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## Editorial

### Editor in Chief: Dr Sharif Kaf Al-Ghazal

Assalamo Alaikom,

It has been a long time coming but after months of preparation, we're delighted to announce we're finally here. Welcome to the inaugural edition of the long-awaited Journal of the British Islamic Medical Association (JBIMA), the first Islamic medical journal of its kind in the UK. We will be publishing three times a year inshaAllah and it is an exciting time to be involved in JBIMA. Since my election as current president of the British Islamic Medical Association (BIMA) in December 2017, we have been working towards the creation of this project and I am proud that due to the momentous joint-effort of the team at BIMA, JBIMA is a reality.

We are looking to fill a real gap in the UK academic community. There are plenty of academic journals in circulation but none in the UK which put the relationship between Islam and health at the very heart of their existence. Conferences, seminars and webinars aren't alone to satiate BIMA's growing membership's hunger for medical education, a journal will go some way in addressing this.

The remit of JBIMA is broad; we aim to cover a wide variety of topics including but not limited to Islamic medical ethics, the history of Islamic medicine, health advocacy and various Muslim public health issues.

One thousand years ago, Islamic medicine was the most advanced in the world at the time. Even after ten centuries, the achievements of Islamic medicine look amazingly modern. At that time, the Muslims were the great torchbearers of international scientific research. Every student and professional from each country outside the Islamic world, aspired, yearned, and dreamed to go to the Islamic universities to learn, work, live and lead a comfortable life in an affluent and most advanced and civilized society. The Bimaristans of the time (hospitals of the Islamic world) were large and well renowned for their advancements in medicine at the time. Golden era medical practitioners such as Ibn Sina, Al-Zahrawi, Ibn Al-Nafis and others became greatly influential to modern medicine. The impact of their work was a contributor to the Renaissance, though this is still not as well-known as it should be amongst non-Muslim audiences. We aim to share this knowledge and instil this into our psyche.

Rapid advancements in the innovation of medical technology have given rise to the critical need for expansion of the bioethical field to keep up with medical practice and research while relating the ethical decisions to their religious sources and reliable medical knowledge. Muslim bioethicists are doing their utmost to keep pace with and produce answers to the questions posed by the medical establishment. The questions brought up by various topics including abortion, assisted reproductive technology, cloning, organ donation, end of life care and euthanasia are difficult and need to be discussed and debated. The physician-patient relationship, ethical questions regarding consent, confidentiality, as well as the regulation of the Medical Profession and Medical Research are important topics within the professional sphere and should also be explored. JBIMA will provide a platform to facilitate discussion on these topics and help stimulate academic scholarship.

The relationship between Islam and health is one that has not been adequately explored within the UK academic community; focusing on health guidelines contained in prophetic texts (al tib al-nabawi) and in Islamic teachings is a worthwhile endeavour. The noble Quran and Sunnah reflect this and offer guidance on health, physical and mental wellbeing too.

Moreover, JBIMA aims to provide a space to discuss issues concerning the challenges Muslim healthcare professionals face in their workplace which are multifaceted and complex. The diversity of opinion and background of membership within BIMA provides an opportunity for these discussions to take place. These workplace challenges are manifold but include issues such as dress code restrictions for Muslim female healthcare professionals and equality and diversity initiatives in their workplace.

The journal will also provide a platform to publish various opinion articles, letters to the editor, book reviews and other pieces of interest that are relevant to our readers. We hope that the space that JBIMA offers to discuss issues pertinent to our membership keeps them engaged nationally and even appeals to those reading it internationally.

BIMA's mission statement is to Unite, Inspire and Serve. We at JBIMA would like to contribute to the achievement of the goals of this mission statement through our work over the coming months and years. We hope that this journal and its sharing of knowledge can unite and bring the Muslim healthcare community closer together. We hope that the information gleaned by its readers inspires and motivates them to even greater heights. We hope that what is published within the journal benefits those reading it.

And with the dedication of the BIMA family, there is no reason why through the efforts of JBIMA, we cannot make the above a reality. As BIMA has grown from strength to strength since its founding in 2013 until now, we are confident that JBIMA will experience similar success and act as an outlet to ensuring BIMA's mission statement is a reality.

