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REVIEW ARTICLE

Personal autonomy in health settings and Shi'i Islamic Jurisprudence: a literature review

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Abstract Respect for personal autonomy in decision-making is one of the four ethical principles in medical circumstances. This paper aims to present evidence that can be considered good exemplars in the clarification of the ethical viewpoints of the western and Shi'i Islamic perspectives on this issue. The method followed was originally a search in international indexing services in April 2016. Our findings point towards various controversies on individuals' autonomy lead to different decision making outcomes by health workers in both different traditions. We concluded that although Shi'i Islamic jurisprudence does not seem to allow for personal autonomy in the sense it is understood in a western context, evidence indicates that Shi'i Islamic jurisprudence respects personal autonomy.

Keywords Ethics · Islam · Personal autonomy

Introduction

In its traditional guise, the ethics has focused on answers to questions on personal morality such as 'What should I do?' as well as social ethics, such as 'What constitutes a good society?'

Applied ethics can be considered a subdivision of ethics which is quite distinct from ethics as a general concept because of its particular focus on applied angles. In this sense, it includes parts of the philosophy of ethics, which deals with medical ethics, nursing ethics, environmental ethics, ethical issues relating to society in relation to technology, healthcare, trading, and commerce, and many others.

Bioethics exists in parallel with this knowledge and seeks solutions to ethical conflicts that arise as a result of medical or environmental practices. Such conflicts and their ethical solutions differ according to time, place, social beliefs and traditions; in addition, with the passage of time and the shaping of various cultures and viewpoints, such conflicts become all the more obvious (Aksoy and Tenik 2002:1).

In response to this issue, Beauchamp and Childress (1994), referring to their 1979 book *Principles of Biomedical Ethics*, introduce four ethical principles: respect for personal autonomy, non-maleficence, beneficence, and justice, which in their view, can be applicable to all cultures and societies. This view, which has come to be named The Four-Principle Approach, can be in accordance with various morality schools of thought such as utilitarianism and deontological ethics.

The first of the four principles that of 'respect for a person's right to autonomy' will herewith be referred to as 'personal autonomy'. According to Medical Subject Headings (MeSH) of the U.S. National Library of Medicine definition, personal autonomy means "self-directing freedom and especially moral independence" (available at: http://www.ncbi.nlm.nih.gov/mesh/68026684).

Personal autonomy, or an individual's right to take his/her own decisions, is rooted in the respect of society for an individual's ability to take an informed decision on his/her personal issues. At first, this concept may seem clear and straightforward; however, once it is examined

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more carefully, it becomes clear that writers in this field have often considered it outside its psychological, belief and social dimensions (Barth-Roger and Jotkowitz 2009: 39–40).

On the other hand, Islamic, and in particular Shi'i, jurisprudence contains rules which, although not formulated specifically in respect of health worker–patient relationships, can be used to deduct the principle of personal autonomy in medical matters.

The main purpose of this paper is to present a literature review on personal autonomy from an Islamic framework, particularly in the light of Shi'i jurisprudence.

The development of the meaning of 'personal autonomy' in the present time

Patients-health workers (physicians, nurses, pharmacists, dentists…) relationships at different time periods have always been influenced by social conditions. For example, in the 18th c., a time when most of patients belonged to the upper social classes, physicians competed with each other over patient satisfaction. Towards the end of that century, when a number of hospitals of charitable status were founded, physicians came face-to-face with needy patients, which fact gave rise to a new relationship that of the doctor in charge and the patient as a passive recipient of care (Armstrong 1378: 202–203).

However, personal autonomy as a social value attained significance when its outcomes became clearer to patients. Such an increase in significance and reaction against the tradition of paternalistic behaviour in healthcare led to the imposition of limitations in patient decision-making (Pollard 1993: 6–20). According to the paternalistic viewpoint, health worker-patient relationships are similar to father-child relationships, in which the health worker, like a father, has the right to apply his/her personal opinion in the treatment issues of his/her own patient (Chin 2002: 152). In this model, the patient is assumed to have four characteristics: the patient temporarily relinquishes his/her usual responsibilities; s/he bears no responsibility in respect of his/her condition; s/he must try to regain health by being obliged to follow the health worker's instructions (Armstrong 1378: 203–204).

