Doctor-Patient Relationship in Islamic Context

Dr Hassan Chamsi-Pasha MD, FRCP, FACC
Head of Non-Invasive Cardiology
Department of cardiology
King Fahd Armed Forces Hospital, Jeddah, Saudi Arabia
Counselor to The International Islamic Fiqh Academy
drhcpasha@hotmail.com

Dr Mohammed Ali Albar MD, FRCP (Lond)
Director of Medical Ethics Center
Department of Medical Ethics
International Medical Center, Jeddah, Saudi Arabia
Counselor to The International Islamic Fiqh Academy and Islamic Fiqh council
malbar@imc.med.sa

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Summary

The doctor-patient relationship constitute one of the foundations of contemporary medical ethics. It is the cornerstone of the practice of medicine and essential for delivering high-quality health care. In the current era, the financial targets, sophisticated investigations, media, and internet, all distract from the central, human interaction between physician and patient. Good doctor–patient communication is mandatory in all branches of medicine. Obtaining informed consent must be culturally sensitive, and is the first step to an appropriate communication respecting the patient's values. Protecting confidentiality has a vital importance in Islam. In specific circumstances, an individual can be lawfully authorized to release negative information about specific individuals. When treating a Muslim female patient, recognizing and understanding her concerns about modesty is invaluable in developing an unruffled physician-patient relationship. Breaking bad news will always be one of the most intimidating tasks facing physicians and drastically affect patients and their loved ones. Formal training in breaking bad news is strongly encouraged.

Introduction

The doctor-patient relationship is a central concern of both medical ethics and practice, as it stresses how the interaction between the doctor and patient ought to be. The first consultation with a patient is the beginning of a doctor-patient relationship. Hence it is of major importance to conduct this in a proper and correct way. Consulting with a patient is a complicated skill that is gradually learned during medical training and perfected when one becomes an experienced doctor (Terpstra 2012).

Beyond the consulting rooms, for instance in the hospital ward, the doctor-patient relationship is far more complex as it is beyond just the two interacting individuals, since many other people are involved when somebody is sick. These include patient's relatives and neighbors, nurses, technicians, social workers and others such as hospital administrators (Balint 2008).

It has been proposed that an ideal doctor–patient relationship (DPR) has six components, namely voluntary choice, doctor's competence, good communication, continuity, doctor's empathy, and absence of conflict of interest. A poor DPR, on the other hand, has been proved to be a major hurdle for both doctors and patients, and will eventually affect the quality of healthcare provided and the ability of the patients to cope with their illness. In the case of poor DPR, patients do not show compliance with doctor's advice; they may practice doctor-shopping by frequently changing their doctors; remain anxious; may choose quacks or other non-scientific forms of treatment; and result in a significant increase in medical expenses (Terpstra 2012).

The DPR has changed dramatically over the years due to the commercialization, quality of healthcare services offered in government set-up, and privatization of the health sector, especially in developing countries. Doctors may, nowadays, ask for unnecessary investigations or may give over-prescriptions, just to be safe. There is also a remarkable decline in human touch or empathy; and a significant rise in unhealthy competition among doctors.

The modern medical science is technology based and there is investment behind the technology. Many doctors do not think of the low socioeconomic condition of their patients. The patients, therefore, think of the doctors as avaricious and hungry for money. The poor farmer imagines his dark future when he looks at the costly medicines and expensive investigations. He looks blankly to the prescription as if he sees the document of his sold last belongings (Islam 2012).

Factors like socio-cultural determinants, poor communication skills of the doctors , use of medical terms by the clinicians , doctors not listening to their patients complaints, and a mismatch between the doctors' objectives and patients expectations, have together created a wide gap in the DPR. All these factors have caused a massive impact on the trust level and the bonding pattern between the physicians and their patients (Banerjee 2012).

Doctor must feel the distress of the patient cordially and do his best to eradicate the disease of the patient not only the symptoms. Without full understanding of the cultural background of the patient, it is impossible to make an effective relationship with the patient.

