RESEARCH ARTICLE

Medical Practice Between Practical Dilemmas, the Demand for Humanization, and Patient Care

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Abstract

The coupling of modernity with industrialization in the 19th and early 20th centuries led to a major turning point in the history of Western thought. This transformation was not merely a chronological shift, but rather a silent unraveling of the dreams of philosophical reason, which had taken shape through a specific historical process since the Enlightenment. Within this context, Nietzsche described the transformation as a fall into nihilism, or the collapse of grand narratives and their loss of ability to guide human action—after having once constituted the core of human existence. Karl Marx expressed this condition as the alienation of man from himself. Even amid this collapse, a broad current emerged rejecting philosophy, its methods, and its claims—arguing that traditional philosophy had failed to offer radical solutions to the major problems faced by humanity and society. As a result, there was a shift toward more powerful and reliable scientific alternatives to overcome this impasse, replacing philosophical inquiry with the pursuit of solid scientific knowledge. This coincided with the emergence of what became known as the discourses of "endings": the end of the world, the end of history, the end of philosophy, and even the end of culture and humanity itself. Thus, as the 20th century drew to a close, it became evident that the philosophical project, which once aspired to imbue existence with a humanistic dimension, had encountered a profound failure—the rational dream had turned into an existential question about the limits of reason itself and the fate of humankind in a world that had lost its compass of meaning.

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Introduction

Contemporary moral thought is currently undergoing profound transformations—or, as some see it, is in a state of crisis. Some interpret this as a process of reorganizing the moral house once built by the ancient moral philosophers. This, if anything, indicates the failure of classical moral frameworks and analyses that filled the pages of traditional philosophical works. These frameworks derived their values and concepts from lofty rational principles, religious teachings, and abstract spiritual reflections in an effort to regulate human action and guide it toward goodness in a way that would bring about happiness and peace between the individual and their surrounding world.

Today, we are witnessing the birth of a new moral thought that moves beyond theoretical speculation toward practical application—what is now referred to as *applied ethics*. This new emergence is marked by a growing interest in ethical issues arising from technological advancements, particularly in the fields of medicine and biology, along with related legal, religious, philosophical, economic, and environmental concerns. As a result, there has been a growing call for ethics to be integrated into fields such as medicine, gender issues, education, the environment, media, politics, state institutions, and the public sphere. Voices continue to rise calling for the moralization of all aspects of life.

The study of ethics is no longer merely a theoretical endeavor concerned with the analysis of ethical terminology; it has now shifted its focus toward real-life issues. This shift has sparked interest in applied philosophy, and moral philosophers have increasingly turned their attention to this field. According to some, this represents a return to genuine philosophy—one that connects with people's lives and engages directly with their everyday problems and questions, particularly those related to medical practice and its relationship to the body and the patient's inner self.

Islam, as both a divine law and a way of life, has given the utmost importance to the practical dimension of ethics. The message of Islam does not merely regulate the relationship between the servant and his Lord, nor is it limited to promises and warnings about the afterlife; rather, it encompasses all aspects of individual and social life, including the organization of human relationships in general. Moreover, the moral authority upon which Islamic ethics is founded is not limited to legal authority represented by reward and punishment, but also includes the authority of moral conscience. These ethics are grounded in rational and humanistic justifications that complement religion and are conditioned by it—blending knowledge, reason, and faith.

Today, such a synthesis has become, in the West, a proposed solution to the crisis of modern humanity, a source of pride in defending the human being and the body, and a revolution in the realm of ethics attributed to Western thought. In my view, the reason for this lies in the failure of the Muslim intellectual to elevate these values to a universal level.

Thus, this article seeks to address the following questions:

How can modern medicine play an effective role in liberating human beings from pain, rather than creating permanent dependence on the medical system? Is it possible to establish genuine communication between doctor and patient? To what extent can we speak of "authentic ethics" in medicine, independent of the economic and political considerations that have come to dominate medical practice? Is what we do with the medical body truly care, or is it a form of domination in the name of science? What are the ethics of treating patients from an Islamic perspective?

1-Contemporary Medicine between Technology and Humanity: The Crisis of Meaning

Within this context, many prominent thinkers and scholars of philosophical inquiry have sought—and continue to seek—a way out of this dilemma. One notable attempt is found in the book *The Meaning of Illness: A Phenomenological Approach to the Patient-Physician Relationship*, originally a doctoral dissertation in philosophy by S. Kay Toombs. In this work, the author attempts to summarize her personal experience with illness, which played a pivotal role in shaping her understanding of the subject. She presents her journey with a chronic illness on the one hand, and on the other, she delves into how individuals live with illness and how they construct the meaning of their personal experience with it. This experience led her to draw attention to dimensions of illness that go beyond biological and physiological aspects. She came to realize the importance of doctors approaching illness as a complex human experience—one that implicitly includes psychological and existential dimensions, not merely a physical condition. This book, therefore, raises a central problem in the world of illness and medicine: the troubling disconnect between the medical self and the suffering self. In defining illness, a clear discrepancy emerges—what we might call:The meaning that emerges through lived experience stands in contrast to the meaning derived from scientific understanding. The patient experiences illness as a personal event that affects the core of their subjective life and emotions, while the doctor views illness from a purely scientific perspective—categorizing and treating it according to established scientific principles. This contrast highlights the tension between the subjective view of illness as a lived experience and the objective view, which may be disconnected from the patient's personal reality.

