

**Is “Universal Bioethics” Value free?
Uncovering Culturally Determined Bioethics**
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Abstract

The supposition of this paper is that bioethics in its different strata is culturally determined. Other than universal in the sense of ‘neutral’, secular bioethics-which is internationally leading the field of bioethics academically and in praxis - is an expression of a particular, materialistic worldview that does generally not consider spiritual or other-worldly dimensions. Islamic culture, based on the particular worldview of tawhid - the profession that there is only one Creator who created the universe and mankind, and that the purpose of human existence is the servitude to Him - has produced its own bioethics. Under Islamic bioethics, the human body is not the person’s possession, but rather an entrusted good (amanah) which will return to its Creator after death. The human being will be held responsible for its interaction and care taking of its physical shape. Beginning and end of life are predetermined and not subject to human decision making. The paper looks into the most prominent secular bioethical model, Beauchamp’s and Childress’ principlist approach (Principles of Biomedical Ethics, 2013), more particularly the principle of autonomy, and how it intersects in practice against a background of Muslim recipients in a majority or minority background. Discussed case studies will focus on beginning and end-of-life decisions, such as abortion, prenatal and preimplantation diagnostics, termination of life support, donor consent to organ transplantation after death, euthanasia, and their evaluation through the principle of autonomy at the intersection of secular and Islamic bioethics.

Keywords: Bioethics, Islamic Bioethics, Universal Bioethics, Secular Bioethics, Beauchamp and Childress,Principlism, Autonomy, Worldview

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1. Are secular bioethics ‘universal’?

Secularism stands for “indifference to or rejection or exclusion of religion and religious considerations” or “the belief that religion should not play a role in government, education, or other public parts of society” (Merriam-Webster 2018), and is generally used to describe the division between worldly powers and religion in politics. Although it may express neutrality vis-a-vis religions, it is not necessarily neutral or value-free in itself. Proclaiming to dispel (any) religion out of the public sphere, legislation and arriving at decisions on right or wrong, good or bad, based on human intellect alone is rather expressive of values and ideologically bound. Secular bioethics stands for the attempt at devising bioethical standards under exclusion of religious sources or institutions or by finding a compromise with regional religious perceptions or representatives. The bioethical discourse in the ‘Western’ world is at times characterized by a recourse to Christian ethical and moral concepts (particularly if seen through the lens of people stemming from a non-Western background (De Vries and Rott, 2011), as it is characterized by a participation of different religious representatives of other denominations and societal groups, in an attempt to give credit to the diversity of these societies. Shabana refers to the fact that many founders of bioethics had religious training, but bioethics over time shed its religious outlook and terminology

to find wider acceptance (Shabana, 2011). However, these processes take place in an attempt to safeguard the interests of these societies through participation of diverse societal groups, in accordance with the underlying secular worldview. The secular imprint therefore prevails, particularly as the Christian input is rather philosophical than scriptural.

Given the historical experience of European societies, secularism is considered to be the guarantor of societal consensus and scientific progress. It is commonplace that scientific development in the non-Islamic parts of Europe only started taking place after the rule and influence of the Christian Church and its dogma was broken. As opposed to this, the historical experience of the Islamic world was that scientific and general societal progress was made through and in accordance with the Islamic worldview. The Islamic world was the leading power in the field of sciences during the dark European Middle Ages and had substantial influence on the intellectual fertilization of the European continent in fields of medicine, science, philosophy and others. Secularization in the Islamic world took place in the wake of colonization and its aftermath, not as a result of intellectual and philosophical struggle and revolution. Secular thought in the Islamic world is therefore often still linked to colonialist attitudes. It is important to keep these different historical backgrounds

in mind when discussing the role of and approach to secular thought against the ‘Western’ European and Islamic backgrounds (Bouzenita, 2011).