Doctor's manners in Islam

Preservation of life entails seeking remedy, and that requires knowledge of medicine. Imam Shafi'i (d 204H/820 CE) said that knowledge (science) has two main branches: One of religion and the second of human body (al ilm ilman ilm al adyan and ilm alabdan) It is incumbent of Muslim community to produce health professionals, and it is considered a sin for the whole community if they do not produce the required number of healthcare professionals.

Al Izz ibn Abdul Salam, a renowned Islamic jurist (d 660H/1243 CE) in his book "Qawa'id al Ahkam (Basics of Rulings)", said: "The aim of medicine, like the aim of Shari'ah (Islamic law), is to procure the maslaha (utility or benefit) of human beings, bringing safety and health to them and warding off the harm of injuries and ailments, as much as possible". He also said: "The aim of medicine is to preserve health; restore it when it is lost; remove ailment or reduce its effects

To reach that goal it may be essential to accept the lesser harm, in order to ward off a greater one; or lose a certain benefit to procure a greater one". This is a very pragmatic attitude, which is widely accepted, in Islamic jurisprudence, and it is frequently applied in daily practice in all fields including medicine (Albar, Chamsi-Pasha 2015).

The Quran and sayings of the Prophet Muhammad Peace Be Upon Him (PBUH) established morality and mode of conduct of physicians and surgeons. The Prophet gave many rules regarding seeking remedy, and the importance of consent. The Islamic jurisprudents required from the practitioner to be competent and obtain licensed to practice. He also should get the consent of the patient or his guardian if he is not competent, otherwise he would be liable.

The Quran and Sunna teach the Muslim physician the importance of possessing good "khuluq"

(Manners) which incorporate mercy, patience, tolerance, kindness, and honesty, while avoiding pride, arrogance , and anger (Arawi 2011).

The term beneficence implies acts of mercy, kindness, charity, altruism, love, and humanity. Beneficence is so intimate to the principle of non-maleficence, but it is so dominant to other principles that we can say the principle of beneficence is the starting point in all kinds of human relations. The whole Qur'an and Hadiths of the Prophet Muhammad are full of verses (ayas) and sayings of the Prophet enjoining doing good and refraining from doing harm (Chamsi-Pasha, Albar 2013A). The Qur'an says: "So whosoever does good equal to the weight of an atom (or a small ant), shall see it. And whosoever does evil equal to the weight of an atom (or a small ant), shall see it."(Quran 99/7, 8)

One of the earliest and most thorough books on medical ethics is entitled "Adab al-Tabib" (Practical Ethics of the Physician) by Ishaq ibn Ali al-Ruhawi. Al-Ruhawi was a contemporary to Abu Bakr Al-Razi and lived in the second-half of the ninth century A.D. This book was translated to English by Martin Levey in 1967 (Transactions of the American Philosophical Society). Al-Ruhawi stated that the true physician is the one who fears God, the word fear here enclose love and respect. His conscience is his censor, and he is aware that God's eye is ever watching.

Al-Razi has also written a book fully devoted to medical ethics called "Akhlaq al-Tabib" (Medical Ethics). To establish such opinions in a well-organized book over a thousand years ago is quite significant. Besides, these ideas still maintain their validities nowadays and are laid down in several ethical codes of medicine (Chamsi-Pasha, Albar 2013B).

According to Al-Razi, the physician has duties to the patients. The first of which is to treat the patients kindly, not to be rude or aggressive but soft-spoken, compassionate, and behave modestly. Al-Razi stresses that the second duty is to keep the secret they have learnt during the treatment process of their patients. This principle, put forward by Al-Razi, takes place in the Hippocratic Oath. Another duty is to encourage the patient psychologically. The physician should encourage the patients even who have no hope of recovering from their diseases and instill this hope in them. To Al-Razi, another duty of the physician to his patients is to treat the patients equally regardless of their wealth or social status. The aim of the physician should not be the money he will get after treatment but the cure. Physicians should be even more eager to cure the poor and homeless than curing the rich. On the other hand, the patient has also duties to the

physician. According to Al-Razi, the first thing for a patient to fulfill is to treat the physician kindly and to talk gently. Al-Razi, in this point, supports Hippocrates by quoting his words. 'Find your physician and prepare him before you need him' (Al-Razi 2001)