The book thus argues that illness is not merely a biological condition, but rather a complex experience in which psychological, emotional, and physical dimensions intertwine. It illustrates how a physician can improve performance and effectiveness by recognizing the personal meanings patients attribute to their illness, and how effective communication between doctor and patient can enhance treatment outcomes and provide psychological comfort.The author explains that her proposed approach offers a phenomenological analysis of the experience of illness and how meaning emerges within the doctor-patient relationship. Rather than presenting a shared reality between doctor and patient, illness represents two entirely distinct realities, each with meaning that is strikingly and qualitatively separate from the other. This divergence has serious implications for medical practice—whether in

terms of fostering effective communication, alleviating patient suffering, or implementing more effective medical interventions.By uncovering the way individuals construct meaning from their experiences, the phenomenological analysis reveals that doctor and patient each interpret illness within the context of two different "worlds," with each world providing its own unique horizon of meaning. The difference in perspectives between doctor and patient reflects a distinction between meaning grounded in lived experience and meaning detached from it—between the "natural attitude" and the "scientific natural attitude." (Toombs, 1987, p. 2) The author concludes by challenging the common belief that illness is merely a scientific and largely technical phenomenon, and that health is not a suitable domain for philosophical reflection or intellectual inquiry.

On the contrary, medicine must be understood through its practical application, its vital contexts, and its relationship with the human being as a living, suffering, and resisting entity. Through the approach the book offers, we discover a different face of philosophy—one that strengthens the link between philosophizing and life. This could be described as "medicine through philosophy," where philosophy provides a form of knowledge about illness, health, and the doctor-patient (or human-illness) relationship that surpasses the knowledge offered by science alone.

But it is not the kind of knowledge that surrounds illness with metaphysical interpretations—as if it were a mysterious riddle, a fated destiny, a dysfunction between body and soul, or a symbol detached from the material and biological reality in which the human being lives. Rather, it is the kind of philosophy that treats illness as a new and complex human experience, or a distinct vital condition that requires listening and understanding. More importantly, it seeks to uncover the deep structures that govern our relationship with illness, with medicine, and with the power exerted over bodies. If illness places the human being face-to-face with fragility, death, weakness, and pain, then philosophy must deconstruct these phenomena to reveal what language conceals—whether it be meanings of power, alienation, or even hope. At this point, philosophy intersects with the critique of rigid medical ideology that does not adequately value the experience of the ill self.

S. Kay Toombs writes in her aforementioned book: *At the doctor's clinic, I had read just a few days earlier an article telling the story of a young woman (a former beauty queen) who had been diagnosed with multiple sclerosis and was now severely disabled and confined to a wheelchair. So, upon hearing my diagnosis, the first question I asked was: "Will I end up in a wheelchair?" The doctor replied that he couldn't give me any guarantees about the future. Unsurprisingly, I interpreted this response to mean that I would, in fact, become disabled—perhaps even in the near future. It's true that the doctor's response wasn't incorrect (he really couldn't guarantee what my physical condition would be in the future—who could?), but the reality is that not all multiple sclerosis patients end up with severe disability. My pessimistic interpretation of my condition might have been less distressing if the doctor had included this piece of information in his reply. The point is that if the doctor is sensitive to the patient's interpretive understanding of their illness, he can act as a mediator in the meaning-making process, and perhaps help the patient to adjust or reconsider an interpretation that doesn't appropriately reflect their health condition.*(Toombs, 1987, p. 4)

It becomes clear from the doctor's response here that he does not share the same interpretation or perspective on the illness as the patient. Rather, he offers an objective and realistic answer, but one that lacks engagement with the patient's emotional anxiety or personal interpretation. The philosophical idea here is that the meaning the patient assigns to their condition may differ from the meaning seen by the doctor. This highlights the importance of the patient's interpretive awareness, especially given the variation in illness experiences among individuals suffering from the same condition.

In this context, the doctor can serve as a mediator who helps the patient construct meaning, and can also contribute to reshaping a negative or pessimistic interpretation. This requires a deep understanding of the patient's emotional and intellectual state—not just the medical one. From this perspective, the doctor can participate in the interpretive process with the patient, helping them to reformulate their thoughts about the illness and about their future.

Based on this idea, the doctor, from another angle, can help the patient see a greater meaning in their health condition, even when medical diagnoses are difficult or discouraging. The patient's self-interpretation can shift from resignation to inner strength if the doctor helps them find a different meaning in their illness.