In other words, this view is seen as interfering negatively with patient personal autonomy as a criterion in healthcare. With the shaping of liberalism in the West, this confrontation has become more observable in the change of phrasing in the ethical codes of practice issued by the American Medical Association (AMA). The second paper on ethical codes of the American Medical Association (1847) entitled 'Obligations of patients to their physicians' mentions that patients should obey their doctors' orders unconditionally and without delay. They should also avoid putting forward their uninformed opinions and allow them to interfere with the course of treatment, a situation that can transform an effective course of treatment into a dangerous one, or even cause death. (American Medical Association, Code of Ethics 1847, "The rule of Nafy-i wilayah" section).

With the passage of time, such views were met with various reactions. The first article of the Belmont Declaration, which oversees patient personal autonomy and the right of patients to be informed of issues relating to treatment, refers to patients' giving of informed consent by the AHA (American Hospital Association 1973); it is also mentioned and stressed by the American Civil Liberties Union (ACLU) and the National League for Nursing (NLN) in numerous other countries. We should add that according to the definition of 'informed consent', a patient is not just a passive recipient of medical care; s/he is a completely independent, active member participating in his/her treatment process (Etchells et al. 1996a: 177–180).

Eventually, in their publication entitled *Fundamental Elements of the Patient-Physician Relationship* and published in 1990, the AMA put forward a set of diametrically opposite views from those of 1874: ' Patients are entitled to take their own decisions in respect of the course of treatments suggested to them by their physicians, and can, therefore, accept them or reject them (American Medical Association 1990) on condition that the patient is able to make a voluntary decision independently of any internal influence such as pain, or external ones such as force, coercion or manipulation. In addition, the physician has the duty to strive towards the minimization of these factors (Etchells et al. 1996b: 1083–1086). Of course, other principles were raised throughout the attempt to clarify the meaning of 'personal autonomy', including the principle of disclosure, in which the treatment team provides reliable, relevant, and sufficient information to the patient in order to help him/her reach an informed decision on his/her treatment plan (Etchells et al. 1996c: 387–391).

At the same time, psychiatrists and clinical psychologists focused on the capability of a patient to make important decisions such as those on his/her life, death and palliative care. The outcome of such research shows that in some psychological conditions such as depression, the patient's desire for his/her life to end cannot be pursued; on the other hand, patients who fulfil mental health conditions for an informed decision have the right to oppose the continuation of their treatment and bring their lives to end before its appointed time (Ryan 2010: 26–27).

Methods

We searched the international databases of PubMed and Scopus. No time limitation of search was considered, and the key words were "personal autonomy" AND ("Islam" OR "Shi'a OR Shi'i OR Shia OR Shii"). The search was carried out on 20th and 23th April 2016, and yielded fifty-six titles in PubMed and sixty-three titles in Scopus. After excluding the titles without abstracts, non-English papers, duplicated titles, and books, the contents of the remaining papers were reviewed the full-text articles subsequently assessed. The authority of the journal being considered sufficient; no more evaluation was conducted on the quality of the manuscripts. The study was conducted in accordance with the rules of the ethical review board of Tehran University of Medical Sciences.

Results and discussion

Based on Beauchamp's and Childress' four principles, Aksoy and Elmali evaluated the roots of these criteria in the Islamic context. They believe that the principles can be acceptable and applicable in every society irrespective of their religion. They claim that the elements are already in force by Muslims and present numerous examples in which Islamic tradition shows respect for patients' autonomy (Aksoy and Elmali 2002: 211–224).