Patients and students of medicine frequently complain about attending physicians who do not want to spend more than minimal time with them and lack patience in answering their worries or queries. The physician should always be honest, benefit his or her patients, and speak kind words to others. The Sunna warns against pride and arrogance, two major transgressions that have marked modern medicine. Several studies revealed the public dismay at the attitudes of physicians who often act with superiority towards their colleagues and patients. A primary complaint commonly found in these studies is that physicians are often arrogant and prideful. The Prophet (PBUH) said: "Allah will not look, on the Day of Resurrection, at a person who drags his izār (garment) [behind him] out of pride and arrogance (Sahīh Al-Bukhārī).

The physician must behave in a way that does not abuse the societal advantage given to him or her directly or indirectly. With the advancement of diagnostic medical technology, many modern physicians refer their patients for sophisticated investigations without even performing a physical examination, thus failing to treat the patient as a human and instead treating the patient as a number or a disease to be dealt with as rapidly as possible. With health systems facing financial problems, physicians often see their patients as customers, and medicine is turning into a market place. Many medical codes of ethics request that physicians waive their fees for poor patients. In reality, waivers are often granted to rich and powerful patients who could provide physicians with societal benefits (Arawi 2011). The Prophet (PBUH) said: "Feed the hungry, visit the sick and set free the captives" (Sahīh Al-Bukhārī).

Medical Profession is unique in that the client is not denied the service even if he cannot afford the fee. In private practice, the Doctor's fees are his lawful right and his earnings are legitimate. If medical necessity or emergency, however, puts a needy person under his care, it should be the Doctor's duty to be considerate and kind, and avoid his fees if any being a further burden atop of the ailment. For as you give the poor it is God you are giving and alms giving is not only due on material possessions but on knowledge and skills too.

Fully entitled to make a decent living and earn a clean income a Doctor shall always honor the high standards of his profession and hold it in the highest regard, never prescribing to activities of propaganda, receiving a commission or cutting earnings or similar misdoings. The way a

Doctor deals with his various patients is a perfect portrayal of his personal integrity. The sphere of a Doctor's charity, nicety, patience and tolerance should be large enough to encompass the patient's relatives, friends and those who care for or worry about him but without of course compromising the dictates of "Professional Secrecy". (Islamic Code of Medical Ethics 1981).
It is imperative for a Muslim doctor to always remember the Prophet Muhammad saying:
"The best among you are those who have the best manners and character" (Sahīh Al-Bukhārī).

The Family role

One major factor that must be considered in the care of Muslim patients is the importance of the family. The fundamental roles of education, spiritual development, and distribution of traditions and practices are shared within the context of a stable family. This unit provides both security and support for its members and often includes close relatives. Elders are treated with kindness and respect, and children are loved and cherished (Ott 2003). Even in the context of a hospitalization, parents often assume direct responsibility for the care of their children.
It is not uncommon for elderly parents to care for their sick adult children, or for their distant relatives. Commonly, one or both parents request to remain with the child at all times. Similarly, adult children are also obliged to care for their parents, and this responsibility frequently extends to both in-laws and grandchildren. Providing additional bedding and meals, or allowing relatives to remain with their family member after visiting hours would permit parents or children to fulfill their family obligation. Likewise, permitting a parent or family member to attend simple procedures or to accompany his or her loved one to surgeries would be beneficial. However this may be prevented if the relative is weak-hearted, as he may faint when seeing blood or operative intervention, or may be intrusive, and even may be a source of trouble during the operation. During such events, relatives often recite prayers or read the Quran, appealing for the cure of their loved ones. Recognizing these issues and appreciating their importance is a key step in caring for Muslim families (Hussain 2010). Besides, visiting family and friends in the hospital is extremely important in Islam. Muslims are required to visit those who are sick or injured and provide patients and their families with comfort and support. The teachings of Islam dictate that Muslims not only meet with those who are ill but also converse with them, provide words of encouragement, and pray for their well-being and prompt recovery. This important obligation is vital to the care of Muslim patients, and measures should be taken to accommodate these

visitations (Hussain 2010, Ott 2003). However, it is important to recognize that these events may provide additional stress to the nursing staff or adjacent patients sharing semiprivate rooms. In a recent survey of an intensive-care-unit nursing staff caring for Muslim patients in Saudi Arabia, families and friends were viewed as providing additional demands and distractions to the nursing staff (Halligan 2006).