The abnormal sensory experience transforms the body into an object of consciousness. Whereas a person normally lives with their body without giving it much thought, the patient turns their attention toward the physical disturbance and seeks to uncover its meaning. Furthermore, at the level of *disease*, the patient objectifies their body, shaping it as a neuro-physiological entity separate from themselves using concepts acquired from others. This objectification of the body leads to a sense of alienation between the body and the self—an essential feeling in the experience of illness. This alienation becomes even more intense due to the physician's treatment of the body as a scientific object within the framework of the *naturalistic attitude*. As with illness itself, the constitution of the body

reflects the distinction between meaning rooted in lived experience and meaning detached from it.(Toombs, 1987, p. 108)

Meanwhile, according to Michel Foucault, our contemporaries regard the experience of approaching the individual—through the establishment of a "unique dialogue"—as a more focused embodiment of an old humanistic tendency in medicine, one as ancient as human compassion. Yet the clumsy manifestations of understanding mix this underdeveloped idea with the sands of its own conceptual desert. The terms *encounter* and *doctor–patient dyad*, though charged with a certain excitement, seem to exhaust their potential in the pursuit of connecting the feeble powers of dyadic imagination with a substantial share of the unthought.(Bell, 2008)

Although contemporary medicine strives to be more humane, some of its discourse still requires deeper philosophical reflection to restore the true human significance to the encounter between doctor and patient, viewing it as an existential event rather than merely a technical or emotional procedure. Despite the good intentions behind many efforts and voices calling for the humanization of medicine, some forms of this contemporary humanization—despite their noble intentions—may slip into a superficial reproduction of outdated concepts without philosophical questioning. This produces discourses heavy with emotion but shallow in depth, where words like "understanding" and "coexistence" are used prematurely, without truly activating these concepts. What is missing is fundamental: the recognition of the Other as Other—not as a mirror of the self or an object of pity.

Thus, the way this relationship between patient and doctor is sometimes viewed remains superficial and confused, employing language that mixes moral feelings with polished concepts in a fleeting manner. Especially when the body is weak or ill, there is often no true communication or balance in the relationship, only a deep feeling of responsibility toward it—responsibility arising merely from our perception of its weakness. But when this relationship is emptied of its content and presented in an exaggerated way or adorned with emotionally charged terms, it loses its true ethical dimension. Therefore, what is required today from critical philosophical discourse is a critical deconstruction of the new humanistic language in medicine, so as not to fall into the trap of reproducing old methods under a modern guise that appears compassionate but is conceptually empty. Instead, critical practice should enable a return to the depth of the human encounter—not as a formal event, but as a revealing experience of existence, vulnerability, and mutual responsibility.

Illness is not merely an organic dysfunction, but a disturbance in the human experience of the body and the world. Based on these perspectives, it becomes urgent to rethink the relationship between doctor and patient—not as a mere therapeutic encounter, but as an existential communicative space that carries, alongside ethical responsibility and care, a mutual recognition of the fragile humanity that unites both parties.

After a century of striving toward the ideal medical city, and contrary to what contemporary conventional wisdom promotes, medical services have not been the primary factor behind the transformations witnessed in life expectancy. A large portion of contemporary clinical care is not essential for curing illness, while the harm caused by medical practices to the health of individuals and communities is critically significant. These facts are clear and well-documented, yet they remain tightly suppressed (Fisher, 1976). This reality compels us to seriously reconsider many practices that may be far from the intended goals derived from the progress and development of medical services.

Despite the achievements made, and although contemporary wisdom constantly praises the benefits of medicine and medical practices, it neglects an important aspect of reality: those medical services have not been the main factor behind the transformations we have witnessed in medical accomplishments. This calls for a philosophical reflection on the role of medicine in the modern world, where the facts reveal a picture different from what we commonly believe. Contemporary medicine is sometimes accompanied by significant harm. Medical practices that focus on treating symptoms rather than roots can lead to undesirable side effects, and modern medicine has become increasingly linked to industrialization and globalization, turning it into a commodity that can be exploited in health markets instead of being seen as a humanitarian service.

Therefore, it has become clear that medicine today requires a deeper philosophical critique that can help return to the original concepts of healthcare—those that do not merely address the body but recognize the human being in their entirety and existence. The physician should transform from a "technician treating symptoms" into an existential companion who understands illness in its existential, psychological, and social context. Here, the therapeutic relationship becomes not just a "procedure," but a genuine human encounter.

Philosophy does not call for abandoning medical progress; rather, we must acknowledge the non-technical influence that medical technology exerts on the health of society, which is a positive influence. For example, an unnecessary injection of penicillin can magically restore confidence and appetite. A forbidden operation can resolve a marital problem and reduce symptoms of illness in both partners. Not only can the sugar pills prescribed by the doctor but even their toxins be powerful influencing factors. However, this is not the prevailing outcome of

the non-technical side effects of medical technology. It can be said that in those narrow fields where high-cost medicine has become more precisely effective, its symbolic effects have become profoundly negative on health: the traditional white magic of medicine that supported the patient's own efforts to heal has turned into black magic. To a large extent, the social illness caused by medicine can be interpreted as a distant negative effect.(Fisher, 1976, p. 39)

Medicine has become a mysterious force that places the patient in the position of a spectator of their own treatment. Instead of being an active participant in their healing process, the patient is treated as an ineffective being. Treatment thus becomes something external imposed upon them by others, reinforcing their alienation from themselves and their capacity for self-healing. This perspective empties medicine of its human dimension and transforms it into a mere technical procedure devoid of existential meaning. In this context, medicine can even become a contemporary religion promoting the idea of "salvation" through science, placing the patient in a position of submission to doctors and medical treatment as saviors. Medical practices become a kind of ritual that does not encourage the patient to understand or interpret their suffering but rather convinces them that the solution lies only in medical intervention. This vision diminishes the patient's ability to seek deeper meanings for their pain, whether in religious or philosophical tradition, turning medicine into a divine system that undermines humanity.