Secular bioethics of Western provenance, among them the American principlist model advocated by Beauchamp and Childress, is often appraised as universal or (ideologically) neutral. Its global proliferation through inter – and transnational organizations, such as WHO or CIOMS, seems to support this claim. But are ‘universal’ bioethical standards truly universal in the first place? The bio-ethical codes of international institutions, such as the Helsinki declaration (developed by the World Medical Organization, first declared in 1964, with various amendments to date, the latest in 2013) (<http://www.wma.net/en/30publications/10policies/b3/>), the 2002 declaration of CIOMS (Council of International Organizations of Medical Sciences) , a non-governmental institution set up jointly by WHO and UNESCO, International Ethical Guidelines for Biomedical Research Involving Human Subjects (<http://www.cioms.ch/>), or the UNESCO declaration on bioethics and human rights 2005 (<http://www.unesco.org/new/en/social-and-human-sciences/themes/bioethics/bioethics-and-human-rights/>), mainly reflect a Western secular background claiming universality. This claim to universality does not go unchallenged in academic circles and the reception of bioethics on the ground. With regard to ‘universal’ bioethical codes, Chattopadhyay and De Vries aptly criticize

the taking over of power of definition through transnational agents: “Once you dispense with the unfounded fears of relativism, unavoidable questions remain: who decides what a ‘moral universal’ is? How should we handle conscientious disagreements with so-called ‘universal’ ethical principles? It is important to note in this regard that a number of scholars- from East and West, North and South - have even questioned the supposed universality of the supposed universality of the so-called Universal Declaration of human rights.”(2013, p.644).

Snead (2009) gives a meticulous account of the difficulty to reach consensus even at the UNESCO level in negotiating the Universal Declaration on Bioethics and Human Rights. Different perspectives (industrialised countries’ perspectives as opposed to developing countries, different background (international law, bioethics, etc), diversity or rather the lack of the same, different agendas played an important role in negotiating and criticising the declaration. Critical reception of the declaration in (Western) bioethicist circles (Landman and Schueklenk, 2005; Macpherson, 2005) evidences this difficulty further.¹

¹ For a detailed account of UNESCO’s global negotiation of bioethics see Langlois, Adele (2013) *Negotiating Bioethics. The Governance of UNESCO’s Bioethics Programme*.

If we take into account that trans-national organizations which sign responsible for ‘universal’ declarations may reveal a diversity in national backgrounds, but that members of these institutions are generally cultivated through their professional backgrounds which already carry a Westernised imprint through Western conceived and secularised curricula worldwide, the possibility of a global bioethical consensus deserving its name seems even more narrowed down.

While some contributors, such as Chattopradhay and De Vries (2013, p.640), who may be quoted exemplarily, speak of a moral imperialism of Western bioethics, others do appraise the UNESCO’s Universal Declaration on Bioethics and Human Rights as a “welcome beginning, but efforts to ensure the efficacy of these formal declarations and statements must continue through serious cross-cultural and interreligious dialogue.” (Shabana, 2011)

The UNESCO declaration has been criticised for “universalising” non-universal values, as in their postulation that the interests of the individual are of greater importance than the interests of science and society. (Landman and Schueklenk, 2005.) Chattopradhay reminds of their particular cultural embeddedness, saying: “Interestingly, the culturally embedded Western Philosophical worldviews of universalists – local in nature – become the vision for the global ethics.” (2013, p.642)

As is the case in other ‘universal’ declarations (such as the declaration of human rights), Western natural law concepts have become so prominent that they are hardly questioned in origin and conceptualisation.²

As for international declarations such as the UNESCO’s, it is questionable in how far they really have an impact on the ground, as they will be binding only after being translated into national legislations (Langlois, 2013). Landman and Schueklenk (2005) wittily state that the declaration may probably not do much harm, thereby alluding to its lack of (practical) impact for the field of bioethics.