Communication and Informed consent

One of the most important roles for a physician is facilitating communication. The effective transfer of information from the doctor to the patient for his or her full understanding is vital to the success of a healthy physician-patient relationship. Many barriers to information exchange can arise when Muslim patients are treated in the clinic or hospital. Regardless of the means, overcoming language barriers is mandatory for effective communication. As physicians, we have to talk both with our patients about future issues that will affect their health and with each other about the patients we share (Frey 2013).

Basic requirements of informed consent include a discussion and an enumeration of risks, benefits, and alternatives. This discussion should address either serious or frequent risks or both. Patients should be encouraged to ask questions and express concerns. The process should be voluntary and without coercion. In addition, this procedure must be witnessed (Packer 2011).

It must be comprehended by all parties involved. An interpreter may be beneficial in obtaining informed consent from patients whose native language is not that used in the consent form.

In certain circumstances, patients would prefer not to make decisions by themselves. They often wish to share decision-making with their family or physician or want others to make decisions on their behalf. We should ask first who they want to engage in the decision-making process and how they want to make decisions, rather than what decision they want to make (Terry 2006).

The history of informed consent focused on the principle of autonomy. As noted by Beauchamp and Childress: “A person’s decision is autonomous if it comes from the person’s values and beliefs, is based on adequate information and understanding, and is not determined by internal or external constraints that compel the decision” (Beauchamp, Childress 2013). Clearly, all of this works in a dyadic view if the patient is competent, if the situation is not an emergency, or the patient states that he does not want to be informed.

The ‘four principles’ are prevalent throughout Western and Eastern cultures, however, the weight with which they are considered and their understanding differ. Although the principle of autonomy is acknowledged in Islam, the right is restricted by Islamic law and there are certain differences in the understanding and applications of autonomy. Accordingly, the principle of autonomy does not bear the same weight as it does in many Western cultures. Autonomy is only applicable for actions that are permissible in Islamic teachings where an individual should not inflict on himself, his own property and honor, actions that are deemed forbidden, as the rights of God supersede individual rights (Chamsi-Pasha, Albar 2013 A).

Physicians must give patients proper informed consent and right of informed refusal. The patient must be aware of, understand, and accept the risks of leaving out this action and this should be documented.

Obtaining patient’s permission prior to delivering medical treatment is obligatory in Islam if the patient has full legal capacity, or their legal guardian if the patient is a minor. This is only if the treatment prescribed is permissible. However, according to the International Fiqh Academy (1992), consent is not required if the treatment and the medical procedures are needed in emergency to save a life, or organs, when the patient is unconscious or a minor, and no guardian is available, or in cases of contagious diseases and preventive immunizations ordered by the health authorities . Similarly, consent is not a required if a minor’s legal guardian refuses to give permission and it is clearly detrimental to the patient under his/ her guardianship.

While this may be different to the conventional law in medical practices, it is derived from the principles of fiqh (Islamic Law), “harm should not be inflicted nor reciprocated” (laa dharara wa laa dhiraar), and “public interest should be prioritized over personal interest” (al-maslahah al-‘am tuqaddam ‘alaa al-maslahah al-khassah). Hence, refraining from treatment is an act of misconduct if the treatment is obligated, and preventing misconduct is an obligation upon all Muslims (Sharifudin 2014).

<u>Advice and Waiver</u>

Sometimes the patient may say to his doctor: “What is your advice in my condition? What would you do if your parent was in my situation? The physician may feel embarrassed, but he/she should be honest and give the sincere advice. The matter may be more complicated when the patient relegates the decision-making to the doctor saying: “Look I have trust in you, and whatever you decide I will accept.” The physician should be tactful and try to explain the

situation and give information to the patient and/or his family, and reach with them the course to be taken. As far as he can make it, the physician should explain that the decision should be in the hands of the patient and his family. He might help by giving all the required data, and give his personal advice.