Conversely, some authors disagreed on the existence of such correspondence between Islamic jurisprudence and the four principles, particularly personal autonomy. Westra et al. state that personal choices can be acceptable in the Islamic viewpoint only if Islam considers it right they are right, while doubtful decisions that might be admissible based on non-religious respect for autonomy cannot be allowed in Islamic jurisprudence. They conclude that Islamic jurisprudence can be seen as a kind of paternalism that opposes personal autonomy (Westra et al. 2009: 1383–1389).

In addition, Packer mentions that personal autonomy is a culturally determined concept which is not specific to Muslims firstly because of their responsibilities towards God and secondly because of the social and familial situations of individuals (Packer 2011: 215). Furthermore, Hedayat attempt to answer the question whether a universal declaration of biomedical ethics could be prepared particularly regarding personal autonomy. He compares the value and extent of this principle in Western and Islamic fields and concludes that despite the numerous similarities between the two, they are not fully compatible (Hedayat 2007: 17–20).

Additionally, Mustafa believes that the principles of beneficence, non-maleficence and justice are compatible with Western and Islamic views. However, he considers a significant difference between personal autonomy and the other three principles so that Islamic medical ethics places lesser emphasis on personal autonomy. Nonetheless, Islamic jurisprudence has the capability to adapt itself to contemporary needs (Mustafa 2014: 472–483).

Some Islamic rules regarding personal autonomy

Among such rules those of *qa'idah nafy-i wilayah* and *hadith-i raf'* can be cited.

The rule of Nafy-i wilayah

Grammatically the word *walayah*, means to be a friend of someone or something, also be friend with (Wehr and Cowan 1979: 1099). *Wali* also means 'helper', 'supporter', 'protector', and, 'sponsor' (ibid: 1100). Also there is another word In jurisprudential terms *wilayah* means superiority or guardianship of one person over another in terms of intellectual and jurisprudential position, whether this superiority applies to the person him/herself, his/her possessions or both (Al Bahr ul-Uloom 1403, vol. 3: 209).

Wilayah is conceivable as general and particular; *wilayah* in its particular meaning such as the guardianship of a father and of the senior paternal relatives or the guardianship, ownership and disposal of a property owner on his/her property.

In its general meaning, *wilayah* means absolute rule in the possession and the use of an object, such as the full authority of a legal representative and the person granting power of attorney (ibid. vol 3: 211). On this basis, no individual has rights of guardianship over another, so the principle of *nafy* or lack of personal guardianship (*wilayah*) on another person is not valid apart from the cases which are mentioned in the book and legislator as exceptions.

The rule of *Hadith–i Raf'*

The other rule known as *hadith–i raf'* is based on these words (Kulayni 1407: 462) of the Prophet of Islam (peace be upon him): "Nine things have been removed from my people…one of these is where they should not be punished if they are forced to do something."

According to this, if an individual is forced to carry out a certain action, the action itself and its outcomes has no validity for the person applying force. On this basis, if a physician forces a patient to undergo an operation or procedure and takes away the patient's right of decision, the

physician is held responsible for any outcome arising from the operation or procedure.

Issues pertaining to the principle of autonomy

A few issues pertaining to the principle of autonomy still need discussion. The first is whether, when looking at autonomy, we need to consider the implications of the relationship between traditional bioethics and other values. This approach towards health and illness can lead to the rise of ambiguity and lack in ability to distinguish between realities and values, as well as in the confrontation between traditional models of patient autonomy and medical responsibility in treatment (da Rocha 2009: 37).

As Anderson and Funnel believe (Anderson and Funnel 2005:154–155), the new patient-based system of bioethics places more emphasis on informed consent, and instead of an increased sense of responsibility on the part of the medical team towards the patient, the responsibility of every decision is placed on the patient's shoulders. Accordingly, the patient can in fact harm him/herself physically.

Anderson and Funnel believe that doctors and the rest of the treatment team should not deal with a patient's lack of agreement that can possibly stem from the patient's personal motives or other issues; instead, they should try to cooperate with the patient in order to obtain the patient's agreement on the treatment aims (De Marco and Stewart 2009: 36).