Moving away from the transnational arena, consensus on what bioethics is has not even been arrived at by American style bioethics within its own borders (Solomon, 2006). As Solomon points out, if bioethics are truly universal, they need to be truly received by people worldwide – fact is that 9/10 of the world struggle with the most basic bioethical problems, such as access to proper nutrition, basic affordable medical care, and are not even aware of ‘universal bioethics’. In addition, many academics in the Western as well as the non-Western world have become vocal on how universal bioethics have failed to convince people of its superior approach to justice – with major lack of agreement on what bioethics is in the American heartland itself (Solomon, 2006).

Parallels to colonialist and mission

ary attitudes are frequently drawn. Chatto-pradhyay (2013, p.640), quotes Engelhardt on some observations made in American -Japanese bioethics conferences: “It was clear that the Americans ... and Japanese saw issues of bioethics from radically different perspectives. The response on the part of most of the American bioethicists was again to assure...that the bioethics they (the Americans) were expounding reflected the common morality of mankind, whether or not the Japanese recognized this to be the case.” In this scenario, the “Other” needs to be “convinced” of the benevolent mercy bestowed upon him through a “superior” culture. Negotiating the power of definition is not even a topic for discussion in this scenario.

As to the **practical implications of globalised bioethics**, Marshall and Koenig describe how ethical guidelines (for research) are too often simply exported, without giving credit to different cultural contexts. While international guidelines for informed consent rely heavily on the notion of individual autonomy and personal decision-making, these decisions are in many cultural contexts made in the context of the family or other social networks (2004, p.258). Anecdotal evidence reports of people in rural parts of India bringing their age-old informed consent forms to the

clinic, believing them to be guarantee letters for medical treatment (Chattopadhyay and De Vries, 2013). In other words, guidelines have externally been met to the letter, without adherence to and understanding of the substance involved. We may conclude with Marshall and Koenig: “It is insufficient simply to assume the applicability of legalistic procedures – based on broadly-stated principles – in diverse settings across the globe.” (2004, p.263)

De Vries and Rott (2013) have alerted to the fact that Western pharmaceutical companies demand these guidelines as they increasingly outsource medical trials to developing countries – which defies the sense of their existence. The FDA, U.S. Food and Drug Administration, regularly offers seminars on the conduction of drug trials in the developing world. The adoption of these standards can therefore not necessarily be called a consensus based on common universal morality and standards, but rather a globalised pressure to abide by the rule of the powerful – with no power to negotiate the same. In this vein, Marshall and Koenig point out the difficulty “for health professionals and researchers in the developing world to resist the strong and influential voice of Western bioethics”, due to the identification of bioethics as “‘progress’ and modernity”, but also the requirements of international sponsors of research projects to comply with international ethical guidelines in order to obtain funding. (2004, p.258).

² For the discussion of the dissemination of natural law concepts in international law, see Weeramantry, C.G. (2003). *Universalising International Law*. Leiden: Brill.

They summarise: “The pressure to conform to international ethical guidelines may create the illusion of consensus, rather than adherence to “universal” ethical principles, researchers may see human subjects’ protections as one more hoop to jump through.” (p.258)

The reception of ‘globalised’ bioethics on the ground, particularly among the poor in developing countries and the traditionally righteous in the developed world **are often characterized by lack of trust and confidence in (medical) authorities.** Simpson, in his study on Sri Lanka, writes “confidence on the benevolent operation of power and authority has been severely shaken” (2011, p.46). Marshall and Koenig (2004) refer to the ‘lack of trust’ in Afro-American patients with regard to end-of-life aggressive interventions as acquired through the historical experience of racism. It is to be expected that this lack of trust is pervasive in countries with a history of colonization, where medical and legal systems and their representatives, an elite trained along these curricula, mostly in the former colonial language, or transnational organisations are identified with colonialist history or neo-colonialism and are contrasted to a local community that differs in language, beliefs, cultural practices, approaches; the Islamic world will not be excluded from this phenomenon. In addition, the phenomenon of cultural confusion (Simpson, 2011) (which unfolds itself with regard to the power of definition) in the setting of a post-colonial (or still colonial) society is pervasive in the

developing world, and most of the Islamic countries with it.