In cases where the patient does not want to know the diagnosis, the physician should discuss the condition fully with the family, and let them try to persuade the patient, at least to take part in the decision-making .The question of confidentiality will crop up here, if the family gets to know the details of the ailment and its management. If the patient agrees to divulge the intricacies of his medical condition to the family or proxy, then there is no breaking of confidentiality, as it is done after getting the consent of the patient himself. (Albar, Chamsi-Pasha 2015)

Informed consent in clinical research

Clinical research has created a more complicated informed consent process that exceeds the subject's capacity to understand what participation entails. Clinical investigators should be aware that the informed consent document alone does not assure the subject's full understanding of their participation. Therefore, before the subject makes his decision, the research team should discuss the study purpose and procedures, risks and benefits, and the rights and obligations of the participant. If the subject decides then to participate, he will sign the consent form. Furthermore, even after the subject decides to participate in the study, the research team should continue to draw the participant attention to any new information that may affect his situation. Before, during, or after the study, subjects should also have the opportunity to ask questions and discuss any issues they may encounter. Thus, informed consent is a continuous process, rather than a single training session (Alahmad 2012, Chamsi-Pasha, Albar 2008).

When obtaining informed consent in situations that involve end-of- life decisions, the patient's values gain importance, and the physician acts as an advisor, rather than an agent.

Cross-gender relations in the doctor- patient relationship

Gender roles, relationship dynamics and boundaries are culture specific, and are frequently shaped by religious teachings. It requires acknowledgement of the importance of cultural practices in patients' lives and working to minimize the negative consequences of cultural differences in medical care (Padela, Rodriguez del Pozo 2011). For example, if you ask an American unmarried girl if she has children, she would not be offended. However, if an

unmarried Muslim girl asked the same question she would be offended since such girl does not usually participate in relations outside of wedlock.

Dress code

The Qur'an tells both men and women to 'lower their gaze and guard their modesty' and further addresses women to 'not display their beauty and ornaments except what (must ordinarily) appear thereof (Quran 24:30-31).' A statement of the Prophet Muhammad (PBUH) goes further 'it does not suit (a woman past the age of menarche) that she displays her parts of body except this and this' pointing to the face and hands (Sunan Abu Dawud). These verses and multiple other Traditions from the Prophet (PBUH) form the basis of an Islamic dress code, specifically the regulations of "awrah", the areas of the body that must be clothed. These regulations are intended to safeguard honor and dignity (Padela, Rodriguez del Pozo 2011).

Muslim women often choose to cover their hair with a scarf called a hijab, and it is essential that physicians respect this decision and allow them to do so whenever possible. For example, even when going to the operating room for surgery, it is preferable to allow a Muslim woman to wear her hijab in addition to the hospital gown. If this is not permitted, using a surgical head and neck covering can allow a woman to maintain her sense of comfort and dignity without compromising hospital and operating room policy (Hussain et al 2010).

When the patient gown is a necessity, hospital staff could offer to keep the curtains drawn, or the door closed, so that patients could be saved from onlookers. Another effective way is a 'knock, wait, enter' policy by which staff knock, wait for permission and then enter patient rooms. It must be stressed that the clinician uncover only that part of the body that needs to be examined, and cover those that are not part of the exam or have been examined already (Padela, Rodriguez del Pozo 2011).

Avoiding unnecessary exposure is an important priority. In the clinic, asking a Muslim woman to undress and apply examination shorts or a robe may be uncomfortable for her. Muslim women are encouraged to wear loose fitting clothing that can be stretched to allow adequate exposure for examination while maintaining as much coverage as possible. Although a patient may be unconscious, covering the genital area in the operating room with a surgical towel during skin preparation is also encouraged and conveys an additional element of trust between the patient and the surgeon (Hussain et al. 2010).

Seclusion

"Khalwah" is defined as the situation where a 'man and a woman are both located in a closed place alone and where sexual intercourse between them can occur'. This situation is prohibited between non-mahram (a very close relative or husband) adult members of opposite sexes in order to prevent the accusation, and committal of, illicit relations.