In addition to the negative role played by medical institutions, especially in developing countries, which isolate the patient from society and treat them as a being treated separately, thus contributing to the loss of their connection with their social environment. Instead of medicine contributing to the strengthening of values such as social solidarity and compassion, it often isolates the patient in a medical environment that leaves them surrounded by machines and doctors, reinforcing feelings of isolation and alienation. In this way, the impact of medicine is not limited to physical healing but also includes the destruction of the human bonds that connect the individual to their community.

The separation between medicine and ethics has been defended on the basis that medical fields, unlike those of law and religion, rely on scientific foundations exempt from ethical evaluation. Medical ethics was introduced as a specialized department that reconciles theory and actual practice. As for courts and the law, when they are not used to impose the monopoly of "Aesculapius" (the god of medicine in Greek mythology), they become gatekeepers of hospitals who select from among clients those who can meet the doctors' standards. Politically mediated medical harms are viewed as inherent in the mandate of medicine, and their critics are seen as interested in justifying unprofessional interference in the medical specialty. Therefore, the claim of healing and care free of values is clearly a malicious nonsense, and the taboos that protected irresponsible medicine have begun to weaken (Fisher, 1976). For this reason, many voices have risen calling for philosophy to refine medicine and subject it to ethical values different from those traditionally found in classical ethical codes. The rapid changes that have affected medical biology and the new ethical dilemmas have led to the revival of old concepts that appear traditional but differ in substance, necessitating a reconsideration of ethical rules in their old form to align with new developments.

Therefore, among the important non-technical and non-classical functions of medicine, there is a third function with a more ethical character than magical, and more secular than religious. It does not rely on a conspiracy involving the sorcerer and his follower, nor on myths shaped by priests, but on the form that medical culture gives to relationships between individuals. Medicine can be organized in a way that encourages society to treat the weak, the disabled, the sick, the injured, the depressed, and the mentally ill in a more or less personal manner, by fostering a certain kind of social personality.(Fisher, 1976)

2-Contemporary Ethical Thought: Ethics of Care

Building on this, a new independent ethical theory called the "Ethics of Care" emerged decades ago, in which care is manifested in its clearest forms and expressions. It is more a practice and a virtue than a theory, aiming to preserve ourselves and others, and to strengthen bonds and relationships between individuals in a way that serves humanity. It promotes the motivation to care for those vulnerable individuals who depend on others (Gilligan, 1993).

The main focus of the "Ethics of Care" is on the moral silence regarding attention to and meeting the needs of vulnerable people and those who require others to fulfill certain needs.

A collection of articles and works ignited the spark of this new ethical direction. It began with the publication of Sarah Ruddick's article "Maternal Thinking" in 1980. At that time, motherhood was not regarded as carrying ethical value but rather child-rearing was viewed as a purely biological nature, similar to how animals care for their young. She argued that society should elevate the value of maternal practice, which is primarily based on the principle of protecting an infant who needs care. Following that, several works appeared in the same vein, such as Gilligan's book *In a Different Voice*, Nel Noddings' *Caring* (1984) (Noddings, 2005), and articles like "Women and Moral

Theory" and "Science and Feminist Moral Theory" by Eva Kittay and Dina Meyers. All these writings expanded the scope of discussion on women's ethical theorizing and established the Ethics of Care as an independent ethical theory. However, some consider Virginia Held's book *The Ethics of Care* to be the first thorough work defining what is now known as the Ethics of Care.(Suad Bin, 2020, p. 5)

The Ethics of Care emphasizes the moral strength of the responsibility to respond to the needs of those who depend on us. Many people will become ill and dependent on others for some time during the later years of their lives, including the frail elderly, and some who are permanently disabled will require care throughout their lives. Rational theories based on the image of the independent, rational individual who governs themselves ignore the reality of human dependency and the ethics it requires (Held, 2005). The Ethics of Care addresses this central and important aspect of human life and deals with the moral values associated with it, rejecting the relegation of care outside the framework of ethics. It Means Institutions Thus, the new approach perhaps offered by the Ethics of Care seeks to activate the practical and social aspects of ethics.

This approach deals with what exists as an ontological reality, rather than within the framework of what ought to be. In our response to marginalized members of society with care and compassion, we embody the principles of justice and equality in a genuine way. In the Ethics of Care, the values of trust, solidarity, mutual concern, and reciprocal emotional embrace take precedence.In care practices, relationships grow, needs are met, and humanity prevails over individualism because it is based on the idea that humans inevitably suffer at some point from weakness and frailty, and at that time there is a need for others to overcome this weakness. More precisely, the Ethics of Care shifts focus from the self to the other, which is in complete contrast to the liberal philosophy that claims the independence of the individual through their capacities and freedom, and their separation from the community, and consequently their ability, based on what they possess, to meet their own needs.