2. Islamic Bioethics

Islamic concepts on bioethics are embedded in the larger Islamic worldview. There is no original term for ‘Islamic bioethics’ in the original Islamic sources, the Qur'an and the Sunnah of the Prophet Muhammad (peace be upon him). Albeit a terminological newcomer, concepts related to it (beginning and end of life, doctor's responsibility and ethics, general health ethics) permeate Islamic thought and literature.

Foundational Islamic concepts with impact on bioethics are, first and foremost, the conviction that there is only one Creator, Allah, who has created the entire existence; universe, man and life. The human being has been created with the main purpose of serving his/her creator (“I have not created the jinn and the humans except that they worship Me” The Holy Qur'an, 51: 56). This-worldly life is considered to be only a temporary transition to the next life, which is eternal. (“Every ensouled being (nafs) shall taste death” 3:185) It is a test the human being is to pass, with the result of entering either Paradise or Hell-Fire in the next world. The Creator has sent Prophets and Messengers to humankind to guide them to what is right and prohibit them from what is wrong. While previous Prophets and Messengers (including but not limited to Adam, Abraham, Moses, Jesus, peace be

upon them all) have been sent to different tribes and peoples with the essentially same message, the last Messenger Muhammad (pbuh) has been sent to all of mankind. The revelation he received, in form of the Qur'an (the revealed word of Allah) and the Sunnah (the practice of the Messenger of Allah, Muhammad, pbuh), are therefore considered sources of legislation and Islamic culture generally and are directed to all of mankind. As the human being is held accountable for his/her deeds on the days of Judgment, there is a need to know the injunctions of the revelation with regard to any human action. Bioethics in theory and practice is part of this larger picture.

Islamic bioethics is embedded in this worldview. Islam as a way of life regulates the relationship of the human being to his creator, towards himself (in food, personal hygiene, clothing, and also seeking medical treatment), towards his creator (in terms of worship) as well as to other human beings on the levels of family, society and international relations. There is a very rich biomedical and ethical heritage in Islamic civilization that can only be alluded to here.³ The main bioethical suppositions are that medical treatment may take different legal evaluations, from the permissible, to the recommended or even obligatory, as well as it may take the rule of being disliked or prohibited, under consideration of the kind and degree of illness, means and circumstances of medical treatment and its possibilities of

success.

Illness is regarded as a test as well as an expiation of sins. It does not stand in contradiction to the divine will. Medical treatment is rather seen in a circumstantial than a cause-and-effect-relation with illness and healing.

Focus is given – through the Islamic lifestyle – on preservation of health; through the prohibition of harmful and intoxicating substances, movement and hygiene. Moreover, the spiritual aspects of human existence and their effects on health are never neglected nor denied.

The physical manifestation of human existence, the body, will be subject to illness and ultimate death, the soul will live on. The body is not a possession of the person. It is rather seen as an amanah, an entrusted good, that needs to be taken care of and held in good shape (Sachedina, 2009).

There is no divorce of Islamic bioethics from the injunctions of Islamic law. Islamic legal rules can be, depending on the quality and clarity of the underlying sources, decisive with no room for difference of opinion (qatci), or not decisive with the possibility of diversity of legal opinion (zanni).

³ For details see Fazlur Rahman (1998). *Health and Medicine in the Islamic tradition. Change and Identity*. Chicago: Kazi Publications.

The decision of right or wrong, good or bad is not left to human ratiocination, but rather subject to the stipulations of the Qur'an and Sunnah. New cases not stipulated in the texts of revelation, and most bioethical questions belong to this group, are subject to ijтиhad, a clearly defined methodology of deduction of legal rules from the sources, the Qur'an and Sunnah.

3. The problem of autonomy – different interpretations at the interface of bioethical concepts

Among the four principles stipulated by Beauchamps and Childress, autonomy seems to be most prone to criticism by bioethicists.