This prohibition stems from Prophetic traditions stating that when a non-mahram male and a female are alone, 'Satan' is the 'third among them' and his stating that 'a man must not remain alone in the company of a woman' (Sahīh Al-Bukhārī).

Physical contact between the sexes

There is also more sensitivity on the part of the patient, both man and woman, in the Islamic ethics. The patient does not want to be looked at completely naked when being examined, so their interest and privacy is considered more.

A Muslim doctor examining a female patient must have a third party in room (i.e. nurse) in order to have a go between so that the issue of sexual harassment will not be a serious problem.

Also, there is extreme sensitivity about the question of virginity in the unmarried Muslim girl. The rate of virginity in Muslim girls at the age of marriage should be in the region of 100% and so it should only be a last resort to do a vaginal examination to the unmarried girl (Hathout).

The Qur'an exhorts 'Nor come nigh to adultery: for it is a shameful (deed) and an evil, opening the road (to other evils)' (17:32), and thus Islamic law not only prohibits adultery but also strictly regulates physical contact since the verse bars 'proximity' to adultery.

Most Islamic scholars believe that a patient seeking non urgent treatment should choose a physician according to the following order of decreasing preference: Muslim of the same gender, non-Muslim of the same gender, Muslim of the opposite gender, non-Muslim of the opposite gender.

Provider of the same faith is recommended based on the assumption that a Muslim physician would be able to advise the patient when medical treatment takes precedence over religious obligations. Islamic law does allow for deviation from normal regulations in cases of need and emergency.

All Muslim scholars state that necessity allows things that are ordinarily forbidden to be permissible. Ibn Qudama, an eighth-century Hanbali scholar, writes: ''It is permissible for the

male doctor to inspect whatever parts of the woman's body that the medical examination warrants.'' Ibn Muflih, also of the Hanbali school state: ''if a woman is sick and no female doctor is available, a male doctor may treat her. In such a case, the doctor is permitted to examine her, including her genitals.'' Scholars are also clear that female doctors may fully examine male patients in cases of necessity. In all cases, a third party of the same gender as the patient is required to be present for the examination (Aldeen 2007).

A provider holding the hand of a patient who just lost a family member may be viewed as a boundary crossing by some and compassionate by others. Some Muslim women choose not to shake hands with unrelated males, even in the context of business and health. This abstinence is not a sign of disrespect but is simply an expression of a Muslim woman's display of her belief. The doctor may ask a Muslim woman how she would like to be greeted and this can avoid potential embarrassment for the patient and misunderstanding by the doctor (Hussain 2010).Physical contact outside of the examination should always be approached with caution. Understanding a Muslim woman concerns about modesty is invaluable in developing appropriate physician-patient relationship.

Confidentiality

Professional confidentiality is one of the basic components in building a constant physician-patient relationship. Keeping patient's secrets and maintaining confidentiality is a legal and ethical duty, and disclosure of such secrets is permitted in different legal systems such as notification of births and deaths, infectious diseases, child abuse, sport and relevant events, medical errors, drug side effects and dangerous pregnancies (Milanifar 2014). The Muslim physicians were keeping the secrets of the patient, his family and even his servants and slaves, whom the physician comes across while visiting the patient at his home. This attitude is also part and parcel of benefiting the patient "Beneficence" and not doing any harm to him "Non Maleficence". However, if divulging the secret may be of benefit to the patient, as considered by his physician, then it should be exposed, as far as it is beneficial to him or warding off harm thwarted against him.

Breaking confidentiality to prevent harm e.g. if a psychiatric patient tells his doctor that he is going to kill a person (due to delusions and hallucinations), then the psychiatrist has a duty to inform the police, and also to inform the person to be attacked, so that he may take steps to avoid

being attacked. Similarly if a consort is having HIV, then the physician has a duty to inform the other consort of the true diagnosis (i.e. HIV). He should take the permission from the infected person, or require him to tell his consort in his presence of the true diagnosis; otherwise he would be allowing harm to occur. If the health authorities require reporting infectious diseases, then it should be reported, so that measures could be taken to protect the whole community; and breaking confidentiality in such cases is allowed. If the magistrate ordered the physician to divulge the true diagnosis, in most cases he has to obey, lest he would be accused of obstructing justice (Albar, Chamsi-Pasha 2015).