The liberal individualistic conception of the person not only reinforces a mistaken image of society and the people within it but also, from the perspective of the Ethics of Care, weakens this image as an ideal. The Ethics of Care values the relationships that connect us with specific other people, as well as the real and particular relationships that shape our identity. The values of equality, justice, and individual rights celebrated by liberalism do not conflict at all with the Ethics of Care; each examines the ethical practices and values embodied by these practices, and each understands that ethical practices must be nurtured, developed, and shaped (Held, 2005, p. 22).

The philosophy of the Ethics of Care is based on the view that society must recognize its responsibilities toward children and other vulnerable individuals and strive to provide the best possible care. It must respond appropriately to its members who need health and social care. More broadly, the Ethics of Care implies that members of wealthy societies should acknowledge their responsibilities in alleviating the burden of hunger and the severe deprivation experienced by poor communities.

3-Islam and Applied Ethics:

If applied ethics—a new branch that suggests the birth of a new ethical thought whose main goal is to bring ethical theory down from the level of contemplation and thought to the level of action, practice, and implementation, thereby contributing to strengthening relationships and bonds, especially social ones among individuals—has emerged as a result of the overwhelming technological advancement in all fields, especially in biology and medicine, then Islam, as a divine law and way of life, has paid great attention to the applied aspect of ethics. The message brought by Islam is not limited to organizing the relationship between the servant and his Lord, or to threats and promises related to the afterlife; rather, it is comprehensive, covering all aspects of social and individual life, such as organizing relationships between people in general. The moral authority on which Islamic ethics is based is not only the religious authority represented by reward and punishment but also the authority of the moral conscience. Moreover, Islamic ethics is grounded in rational and humanistic justifications that complement and are conditioned by religion.

It integrates knowledge through reason and religion.Today, this approach has become, in the West, a way out of the crisis facing contemporary humanity, a source of pride for defending human beings and the body, and a revolution in the world of ethics credited to Western thought. The reason for this, in my opinion, is that the full responsibility lies with the Muslim intellectual who has not yet elevated these values to the level of global recognition.

4-Islam and Medical Ethics:

Islam refined the profession of medicine and established rules and conditions related both to the practice of the profession itself and to the practicing physician. Muslim scholars, across different eras, showed great interest in medicine and physicians. Many outstanding doctors emerged from the Islamic world who left clear marks on the history of global medicine. They wrote, classified, diagnosed, treated, invented instruments, and performed surgeries, remaining valuable sources and references for later physicians, especially Europeans.

Muslim scholars played a major role in laying the foundations of medical ethics. In this regard, we refer to the book by Abu Bakr al-Razi titled *The Ethics of the Physician*, which is one of the earliest works to address this subject, preceding all Western literature in the field of medical ethics. Another notable work is *The Conduct of a Physician* (*Adab al-Tabib*), one of the earliest comprehensive treatises on the topic, written by Ishaq ibn Ali al-Ruhawi, who lived in the second half of the ninth century AD. This book was translated into English by Martin Levy in 1967.(Ghaly, 2013, p. 333)

The Conduct of a Physician is a remarkable work that reveals the truth that issues related to responsibility, ethical dilemmas, and societal needs are not new but have long been known in the medical field. Reading this book makes us question whether today's physicians might be neglecting their responsibilities toward current ethical needs.(Ghaly, 2013, p. 334)

Al-Antaki, in his book *Prophetic Medicine*, in the margin of *Tashil al-Manafi'* regarding the ethics and values of the physician, says: "If the one knowledgeable in medicine is not trustworthy, endowed with divine laws, ruling over his intellect, overpowering the desires of his soul, fulfilling the aims of his passion, and reaching the goals of his enemy, and if he is rational and able to do so, then victory over the soul's bestial desires, patience, and entrusting the Creator (God) are among the wise prophetic morals."(Brockopp, 2003)

As for Ibn Sina (980–1037 AD), the master of Muslim physicians, he combined wisdom, science, and Sharia in his medical practice. The concept he presents to us about this noble science is a clear indication of the close connection between ethics and medicine. He says:"Medicine is a science through which one understands the conditions of the human body regarding what is healthful and what removes health. Some might say: Medicine is divided into theory and practice, but you have considered all of it theory if you say it is science. To this, we respond: There is medicine that is theoretical and medicine that is practical... So, if it is said that some of medicine is theoretical and some is practical, it should not be assumed that they mean by this that one part of medicine is teaching the science, and the other part is the actual practice, as many researchers think... Rather, you should know that what is meant is something else: neither of the two parts of medicine is anything other than science. But one is the science of the principles of medicine, and the other is the science of how to practice it.