“Principism’s troubles are well known. [...], bioethics has been called to task for its emphasis on rights and duties over the development of character and virtue, as well as for its relative inattention to social, religious, and cultural features of moral experience and moral agency. Chief among the complaints has been its perceived preoccupation with the maximization of individual autonomy and its willingness to accept as its goal the achievement of minimum consensus among ‘moral strangers’” (Ryan, 2004, 158f)

Secular bioethics of Western provenance is reminiscent of many different approaches and methodologies. The principlist approach of Beauchamps and Childress (as first expressed in their seminal “Principles of Biomedical

Ethics in 1977, reference is subsequently made to the 2009 edition of the book) has been chosen here as exemplifying ‘Western secular’ ethics. The choice has been made on the basis of the wide usage and reference of this model in the biomedical field in Muslim countries today and through Muslim authors’ reference to and discussion of the model. Bioethicists from the developing world are being trained in various centers in the U.S., Europe and the U.K. (Chattopradhay, 2013), aiding the global proliferation of the model.

Beauchamp and Childress differentiate between universally shared values and principles they refer to as ‘common morality’ (the four principles of autonomy, nonmaleficence, beneficence, and justice) on one hand, and ‘particular moralities’ which are not universally shared by people on the other.

“The common morality is the set of norms shared by all persons committed to morality. The common morality is not merely a morality, in contrast to other moralities. The common morality is applicable to all persons in all places, and we rightly judge all human conduct by its standards.” (Beauchamp and Childress, 2009, p.3) Particular moralities are “specific moralities [which] include the many responsibilities, aspirations, ideals, sympathies, attitudes, and sensitivities found in diverse cultural traditions, religious traditions, professional practice standards, institutional expectations, and the like.” (Beauchamp and Childress, 2009, p.5)

The power of decision making is thereby (unwittingly?) referred to particularity, while proclaiming the existence of universality. What exactly is justice, or autonomy, and on which grounds do you define it? It does not alleviate the user of the need to resort back to a particular value system, a framework of reference, a worldview. It may be for this reason that the model is so successful – as it provides generalized guidelines without having to answer crucial questions of human existence. The model does also not solve issues at the intersection of these values. How do they relate to each other? And which principle is to be given preference in case of conflict?

The difficulty to translate this “common morality” into practice has been pointed out. Marshall and Koenig vocalize their criticism: “This parsing of universality and particularity may help explain the diversity and malleability of behavioral norms for morality across cultures (or religions, or institutions) but is less helpful in relation to the application of bioethics practices in particular international or culturally “different” settings.” (2004, p.256)

In addition, the weightage between different aspects of morality may sensitively influence decision making. As Engelhardt states: “It may be the case that humans in general are interested in such cardinal values as liberty, equality, prosperity, and security. However, depending on how persons rank these values, they will live within quite different

moral viewpoints and affirm substantively different, settled moral judgments.” (Engelhardt, 2003).

Beauchamp and Childress defy criticisms to their understanding of autonomy as overriding “all other moral considerations of our work, reflecting a distinctly American bias weighting autonomy higher than other principles. This interpretation is profoundly mistaken. In a properly structured theory, respect for autonomy is not an excessively individualistic, absolutistic, or overriding notion that emphasizes individual rights to the neglect or exclusion of social responsibilities.” (2009, viii)

Muslim bioethicists may be even more articulate in their criticism on this point (see Albar and Chamsi-Pasha, 2013; Rathor, 2011; Sachedina, 2009). This is due to the difference of opinion on the autonomy of the human being in comparison between the Western secular individualist and the Islamic worldview.

Under autonomy, Beauchamp and Childress mainly discuss the competence of decision making and informed consent. They do not allude to human ratiocination in decision making on moral values (right and wrong), as this seems to be taken for granted. The authors themselves are aware of cultural disparities: “Respect for autonomous choices of persons runs as deep in common morality as any principle, but little agreement exists about its nature, scope, or strength.”(2009, p.99 ff).. But what does ‘autonomy’ mean from an Islamic point of

view? Definitions of autonomy affect every bioethical case involving beginning and end of life; questions of abortion, stem cell research, brain death, organ transplantation, preimplantation diagnostics, and many more. A detailed analysis of these questions with regard to autonomy exceeds the scope of this paper. I will therefore alert the reader to the main point these cases have in common.