This issue is not synonymous with what was discussed and criticised earlier as a traditional paternalistic doctor-patient relationship, because a strict paternalistic relationship is unacceptable in modern medicine.

Despite the fact that many patients do not have the maturity and do not fulfil the conditions for autonomy in an absolute sense, instead of a 'strict paternalistic relationship', we should steer course towards a 'guiding paternalistic relationship', on which depends the attempt to facilitate and increase patient autonomy (Quill and Brody 1996: 763–769). In this model, the doctor assumes the status of a teacher and friend who helps the patient clarify values in his/her mind, and create various intervention capabilities (Chin 2002: 154).

Points related to the issue of patient autonomy in the view of Shi'a tradition

In liberal systems based on individualism, the limits of an individual's autonomy have not been precisely defined; at times, various viewpoints or even conflicting ones can be seen (Russell 2009: 33). This issue gives rise to the fact that at times, the independence of the physician, as a therapist and a person who must follow through a course of treatment with determination and with the aim of restoring the patient's health (which is, after all, the physician's main duty) is at odds with the patient's independence, if we define patient autonomy as any (type of) freedom in any choice.

The outline of the following points, some of which are the subject of moral and jurisprudential tradition of Islam, can help clarify the issue.

Point no 1: Another moral principle such as the goodwill principle requires that the physician adopt a paternalistic stance towards every patient who, because of any reason, has no information on the course of his/her condition. From the Islamic viewpoint, the physician's knowledge of the process of the patient's condition is considered a basis of reference. As a result, the physician is granted authority to inform his/her patient of the negative outcomes of certain acts of worship, e.g. fasting. In addition, if the patient is informed of the harm or the worsening of his/her condition that may be caused by disobeying the doctor's orders, this disobedience results in the invalidation of this act of worship and the cancellation of its worth (Mohammadi Reyshahri 1374, Hadith 758). However, on the basis of the patient autonomy principle, the final decision will have to be taken by the patient him/herself, even if s/he needs sufficient information, guidance, and medical explanation, just as in other treatment decisions, with the caveat that the doctor remain at the role of a consultant (Shojaee 1389: 75).

Point no 2: Apart from the above-mentioned rules from Islam's viewpoint stressing the patient's right to decide, other rules such as the 'rule of benefaction' and the rule of 'no harm' (*la zarar wa la zerar fi il Islam*) are mentioned in Islamic law. These rules to an extent allow the physician to make decisions on behalf of the patient even though the physician's freedom of action is limited.

On the basis of the 'rule of benefaction', if the benefactor in his/her capacity of benefaction carries out an action that later proves not to have been beneficial or in fact proves to be harmful, the benefactor is not to be held liable to punishment or to be taken to task. By way of example, a shepherd finds a sheep in the desert and takes it to his barn for protection. If the barn roof collapses, according to the rule of liability presumption (tort) (*qaʾidah ʾala al yad*), the shepherd did not have permission to move the sheep, in the sense that he was not considered the sheep's owner and he had not been granted permission by the sheep's owner to look after the latter's property; therefore, the shepherd does not have the right of disposal and possession of the sheep, which is considered the property of another. If he does dispose or make use of it, he is liable. However, under the 'rule of benefaction' the

benefactor should not face punishment, and the application of the rule of liability presumption (tort) *qaiḍah ḥala al yad*) constitutes an irreverence and injury to him. As a result, if an individual intervenes out of goodwill, with the best of intentions and takes a decision on behalf of another, even if, supposedly, this decision causes harm or damage, the individual should not be held liable since on the basis of the Quran, Al Rahman (55), verse 60, "Is there any reward for good other than good?" holding a benefactor liable against his/her benefaction is irreverence and harm, not benefaction towards him/her (Mousavi Bojnourdi 1387 AHS: vol. 1: 34 and 38). According to this, to the extent that a physician acts out of benefaction in taking decisions on behalf of his/her patients, s/he should not be taken to account, since his/her intentions have been good. The text above is also confirmed by verse 91 of sura At-Tawbah, in which God says, "No ground [of complaint] can there be against such as do right."