We would like to invite further contributions for upcoming editions. We strive to have a real diversity of expertise and opinion; one that truly reflects the diversity within Muslim healthcare professionals in the UK today. Medical students, Junior doctors other healthcare professionals, and those with an interest in the aforementioned topics, we are happy to publish your work too. The team at JBIMA are more than happy to receive your feedback and suggestions in order to continuously improve our journal and we look forward to hearing from you as we develop.

Wassalamo Alaikom

Yours truly,

Dr Sharif Kaf Al-Ghazal  
Editor in Chief

## Principles of Islamic Medical Ethics

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### Abstract

Islamic bioethics refers to Islamic views on issues related to both the medical and research fields. Islamic bioethics is an extension of Shari'ah (Islamic law), which is itself based on two foundations: The Qur'an (the holy book of all Muslims) and the Sunna (the aspects of Islamic law based on the Prophet Muhammad's words or acts). Islamic law is a compendium of morality, ethics, and legal rules. The fundamental basis of Islamic bioethics is that all rulings and actions must fall in accordance with Islamic law (Shari'ah). The objectives of the Shariah (Maqasid al-Shariah) is divided into three categories, dharuriyyat (essentials), hajiyyat (necessities), and tahsiniyyat (desirables). Of these, the most critical is "dharuriyyat" where five matters are given prominence for protection and preservation, namely the protection and preservation of faith, life, intellect, progeny, and property. Besides, contemporary scholars made use of the five qawā'id fiqhiyya (Islamic legal maxims) namely: intention, certainty, removal of hardship, elimination of harm, and custom, in their endeavor to determine the legal ruling for the various novel issues.

This review summarizes the principles of Islamic medical ethics and the methodology used by the Muslim jurists in deriving rulings on rising issues in the field of medical ethics.

### Introduction

Medical ethics has been defined as "the analytical activity in which the concepts, assumptions, beliefs, attitudes, emotions, reasons and arguments underlying medico-moral decision making are examined critically" (1). According to Beauchamp and Childress, ethics is a "generic term for various ways of understanding and examining moral life (2). Bioethics is a branch of applied ethics concerned with resolving problems in the area of living sciences, including research and practice of medicine. Islamic medical ethics refers to Islamic guidance on ethical or moral issues relating to medical and scientific fields, in particular, those dealing with human life.

Islam made every effort to build a distinct personality of the Muslim that conform to principles of morality and considers medical ethics the same as ethics in other aspects of life. The Prophet Muhammad (Peace Be Upon Him) (PUBH) said: "I was dispatched to complete morality" (3).

While the medicine practiced by Muslims and for Muslims is generally the same medicine practiced in the West today, the medical ethics may be different. This means that the use or nonuse of a renowned medical treatment by Muslim doctors will sometimes be guided more by ethics derived from Islamic law than by purely medical considerations (4). While Islamic ethics incorporates various philosophical traditions it still holds a religious worldview and draws its resources mainly from religious texts (5).

In response to new medical technology, Islamic jurists, informed by medical experts, have regular conferences at which emerging issues such as organ transplantation, brain death, assisted reproduction, genetic engineering are explored and consensus is sought. Our investigations in bioethical issues require Muslim ethicists to examine a number of judicial decisions made by Muslim scholars in response to the growing number of cases in the clinical settings (6).

Today there is an increasing interest in medical ethics from an Islamic perspective in The West. Both Muslims and non-Muslim healthcare providers have shown sustained interest in Islamic viewpoints in medical practice and research to cater to the health care needs of the Muslim population in Western countries (7).

## Usul al fiqh (the principles of Islamic jurisprudence)

Uṣūl al fiqh is the methodology and principles by which Muslim jurists derive legal rulings from the foundational sources of Islamic law which are primarily the Qur'an and the hadith (Sunna). Islamic jurisprudence is divided into two parts:

**I. Usul (fundamentals):** which formulate the basic sources of Islamic laws. The main sources of Islamic law (Shari'a) consisted of:

1. *The Holy Qur'an.*

2. *The Sunna:* (The trodden path) which includes the sayings of the Prophet (PUBH) known as the "Sunna Qawliyya" or Hadith, the deeds and acts of the Prophet "Sunna Filiyya", and the Prophet approvals "Sunna Taqririyya", whether they are expressed or implied.

3. *The Qiyas;* or "Ijtihad" whereby the jurists or Qadi (judge) would use analogy and reasoning to arrive at the judgment that is not mentioned in the Holy Qur'an or Sunna.