The personal autonomy for decision making ends, from an Islamic perspective, where the rights of the Creator may be infringed. Autonomy might be defined as the sovereignty or freedom of decision making. The human being does of course make his own decisions, but is not autonomous in the Western secular understanding of the term. He/She makes decisions in the setting of right and wrong, where right as well as wrong, demand and prohibition have already been specified. The human being is asked to abide by the Lawgiver's (Allah's) stipulated command which he arrives at through the texts of revelation. The human being will be held accountable for the choices he/she makes. Do these choices abide by the Islamic legal rules, are they in accordance with the Islamic world view, or are they not?

It has been mentioned previously that, in the Islamic worldview, the person does not consider his or her body as its own possession, but rather as an entrusted good. Death is an inevitable truth for every living being (“Every ensouled being (nafs) shall taste death.” Qur'an 3: 185). Beginning

and end of life are predestined by the Creator. The human being does not have the capacity to influence either beginning or end, nor does he have the right to attempt ending his or another person's life or the capacity to do so.

“Every nation has its term (ajal). If their term arrives, they can neither postpone it for an hour [i.e. any period of time], nor can they precipitate it.” (Qur'an, 7:34)

These basic beliefs have a major impact on many bioethical questions. To start with the most obvious, no human being has the right to deliberately end his/her own life. The end-of-life decision always remains with the Creator.

From the Islamic point of view, there is no mercy in ‘mercy killing’ or euthanasia.⁴ Differentiation needs to be made, however, between the deliberate and planned induction of death through over dosage of medication, which is unanimously shunned (Atighetchi, 2007), and the termination or discontinuation of treatment in cases where no hope for betterment exists. In this case, the demand (wajib) for medical treatment to sustain a life can transform into the permissibility (ibaha), with the consequence that treatment may be either continued or discontinued (Bouzenita, 2011).

⁴ For a detailed discussion see Sayyed Sikandar Shah Haneef (2015): *Biomedical Issues in Islamic Family Law*. Kuala Lumpur: Thinker's Library Sdn. Bhd., p.147ff., and Atighetchi: *Islamic Bioethics*, p.285ff.

Distinction should be made between original Islamic and “Islamicised” approaches. Many official decisions, be they promulgated through state or state like institutions, do not necessarily mirror Islamic thought and worldview, but rather translate the decisions of transnational institutions into an Islamicised *ductus*, referring to evidences in the Islamic legal sources while circumventing to discuss how they came about. In this vein, most nation states in the Islamic world have adopted the ‘international’ definition of brain death, although ample difference of opinion exists (Bouzenita, 2011). Accordingly, many official pronouncements do not necessarily find public acceptance. In Egypt, public preacher al-Shaarawi was able to mobilize the Muslim masses with the parole “Our bodies belong to Allah” in opposition to the officially sanctioned permissiveness of organ donation and harvesting (after death) (Hamdy, 2012). If we may use an extension to Chattopadhyay and De Vries’ analogy of proliferating Western bioethics to missionary activities, it is most effective to spread the idea in an Islamic garb through agents of Islamic parlance. Questioning the power of definition, here taken over by official or semi-official institutions in the Islamic world, is less expectable in this case.

The inner-Islamic discussion of many other examples, such as pre-implantation diagnostics, elective abortion, harvesting embryonic stem cells, where the definition of the beginning of life is at the centre of

discussion, expresses the delegation of the autonomy of definition to the Lawgiver in the first place, even though difference of opinion may arise when it comes to understanding a particular reality (e.g. brain death) or the texts of revelation and their injunctions.

