Natural Language Processing
OIC	Organisation of Islamic Cooperation
PGD	Pre-implantation Genetic Diagnosis
PI	Principal Investigator
REC	Research Ethics Committee
SCFHS	Saudi Commission for Health Specialties
SFDA	Saudi Food and Drug Authority
STI	Sexually Transmitted Infection
WAME	World Association of Medical Editors
WMA	World Medical Association