4. *Ijma:* this is the consensus of opinion of jurists. It is well-known that true Ijma of the jurists over the world has been always difficult to meet. However, achieving the consensus of the majority of opinions is a more realistic option.

There are other sources like "Almasalih Al Mursalah" which is held by the Maliki School. This simply means taking care of public interest, provided it does not clash with a clear text of the Holy Qur'an or Sunna. The Hanafi School has a similar source which they call "Istihsan"; i.e. seeking the best solution for the general interest. This superstructure is very rational. This is seen especially in the use of qiyas (analogy) in the development of shari'ah

(Islamic law).

**II. Furu'**- i.e. branches of Islamic jurisprudence which includes the details of every aspect of life and worship (Ibadat and Mu'amalat).

The principle of 'Urf or 'A' da: This is a major source of problem resolution that embodies considerations based on custom, tradition or local habits. 'Urf' is accepted as a source of judicial decision making so long as there is no provision of the matter in the revealed texts (the Qur'an or the Sunna). Sadd al- Dhara'i' (blocking the means): is another reasoning procedure that some jurists considered to be a source of legislation, especially in the Maliki school (6,8) .

Al-Shāṭibī (d. 790 AH) suggested that the whole process of ijtihād, whether or not directly linked with the text, should consider maṣlaḥah (utility or benefit) as the "spirit" of the objectives of Islamic law.

## Maqasid al-Shariah (objectives of the Shariah)

Muslim jurists were faced with new ethical problems, and in the absence of clear evidence or juristic precedent on contentious ethical issues, they have taken recourse to the Maqāsid al- shari`a, the purposes of the law.

The five cardinal essentials of Islamic teachings are: 1-Preservation of Faith (di'n), 2- Preservation of Life (al-nafs), 3- Preservation of Mind (al-'aql) , 4- Preservation of Progeny (al-nasl), and Honor (al-irdh), 5- Preservation of Property (al-ma' l).

Numerous branches of medicine are clearly deeply intermingled within all these five purposes, directly or indirectly. Thus, anything that preserves one of these five purposes is regarded as beneficial, while anything that contributes to its detriment is immoral, and preventing it is deemed good (9). Knowledge of Maqasid al-Shariah is especially useful in bioethical applications and an important prerequisite in the formulation of any "fatwa" (religious decisions) through the process of ijtiḥad. Ijtiḥad is a process of self-exertion by a "mufti" to deduce a fatwa on any issue that does not have direct guidance in the primary sources of the Quran and the Prophetic traditions.

The aims of Shari'ah were discussed fully by Muslim scholars 1,000 years ago. For instance, Imam al-Juwayni (d 478/1185) said: "The aims of Shari'ah are nothing but the interests of the entire humanity." Imam al-Ghazali (d 505/1111) discussed al-Maqasid under the principle of the public interest.(10)

The objectives of the Shari'ah (Islamic rules) (Maqasid al-Shariah ) could be divided into three parts: 1- Necessities

(daruriyat): These include preservation of faith, life, mind, progeny, property. They are essential for life, religion, and community. 2- Needed Things (hajiyat): These are needed for the community, or for persons. People can live without procuring them, but they are recognized needs for the welfare of society and individuals. 3- Recommended (tahsiniyat): They are also needed by the society or individuals to make life more comfortable and, more beautiful, and try to reach the level of satisfaction and happiness for both the individual and society (10,11).

Al Izz ibn Abdul Salam, a renowned Islamic jurist (d 660H/1243 CE) in his book “Qawa’id al Ahkam (Basics of Rulings)” said: “The aim of medicine, like the aim of Shari’ah (Islamic law), is to procure the maslaha (utility or benefit) of human beings, bringing safety and health to them and warding off the harm of injuries and ailments, as much as possible.” He also said: “The aim of medicine is to preserve health; restore it when it is lost; remove ailment or reduce its effects. To reach that goal it may be essential to accept the lesser harm, in order to ward off a greater one; or lose a certain benefit to procure a greater one (12). This is a very pragmatic attitude, which is widely accepted, in Islamic jurisprudence, and it is frequently applied in daily practice in all fields including medicine (6).

In medicine, there are sometimes difficult decision-making options for the patient’s care. Thus, a physician at times has to decide for his/her patient in light of available knowledge, his/her experience, his/her peers and consensus of the community. In addition, a Muslim physician derives his/her conclusion from rules of Islamic laws (Shari’ah) and Islamic medical ethics.