The first is specifically called 'science' or 'theory,' and the other is called 'practice.' By theory we mean what is taught as belief only, without addressing how to perform the work... And by practice we do not mean the physical action or bodily movements themselves, but the part of medicine that provides an opinion, and that opinion concerns how to perform the work... This teaching gives you an opinion, which is an explanation of how to perform the work. When you know these two parts, you will have both theoretical knowledge and practical knowledge, even if you never actually perform the practice."(Aristote, 1990)

When Ibn Sina speaks here about the foundations of the medical profession, he emphasizes that this work, which cannot be properly conducted without ethical guidelines, requires the physician to adhere to principles such as mercy, compassion, confidentiality, consideration of the soul and spirit before the body, and good conduct. These are the conditions that have been lacking in this profession, especially in recent decades, as the second half of the twentieth century witnessed rapid and successive developments in medical concepts. These swift changes affected the medical profession, allowing market ideas and commercial practices to widely infiltrate healthcare professions, particularly in developing countries.
The problem in these countries is greater and more dangerous—they suffer both scientific bankruptcy and ethical bankruptcy, which is something not found in Islamic historical texts. In Islamic history, physicians, alongside the knowledge and science available to them, were keenly dedicated to establishing specific ethical principles drawn from Islam for the medical profession and its practice.

Alongside the expansion and progress witnessed in the fields of medicine and nursing, there is, simultaneously, a noticeable decline in ethics that resemble medical ethics, a scarcity of competencies, and nursing has become a profession accessible to those without proper qualifications, lacking wisdom and experience. This overcrowding in the medical field has produced individuals who lack honesty, ethics, and credibility.

George Bernard Shaw summarized this deviation in his book *The* Doctor's *Dilemma* when he said:"The medical profession will not advance and become humane rather than commercial unless we place a barrier between the doctor's hand and the patient's pocket, and the state guarantees the doctor a decent life with a reasonable salary. "He also said: "A hungry or unscrupulous doctor is more dangerous to society than any criminal! A criminal commits one or two crimes in a lifetime, whereas this type of doctor commits more than one crime every week by inventing unnecessary operations."

The purposes of Islamic law (Sharīʿah) and the purposes of medicine converge in that the subject is the human being, and the goal is to achieve the physical, psychological, and mental health of the person, with the ultimate aim being the happiness of the individual. The message of medicine lies in spreading broader healing and greater mercy. As stated in the Qur'an: **"And We send down from the Qur'an that which is a healing and a mercy to those**

who believe." (Al-Isrā' 17:82) Healing and mercy are shared objectives between the medical and religious missions, even though the scope and domain of each may differ.(Ghaly, 2013, p. 269)

5. The Ethics of Caring for the Elderly in Islam:

The phenomenon of aging is a disturbing and alarming issue for both society and the individual. At this stage, the elderly begin to gradually lose their social roles, and their relationships with those around them change. Even society's perception of the elderly changes naturally. During this stage, complex psychological disorders and crises start to appear in the personality of the elderly due to the decline in physical and mental capacities, which society views as the inevitable beginning of death. Hence, it is said that human life fluctuates between two periods of weakness: one when a person is a child and the other when they are elderly. The Qur'an itself describes this stage of life as weakness and frailty, the most despicable age: **"It is Allah who created you from weakness, then made after weakness strength, then made after strength weakness and white hair. He creates what He wills, and He is the Knowing, the Competent."** (Ar-Rūm 30:54) Therefore, the Qur'an laid down a strict approach and imposed specific ethics in dealing with the elderly, to preserve their dignity and honor their status. Among the practical examples that indicate the value and respect owed to the elderly, and the obligation to prioritize and show reverence to them in all generations, is what was narrated from ʿĀ'ishah (may Allah be pleased with her), who said:

The Messenger of Allah, peace be upon him, once came to a man who had an elderly person with him and said, "O so-and-so, who is this?" The man replied, "My father." The Prophet, peace be upon him, then said, "Do not walk ahead of him, do not sit before him, do not call him by his name, and do not ask him to perform istisqaa (seeking rain)." This was narrated by Al-Tabarani.

The teachings of Islam have preceded modern systems for elder care, as elders in Islamic societies generally receive more appreciation, care, and respect. This is evident to anyone who compares the environment of the Islamic family with that of Western or non-Muslim Eastern societies. Muslim elders tend to live in comfort and stability, while their non-Muslim counterparts often experience alienation, loneliness, and hardship. The Muslim elderly live under the protection of their families—among their children, grandchildren, and peers—honored, respected, and cherished.(Al-Qaradi, 1985)

The magazine *Focus* mentioned some of the tragedies faced by the elderly in Japan, America, and Europe. For example, an elderly man was found dead in his apartment in a very upscale neighborhood in Tokyo six and a half years after his death. Another elderly woman was found dead in her apartment, having died of starvation. Most astonishing was the case of an old man who died at over ninety years old, yet no one noticed his death until five days later—despite the fact that he was in a nursing home, and the staff there did not realize he had died.

This does not mean that such phenomena do not occur in our Islamic societies. In fact, the suffering of the elderly in our nursing homes is often worse and more tragic. Elderly people in our societies live under miserable and bleak conditions, not only in nursing homes but also within their own families, where they often lack affection, warmth, and psychological and material care.However, our goal is to highlight how Islam was ahead in caring for this vulnerable group and how Islam considers this care a moral duty for the individual before the state, with severe consequences if neglected. Often, the verses commanding kindness to parents come immediately after the divine command to worship God alone and acknowledge His oneness. Allah says: *"Worship none but Him, and show kindness to parents"* (Al-Isra 17:23). And also: *"Worship Allah and associate nothing with Him, and be good to parents"* (An-Nisa 4:36).And again: *"Say, 'Come, I will recite what your Lord has prohibited to you: that you associate nothing with Him and be good to parents'"* (Al-An'am 6:151).