On the other hand, it should not be thought that despite the physician's best intentions medical negligence and failure to fulfil one's duty constitute immunity from liability towards the patient. This is because the most eminent of the Imami jurisprudents believe that although a physician may be highly skilled and may observe professional protocols and governmental rules, and despite the fact that s/he carries out treatment with the patient's permission, if s/he does not obtain freedom from responsibility (*bara'at*), s/he will be considered liable. They believe that permission or agreement to be treated does not constitute permission or agreement to be led to one's death, since the patient pursues treatment for his/her illness or condition, not death or physical harm or deficiency (Shahid Thani n.d., vol 10:109) Therefore, since the physician has permission to treat, but if, for any reason, his work shows signs of negligence and failure to fulfil his/her duty, s/he is considered liable.

Equally, Article 158 of the Islamic Penal Code states: 'Before the beginning of treatment or surgical operation, as long as the physician obtains immunity from responsibility (*bara'at*) from the patient of his/her guardian, s/he will not be held liable for any psychological or financial harm, or physical handicap or deficiency (Islamic Penal Code 1393: 115). In addition, in urgent cases, when it is not possible to obtain permission, the physician is not to be held liable. In the light of the above explanations, in cases where the patient is in a critical condition, unable to speak, and unaccompanied by anyone [who may act as a representative], and the doctor considers a surgical operation vital, obtaining permission is not necessary. In addition, on condition that the doctor has not been negligent and has fulfilled his/her duties, s/he cannot be held liable for any negative outcomes of his/her actions.

The meaning of the 'no harm' rule is that a jurisprudential ruling leading to harm should not be issued. This means that God, in His grace and kindness towards his servants, has cancelled the ruling on harm (*darar*) (Mostafavi 1421: 243). *Darar* literally means harm, injury, duress (Ibn Manzoor 1408: vol. 8: 46). Therefore, according to this rule not only is it forbidden (*haram*) to oneself to harm another individual, but it is also forbidden to harm oneself, because the component '*la*' [in the formulation of the rule] is an absolute negation applied to the indefinite '*darar*' (noun) and '*deraar*' (inf.) and serving as a general term in the sense that there is no harm, as the writer of *Ȧnaaween al Fiqhhiyah* believes, the meaning of negation in the tradition '*la darar wa la daraar*' is prohibition, so no-one should inflict harm or damage upon others (Hussayni Maraghi 1417 AH: vol. 1: 311), so first of all, inflicting harm on oneself is forbidden. As a result, in the present argument if a patient, despite the seriousness of his/her condition, impedes the process of treatment, according to the rule of 'no harm', s/he is not allowed to cause harm to his/her body, so the doctor is obliged to prevent this from happening.

Point no 3: In Islam's view, human beings are the highest and the noblest creatures of God, as well as His vicegerents and representatives on earth, as mentioned in suras Al Baqarah (2), verse 30 and Al Isra' (17), verse 70. Based on the belief of the distinctiveness between body and soul and the two-dimensionality of human existence, the soul has attained divine status and is therefore higher than the body, so it is eternal, while the body functions as a means for the elevation of the spirit. This is why the individual is not allowed to take any decision in respect of his/her body, which is held in trust for God. In this sense, under the principle of autonomy, a human being is not allowed to cause harm even to his/her own body, or to place it in hazardous situations (Sura Al Baqarah (2), verse 191). On the basis of what is mentioned in the Quran and along with the duty of care every person has towards his/her body, the Holy Prophet of Islam, peace be upon him and his pure household have also referred to one's tongue, ears, eyes, hands and feet, stomach and private parts, which highlights the importance that Islam assigns to an individual's respect towards his/her body and spirit (Sepehri 1370: 51). In addition, concealment of an illness from a doctor is considered a betrayal of duty towards one's body (Javadi Amoli 1391: 99).