Medical confidentiality is an important concept in Islam based on the three Islamic principles: first, the prohibition of backbiting, as mentioned in Quran: 'neither backbite one another' (Qur'an, 49:12); second, the duty to protect secrets; and third, the consideration of the protection of confidentiality as a kind of loyalty, which has to be saved from harm (Alahmad 2012).

A number of revelation texts in the Quran and Hadith emphasize the importance of avoiding negative conversations about other people in their absence (backbiting) even if the facts discussed are true and even after they have died. This is based on several Quranic verses: 'Those who are faithfully true to their Amanât (all the duties which Allâh has ordained, honesty, moral responsibility and trusts) and to their covenants' (Qur'an, 23:8).

In a fatwa issued in1993 by the International Islamic Fiqh Academy, jurists affirmed that a breach of confidentiality can be acceptable only if the harm of maintaining confidentiality overrides its benefits. This fatwa is the most important fatwa to deal with confidentiality and clearly states the obligation of maintaining medical confidentiality in the medical profession. Moreover, it elucidates some situations in which breaching confidentiality is allowed or mandatory (Alahmad 2012).

Visual recording

Visual recording of human subjects is commonly used in biomedical disciplines for clinical, research, legal, academic and even personal purposes. It is most prevalent in the specialties of plastic surgery, wound care, otolaryngology, dermatology and maxillofacial surgery. Images are also commonly used for academic purposes, including publication, training biomedical professionals, and educating the public. The judicial system can require recordings as evidence of an alleged assault. The literature suggests that there are both detrimental and favorable effects

of recording human subjects. Guidelines on practice standards of biomedical recording have been issued by certain health authorities, associations and journals.

Muslim jurists' rulings on human recording vary from permissible to discouraged and forbidden. However, the ruling is ultimately dependent on the purpose of the recording, the intended use of the images, the way in which the recording session is conducted, the type of images captured, and potential consequences of the whole experience. For images to be deemed permissible, all of the aforementioned circumstances must not contradict the Shari'ah (Islamic legal system).

Subjects must receive an explanation about the recording, including the purpose, process, withdrawal of consent, confidentiality and use of the images.

Written consent should be obtained from the patient or his/her legal representatives before the procedure. Subjects' rights and dignity must be respected, with their cultural and religious background taken into consideration. Only the minimum necessary area should be photographed. Images should be securely retained, with access restricted to authorized personnel with justified reasons for viewing the images. Islamic code of conduct must be observed during the recording sessions, where the rules of modesty and cross-gender interaction apply.

Conventional standards strongly recommend the use of a chaperone in the presence of semi or fully naked subjects of the opposite sex, while the Islamic standard obligates the use of chaperones whenever a photographer is dealing with a subject of the opposite sex in an enclosed space, regardless of the extent and area of exposure (Saidun 2013).

Disclosure

One of the challenging decisions to clinicians is whether to disclose the information to the patient, or to conceal it from the patient and disclose it to the family instead. The impact of the truth on the patient depends largely on how it is told. The patient can be prepared by choosing the right time, revealing the news gradually, showing empathy and concern (we will continue to do our best), concentrating on what is more distressing to the patient (pain, discomfort, death, and so on) and softening the news (nobody knows exactly, healthy people die for non-medical reasons, life doesn't end here, you have a chance to put your affairs in order, an opportunity that a lot of people don't have). It may be impossible to conceal the information from the patient. The DPR is based on honesty, trust and respect for the patient's autonomy as well as beneficence to the patient. Disclosure to the patient would improve trust in physicians in general and relieve the

family from the burden of breaking the bad news. The majority of patients' relatives who don't want the patient told would themselves wish to know if they developed the condition. Disclosure to the patient may cause undue distress and even suicide. Patients react differently to being told that they have a terminal illness.

An ethical dilemma physicians frequently face, is informing patients about their terminal illness, or an incurable disease that is expected to result in death within a short period of time. Disclosure of such crucial information to the patient can be considered harmful by the physician and/or patient's family. On the other hand, not telling the patient the truth or revealing it to the family without his/her permission violate the patient's rights of autonomy and confidentiality.