In Islam, social care relies on the principle of social solidarity, which dictates that the responsibility to care for those in need falls on society, and individuals have the right to demand and seek justice regarding such care. Islam assigns the responsibility of caring for the needy and elderly to their family members, whether they are children, women, divorced, or unable to earn. If the family is unable to provide this care, the responsibility shifts to the state, which takes on the care of the needy or elderly. Islam does not treat this care as charity or voluntary kindness but as a mandatory duty.(Ahmed Abdul-Badi', 1971)

Islam does not treat the elderly as a burden on the individual or society; rather, it sees them as human beings going through a stage of weakness after strength—a natural phase that requires special care.

This care aims to achieve psychological, social, and economic fulfillment, which gradually begins to decline, instead of leaving them prey to isolation, deprivation, and loneliness. The treatment Islam offers stems from the very essence of sound human nature.

The philosophy Islam presents in dealing with the elderly can strengthen cohesion and bonds between different social groups. This philosophy appeared earlier than the social functionalist school of thought, such as those of

Parsons and others. If we treat the elderly with this kind and active spirit of participation, we gain more from their growing experience. We protect them from relaxation and laziness, which usually lead to increased worries, anxieties, illnesses, and physical weakness. This participation also helps fill the void they may feel, making them aware of their dignity, self-worth, and importance in life without feeling like a burden or weight on others.

The Islamic view of the elderly differs from the secular perspective, which limits its concern to certain aspects of an elderly person's life. Islam adopts a divine, holistic, and worshipful outlook that cares about their health, spirit, social life, economy, and psychology, whether the elderly person is Muslim or not.

6-Islam's Care for People with Special Needs:

Historically, the fate of people with disabilities or special needs was no better than that of black people and slaves in some societies. (The term "people with special needs" linguistically corresponds to "the disabled," but human rights organizations have replaced the term "disabled" with "people with special needs" because the former description can break a person's spirit and psyche.) Ancient nations, before the advent of Islam, treated people with disabilities with contempt, disdain, mockery, and ridicule. They were always marginalized and deprived of the right to marry, have children, and other basic rights that ordinary individuals enjoyed. Attitudes toward this group of people varied from one society to another and from one era to another, but all shared the view that people with disabilities were a class that did not deserve the status of human beings. Among some tribes, they faced mass extermination or were left to die of hunger. Others believed they were monsters inhabited by the spirits of demons or evil, and thus considered them a bad omen to be eliminated. Even among the Greeks, specifically the philosophers of ethics and virtue, Plato called for the exile of the disabled or anyone suffering from a defect in their constitution because their existence harmed the state and obstructed its function. Aristotle advocated killing them because they were a burden on society.

In medieval Europe, they were shackled, isolated, imprisoned, and left to their inevitable fate. Humanity's terrible mistakes toward this group of people continued until the early twentieth century when perspectives began to change due to scientific and medical progress, which provided scientific explanations for these conditions. Also contributing to this change were the growing roles of humanitarian philosophies, human rights organizations, and increasing human awareness to some extent. People with disabilities were no longer viewed as neglected groups or as negative, unproductive members of society. Instead, the perspective shifted to assisting them to participate in society and fulfill their social roles, aiming to help them contribute to the production process, participate in building the national economy, and achieve psychological and social adaptation.

Thus, the term **"people with special needs"** refers to an individual who requires special treatment throughout their life or during a period of their life in order to grow, learn, train, or adapt to the demands of their daily, family, work, or professional life. In this way, they can participate in social and economic development processes as much as they are able and to the fullest extent possible as citizens.

They are also individuals who differ from the general population because they have special needs unique to them alone. These needs are represented in services, methods, approaches, devices, or tools that some of their life circumstances require. The nature and extent of these needs are determined by the characteristics of each individual.(Shakespeare, 2006)

According to Abdel Moneim Al-Hafni, the definition of a disabled person is as follows: A person who possesses abilities below the normal level or who has an anatomical or functional defect or deficiency that prevents them from competing with their peers. The disability may be physical, mental, or psychological.(Hafni, 1987)

Islam, with its eternal legislation and noble principles, has taken into account the rights of these individuals. The Prophet, peace be upon him, was once preoccupied with inviting a group of Quraysh leaders to Islam when Ibn Umm Maktum, a poor blind man—unaware that the Prophet was busy with the leaders—came to him requesting to be taught what God had taught him. The Messenger of Allah, peace be upon him, disliked this interruption, frowned, and turned away from him.

Then the Qur'an was revealed at the beginning of Surah "'Abasa" (He Frowned), severely reprimanding the Prophet and affirming the true values in the life of the Muslim community in a strong and decisive manner: **"He frowned and turned away Because there came to him the blind man."**— Surah 'Abasa, verses 1-2.