The extent of patient autonomy

The value and status of a patient's autonomy and respect towards them is a well-known, current issue within the medical community. In imparting information on health and illness of an individual, it is necessary to obtain authoritative consent to the carrying out of procedures

relating to treatment. At the same time, the attempt to empower the patient so that s/he can manage treatment also becomes obvious.

However, in the treatment process, there are factors beyond both doctor's and patient's control. In cases where a patient is able to choose, decisions that relate to health become harder to take. This fact gives rise to certain limitations in the rule of autonomy. In other words, autonomy both as a concept and as a practice comes up against limits which are raised in opposition to its running wild.

In eastern thought, which is closer to religious teachings rather than the secular view, individuals are not considered as having independent identities; they are rather considered as a part of a human network, playing specific roles that have been defined in relation to others. In the western view, the individual occupies a rather ambiguous position in terms of meaning: on the one hand, the individual becomes the focus of attention; on the other hand, the individual is also a participant in an active process, that of on-going permanent interaction with others in which s/he attains perfection and becomes the object of respect of others through social participation. An individual is not merely a specific part of a closed system; it rather can and should possess social tendency; in fact the family, more than the individual, is considered a unit worthy of respect. As far as treatment is concerned, the physician should take the family's views and decision into consideration. Family values and the collective common good can lead the patient to a decision in which the rights of the family and society are considered a priority over the individual's personal preference. In addition to the fact that individual responsibility in respect of the group can lead to the satisfaction of personal needs, the attainment of individual rights and the exercise of individual choices (Tsai 2008: 171–176).

Attention to religious norms can fit under the same category. For example, Islamic religious norms and a review of Islamic life ethics, despite the multiplicity of ethical traditions, the ideals that seem to agree with the various Islamic texts give jurisprudential validity (*mashrou'yiat*) to the ethical system in which humankind as a whole rather than its individual members is worthy of respect (Chattopadhyay and De Varis 2013: 639–645).

The concept of autonomy faces limitations, in the sense that patient autonomy can inflict damage or harm to others. We are not allowed to force an individual to carry out an action that is in conflict with the benefit of others. In the case of patient autonomy, it has to be said that the principle of patient autonomy must be considered worthy of respect to the extent that it does not harm others, whether that may be another individual, society or even the patient him/herself (Jonas 2010: 343–346).

In any case, in the light of the above points, this point comes through: patient autonomy should not come into conflict with the best interests of others such as society, religious values, and the patient him/herself. The individual cannot subject others to harm, damage of any kind and cost resulting from his/her own selfish decision. To express it better, an individual's freedom of choice is related directly and indirectly with [that of] others, and an individual's treatment decision should be taken in the light of his/her family and social life (Barth-Roger and Jotkowitz 2009: 39–40).

Lastly, a limitation of our study relates to the search strategy employed. Our search in the databases yielded only a handful of papers that related to the objectives of our paper. We therefore chose to include a search in a number of Islamic books in order to widen the scope of our discussion.

Conclusion

To conclude, the rationale of this paper has been to highlight the conflict between the patients' right to personal autonomy and medical and social compromise. However, what is important in the treatment process as in any other ethical decision is the independence of the whole act, not the independence of each ethical principle individually. Patient personal autonomy does not constitute an absolute principle *optima facie*, but rather *prima facie*.

Accordingly, the Islamic ethical model does not disregard patient's rights to take a decision relating to him/herself as an individual, but the existing possibilities of solving these practical conflicts or oppositions in health worker-patient relationships, can show the way forward. Patient independence is predicated on the idea that less important ethical principles should not stand in the way of more important ones. On this basis, independence of ethics should be stressed, not independence of every ethical principle in isolation. In addition, because Islam places great value on the status of humankind and its position in the scheme of creation, the right of humankind has priority over the right of the individual. This means that no one, be it a patient or a health worker, is allowed to inflict damage or harm to the patient community or to their families with the excuse of consideration of patient rights. This consideration has hitherto been neglected in liberal systems of thought. The removal of these deficiencies can result in better health worker-patient interactions.

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