The power of definition of what is right or wrong is mainly defined by the sources of revelation, the Qur'an and Sunnah themselves. It is indebted to the structure of Islamic law that difference of opinion on most legal issues exists. All legal opinions are deemed acceptable as long as they are evidenced in the sources. While representatives of religious institutions will more often than not ‘islamize’ existing mainstream ‘international’ bioethical concepts, a Muslim individual may still and with good conscience adapt a view that is rooted and evidenced in the texts of revelation, but in contradiction to these.

Westra et al have pointed out culturally informed differences in understanding the four principles at the level of dealing with patients’ parents. They observe that, although principles of non-maleficence and autonomy are present in both “non-religious ethics” and “Islamic ethics”, respective understandings can vehemently differ. “We conclude that the parties involved in the described disagreement may feel committed to seemingly similar, but actually quite different principles.” (Westra, 2009, p.1383). Westra et al plead for more transparency, more sophisticated terminology, and courage to acknowledge differences

between “non-religious” and “Islamic ethics” to arrive at solutions in clinical practice. It may be said that they therefore advocate, if not a negotiation of power of definition, at least the understanding of differences.

In their critique of autonomy from an Islamic viewpoint, Rathor et al (2011, p.32.) state “The concept of a unified standard of medical ethics seems unwarranted. Bioethics needs to expand its vision and acknowledge cultural variations and moral traditions of other cultures. Although autonomy remains a central tenet of bioethics, it should not be the absolute prerogative of the patient but rather a shared responsibility between the patient, family, and the physician.” They allude to an often mentioned aspect; the involvement of family and other social entities in decision making in Islamic culture as opposed to the individualistic understanding of the secular West.

Some examples at the intersection of medical setting / personal autonomy in decision making may show that culturally informed (“universal”) concepts as incorporated by medical systems do not leave room for divergent culturally informed choices. If the legal and medical code of a country asks for the dissection of a person who died at home, or sought medical advice in a clinic 24 hours prior to his death, there is no consideration of his autonomous decision, even if his declaration has been notarially certified. National legislation may supersede a person’s autonomous decisions with regard

to organ harvesting after his death (Liddy, 2000). Even in the secular setting, the personal autonomy of decision making has many limitations.

On a subordinate scale, the term ‘autonomy’ may be expressive of the patient’s legal capacity, i.e. his/her ability to understand and make a decision. These are part and parcel of Islamic legal discussions (under *ahliyyat al-ada'*, the capacity to act). Autonomy can also be understood in terms of empowering the patient with knowledge on his particular disease, status and prospects of healing, different available treatments and their (side) effects; if understood in this sense, autonomy can be crucial in empowering patients (“the educated patient”; as opposed to patient in a hierarchical, paternalistic patient-doctor relationship. Some bioethicists in the Islamic world may be considering this aspect while discussing autonomy as the medical systems in the Islamic world today are mainly paternalistic. As a matter of fact, the Islamic tradition is very rich in pointing out the necessity of the patient’s consent (Athigetschi, 2007, p.47ff).

4. Conclusion

As Boyle emphasizes: “fragmentation of the pursuits of health around the world implies that no authority within any health care or biomedical community such as medical association or expert group [can] qualify as having global bioethical authority.” (De Vries, 2011, p.3)

With the existence of different worldviews

such as the secular and Islamic that affect people's understandings of life and death, and the limits (or non-limits) of their actions, global i.e. universal bioethics that fits everybody is not a feasible idea. As Marshall and Koenig (2004, p.260) point out, the claim to a “universal template for moral understanding flies in the face of the multiple and complex realities lived by people elsewhere.”

Unilaterally declaring certain standards as ‘universal’, thereby claiming power of definition for humankind, may well be perceived

as an usurpation of power on the other, the ‘recipient’ side of the scale, with the expected negative outcome in terms of worldwide acceptance. Attempts at islamising universal standards (Sachedina, 2009) may not prove as successful once the proselytising zeal shines through. In the international arena, it would be most advisable to allow for more room for the acknowledgment and understanding of different bioethical concepts and models that actually coexist.

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