Umar ibn Al-Khattab, may Allah be pleased with him, was very kind and generous to people with special disabilities and the blind. He never denied their requests and did his utmost to fulfill their wishes. For example, with the blind poet Umayya ibn Al-Askar Al-Kinani, Umar responded by recalling his son from jihad so that he could stay with him. (Abd al-Ilah bin p. 30)Umar ibn Abdul Aziz also wrote to the governors of the Levant (Al-Sham) instructing them to register every blind person in the public registry or any person who was disabled,

crippled, or otherwise unable to attend prayer due to physical limitations. He ordered that each blind person be assigned a guide, and for every two such people, a servant was assigned to assist them

As for the Umayyad Caliph Al-Walid ibn Abdul Malik, he declared that caring for the disabled in society was a state responsibility. He ordered the appointment of a guide for every blind person to ensure their comfort and guidance, and he allocated a monthly salary for the blind to cover their expenses.

This type of social insurance, which the state undertakes through its specialized organizations, is directed toward its citizens, who receive it positively from social organizations. The meaning of social solidarity is that the community stands united and supports one another, whether they are individuals or rulers, rulers or subjects, by adopting positive attitudes based on deep heartfelt convictions rooted in the original Islamic faith. Thus, the individual lives under the protection of the community, and the community thrives with the support of the individual, where everyone cooperates and stands in solidarity. This creates a better, more effective, and necessary social group to protect individuals.

Conclusion

In an era where medical technology has advanced remarkably, and biological information governs treatment decisions, it seems that the relationship between doctor and patient has lost some of its deep human dimension. The patient is no longer seen, in many practices, as a person experiencing pain and searching for meaning, but is instead reduced to an X-ray image, a number in a record, or a precise clinical diagnosis. This shift calls for a fundamental philosophical questioning: What has been lost when medicine favored science at the expense of listening? And what has changed when the body became an object of knowledge rather than being understood as a lived experience?

It has become essential to integrate the concepts of care and caregiving within educational, health, and social institutions—not merely as necessary rules for the proper functioning of society, like laws of justice based on reward and punishment, since respecting such rules alone is not sufficient to achieve human happiness—but rather as a primary moral virtue alongside virtues such as honesty, justice, and trustworthiness. Care should be a fundamental practice in our ethical thinking, behavior, and emotions. It does not force individuals to care for others, but rather it is left to human nature. If that is difficult, proper training and upbringing can enhance the ethics of care. The primary goal of care is to help the weak person move from a state of fragility and distress to a state of independence that enables them to live a normal life.

References

1. Abd al-Ilah bin , U. a.-S. *Summary of the Book Nukt al-Humyan fi Nukt al-'Amiyaan by Ibn Aybak al-Safadi,* introduced by Abdulaziz bin Muhammad al-Sadhan*. Dar al-Sumay'i for Publishing and Distribution.
2. Ahmed Abdul-Badi', A. A.-S. (1971). *State Intervention, .* Dar Al-Nahda Al-Haditha.
3. Al-Qaradi, Y. (1985). The lawful and the prohibited in Islam. In: Indianapolis: American Trust Publications.
4. Aristote, L. (1990). 'Ethique à Nicomaque, traduction Tricot J. *Vrin, Paris*.
5. Bell, M. E. (2008). *The Postmodern Cultural Clinic: Medicine, Femininity and Foucault*. ProQuest.
6. Brockopp, J. E. (2003). *Islamic ethics of life: abortion, war, and euthanasia*. Univ of South Carolina Press.
7. Fisher, B. L. (1976). Medical Nemesis: The Expropriation of Health by Ivan Illich. *Perspectives in Biology and Medicine*, *20*(1), 163-166.
8. Ghaly, M. (2013). ISLAMIC BIOETHICS IN THE TWENTY-FIRST CENTURY: with Mohammed Ghaly,"Islamic Bioethics in the Twenty-first Century"; Henk ten Have,"Global Bioethics: Transnational Experiences and Islamic Bioethics"; Amel Alghrani,"Womb Transplantation and the Interplay of Islam and the West"; Shoaib A. Rasheed and Aasim I. Padela,"The Interplay between Religious Leaders and Organ Donation among Muslims"; Aasim I. Padela,"Islamic Verdicts in Health Policy Discourse: Porcine-Based Vaccines as a Case Study"; Mohammed Ghaly,"Collective Religio-Scientific Discussions on Islam and HIV/AIDS: I. Biomedical Scientists"; Ayman Shabana,"Law and Ethics in Islamic

Bioethics: Nonmaleficence in Islamic Paternity Regulations"; and Willem B. Drees,"Islam and Bioethics in the Context of 'Religion and Science'.". *Zygon®*, *48*(3), 592-599.

9. Gilligan, C. (1993). *In a different voice: Psychological theory and women's development*. Harvard university press.
10. Hafni, A. M. (1987). *Encyclopedia of Psychology and Psychoanalysis*. Madbouly Library.
11. Held, V. (2005). *The ethics of care: Personal, political, and global*. Oxford university press.
12. Noddings, N. (2005). Caring in education. In.
13. Shakespeare, T. (2006). *Disability rights and wrongs*. Routledge.
14. Suad Bin, S. (2020). Feminine Ethics: A Contemporary Moral Necessity – Ethics of Care. *Philosophical Currents Journal*, *1*(1).
15. Toombs, S. K. (1987). The meaning of illness: A phenomenological approach to the patient-physician relationship. *The Journal of medicine and philosophy*, *12*(3), 219-240.