The first main principle of Islamic Medicine is the emphasis on the sanctity of human life which derives from the Qur’an: “If anyone saved a life, it would be as if he saved the life of all mankind”(13). The verse says: The person who helps to preserve the life of even one person is the protector of the whole of humanity, for he possesses a quality which is indispensable to the survival of mankind.

The second main principle is the emphasis on seeking a cure. Prophet Muhammad (PBUH) is reported to have said: “Seek treatment, for God the Exalted did not create a disease for which He did not create a treatment, except senility” (14).

## The five Principles of the Law (qawa’id fiqhiyya) of Islamic medical ethics

The qawā’id fiqhiyya or “Islamic legal maxims” refer to a body of abstract rules which are derived from the detailed study of fiqh (Jurisprudence) itself. Numerous maxims and subordinate rules were collectively derived from the application of uṣūl al fiqh on the primary sources, and out of these, there are five major maxims of particular

significance to medical practice and to the field of Islamic medical ethics.

The five universal maxims, including their subsidiaries, are considered the most important in the whole discipline, and seen as representative of the entire field. It is said that the whole fiqh is based on them, and the essence of the Shariah as a whole is grasped between them. They are as follows: 1. al-umur bi-maqasidiha (matters are judged in light of the intention behind them), 2. al-darar yuzal (harm must be eliminated). 3. Almashaqqah tajlib al-taysir (hardship begets facility). 4. al-yaqin la yazal bil-shakk (certainty is not overruled by doubt). 5. al-adah muhakkamah (Custom can be the basis of judgment). It is remarkable that the concepts, which the five maxims represent (namely: intention, certainty, removal of hardship, elimination of harm and custom) are mainly ethical, and are integral to the general Islamic concept of maslahah (utility or benefit), and of course, have legal function in this context (15).

1.AL-UMURU BI MAQASIDIHA (Matters are judged in light of the intention behind them):

This maxim implies that any action, whether it is done physically or verbally, should be judged in the light of the intentions of the doer. Intention (niyya) is very important in any deed in Islam. The Prophet (PBUH) said: “Deeds are judged by intention”(16). According to many scholars, this Hadith is among the traditions upon which the whole spectrum of Islamic knowledge depends. An action though may be good apparently, but done with bad intention will be judged by God on the Day of Judgement, and will be punished. On the contrary, if someone intends to do a good deed, but when performing it, he unintentionally produced some harm, then he will be pardoned. The prayer in the Qur’an touches upon this theme: “Our Lord do not impose blame upon us if we have forgotten or erred” (17). Pain relief in terminal care is an obvious example. The prescription of morphine with the intention of causing respiratory depression and therefore premature death is considered “euthanasia” and would be deemed impermissible. On the contrary, providing analgesia with respiratory depression as an unintended consequence would be deemed permissible (6, 9).

2.AL-YAQINU LA YAZALU BI-L-SHAKK (Certainty is not overruled by doubt):

This maxim means that what is established with certainty is not removed by doubt. Al-Nawawi said expressing the idea of this maxim : “Things are legally assumed to remain as they are unless and until it is established with certainty that they are otherwise; and that extraneous doubts are of no consequence”.<sup>18</sup> . Medical diagnosis cannot reach the legal standard of absolute certainty, (yaqeen). Treatment decisions are based on a balance of probabilities. Each diagnosis is treated as a working diagnosis that is changed

and refined as new information emerges. The principle of certainty asserts that uncertainty cannot abrogate an existing certainty. All medical procedures are considered permissible unless there is evidence to prove their prohibition (19).

### 3. AL-MASHAQQATU TAJLIBU AL-TAYSIR. (Hardship begets facility):

In the medical setting a hardship is defined as any condition that will seriously impair physical and mental health if not relieved promptly. This maxim indicates that if any implementation of the law causes hardship to an individual, then there are alternatives one can do instead, in order to overcome these hardships and difficulties (15). There are several Quranic verses and Hadiths of the Prophet (PBUH) which indicate that Allah intends to provide facility and to lift all kinds of unbearable hardship from human beings. "...Allah wants ease for you and He does not want hardship for you..." (20). "...Allah does not give anyone legal responsibility for anything except what is within their capacity" (21). In this regard, the Prophet (PBUH) said: "God did not send me to be harsh, or cause harm, but He has sent me to teach and make things easy" (22). Several legal principles were derived from this maxim, especially those, which relate to the concepts of *darurah* (necessity) and *hajah* (need). Among them is the rule "Al-daruratu tubihu al-mahzurat (necessity makes the unlawful lawful). However, committing the otherwise prohibited action should not extend beyond the limits needed to preserve the purpose.