The decision to disclose terminal illness information is complex but usually centers on disagreements about the limits of paternalism (on part of the physician and/or the family) and the proper balance between the physician's duty of beneficence to the patient and the patient's right to autonomy and confidentiality.

The physician can withhold information from the patient if he has good reason that divulging the information to that patient is going to cause harm or impair management or cause distress. The physician should document this fact in the patient's file and should get the consent of the substitute decision maker (legal representative).

Breaking bad news

Breaking bad news is one of the most distressing tasks which face physicians on daily basis; however, only few doctors receive formal training on this task.

Bad news is ''any information likely to alter drastically a patient's view of his or her future''. They can range from the need to undergo further laboratory or radiological investigations to confirm the diagnosis , to informing the patient of a life-threatening disease such as cancer or informing the family or friends of death or a major morbidity of their loved ones (Salem, Salem 2013).

The concern about breaking bad news is due to the strong impact it can produce in both patients and physicians. Furthermore, clinicians who feel inadequately trained in communication skills have significantly higher distress levels when faced with patients' suffering. An optimal delivery of bad news is, in turn, associated with increased patient satisfaction (Martins RG, Carvalho 2013).Han and Kagan pointed out that "we do not adequately teach patient communication in

training. This real-world skill is probably more important to a physician's survival than technical proficiencies. Talking to patients about death is quite hard and unlike learning other medical skills, it does not become easier with repetition. Every encounter with a dying patient is unique and once the physician believes he has found the "formula" to appropriately deliver bad news, he quickly discovers that one size does not fit all" (Han, Kagan 2013)

Several problems arise when physicians break bad news; some of which are specific to Muslin countries. Breaking bad news would ideally require lengthy preparation and adequate time. However, due to patient overload, time is a luxury many physicians in Muslim countries do not possess. Besides, physicians in Muslim countries require culture-specific training to break bad news and this is not currently incorporated in the medical curriculum in the majority of developing countries (Tavakol 2008).

The majority of patients in developed countries prefer to know their diagnosis, options of treatment, adverse effects of therapy and prognosis of their malignant disease. The ethics of a number of Asian and Eastern countries require that any fatal diagnosis or prognosis to first be disclosed to a family member. Following discussion with the treating physician, the family judge whether communicating the truth is in the best interests of the patient. The truth is often concealed for fear that it will extinguish the patient's hopes, leading to desperation, physical suffering, anxiety and a hastened death. (de Pentheny O'Kelly 2011).Most families then tend to withhold crucial information that—in their best of knowledge—might lead to psychological suffering of their loved ones.

Physicians working in Muslim communities are required to balance between the patient's rights to be informed (autonomy) and the relative's request to avoid emotional upset to the patient, and thus define the magnitude of bad news that the patient desires to know and act accordingly. (Tavakol 2008)

The physician should ask the patient for approval of the attendance of Family /friends during the bad news breaking encounter. He should conduct the interview in a sizable, private room to allow enough space for desirable family members. Bad news should be disclosed in simple, and clear terms that match the educational level of the patient without going into much details. During the meeting he should pay special attention to the body language of the patient and his/her family. Is the patient afraid, stressed, or at ease? Does the patient have a religious background?. In patients who have strong religious views, physicians should stress the positive

and optimistic religious statements such as, “Everything is in the hands of God”. In patients who prefer a non-disclosure approach, physicians are encouraged to stress a paternalistic approach such as; “Don't worry, I will do everything possible to improve your health” or “You're in good hands.” (Salem, Salem 2013).

If the patient opt for a “dominant guardian” role of a partner or a family member then breaking bad news would be directed to the dominant care taker. Patients or family members should be encouraged to ask questions and the interview should be ended with supportive and empathic statements.

Conclusion

In the present moment doctor-patient relationship is one of the major issues in health-care throughout the world. Medical practice is considered a sacred duty in Islam and the physician is rewarded by God for his proper work. The physician must be pure in character, diligent, and conscientious in caring for his patients.Continuing professional enhancement and education is required to ensure that doctors see their patients as persons, and not diseases.

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