This can be applied to medical interventions, such as sterilisation which is absolutely prohibited in Islam, but it becomes permissible if a potential pregnancy severely threatens a woman's life (6,9). Similarly, prohibited treatment may become permissible if it is considered a life-saving treatment for the patient.

### 4. AL-DARARU YUZAL (Harm must be eliminated):

This maxim is derived from the Prophet hadith "la darar wa la dirar" (23). Darar is defined as "a detriment caused to the interests of oneself or of others". Eliminating harm is portrayed as one of the major principles of Shariah to which all legal determinations can be traced back. This includes preventing its occurrence, since protection is better than cure, and, in case it occurs, eliminating it by whatever means (15). Medical intervention is justified on the basic principle is that injury, if it occurs, should be relieved. An injury should not be relieved by a medical procedure that leads to an injury of the same magnitude as a side effect. In a situation in which the proposed medical intervention has side effects, we follow the principle that prevention of an injury has priority over pursuit of a benefit of equal worth. If confronted with two medical situations both of which are injurious and there is no way but to

choose one of them, the lesser injury is committed (6,19).

### 5. AL-ADATU MUHAKKAMAH. (Custom can be the basis of judgment):

The terms "urf" and "adah" are Arabic terms which are normally both translated as "custom" and what is considered customary is what is uniform, widespread, and predominant and not rare. local custom is taken into consideration, provided it does not contradict the shari'ah legal force. The disclaimer is that the customary practice must be the predominant and widespread practice of medical practitioners in order to be rendered valid (9). Finally, this fundamental methodology, systematized by the early Muslim scholars over one thousand years ago, is still employed by Muslim jurists to deduce rulings on a number of issues, including the more challenging ones brought about by the modern medical advancements over the last few decades.

## Conclusion

Currently there is an increase in bioethical discourse amongst Muslim scholars from all parts of the world. Most of these discussions look at specific issues pertaining to the permissibility of a new technological application. A number of issues in the field of bioethics were raised in the last few decades and Muslim jurists have been active in studying these contentious subjects and providing religious and ethical guidance in the form of fatwas (religious decisions) that are followed by healthcare providers in the Muslim world.

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## Islamic Descriptions of Human Bodily Dignity in the Dead

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### Abstract

There is a serious shortage of organs for transplantation in the UK. This is even more problematic for the UK Muslim community of South Asian ethnicity, as they are at greater need of organs than others, yet they are less likely to donate. It is shown that this is because of their perception about the body, its dignity, and the inter-relationship between the person, her body and God. This normative concept of human bodily dignity and its violation is poorly understood in view of contemporary western bioethical considerations.

This article will examine Islamic understandings of violation of bodily dignity and the ethical-legal relationship between person, body and God, as viewed by the classical Muslim jurists of the past in their legal verdicts and the contemporary Muslim scholars' interpretation of these texts. A scholarly objective account of the differing descriptions will be provided, detailing how all this reflects on modern day medical ethical issues.

### Introduction

Current literature referring to cadaveric human organ use from an Islamic perspective generally refers to rulings that govern the type of actions vis-à-vis the human body, and draws parallels between the kinds of discourse that was present in the early classical text of Muslim jurists to tangible modern bioethical considerations today. This has proved to be quite challenging and has led to an uncomfortable hardening of sensibilities and attitudes towards the conception of self and body.<sup>1</sup> The most important factor which is seen to be the limiting concept to what we are permitted to do with our bodies is the violation of human bodily dignity and integrity (ikrām al-ādmī). There is a lot of classical literature in books of fiqh (Islamic substantive law) which makes mention of human dignity ikrām al-ādmī when this human bodily dignity is to be preserved and not violated.<sup>2</sup> Contemporary Muslim jurists have described human bodily dignity or inviolability (ḥurma) in different ways. They all refer to the preservation of the integrity of the human body as a means of preserving this dignity, in the living as well as in the dead. However, it is unclear what they mean by ḥurma of the body and how this reflects on our current bioethical understandings of human bodily dignity. This article is an attempt to present some coherence to these normative descriptions.

### Modern day bioethical and philosophical understandings of human dignity

Those who do not assign intrinsic value to the body argue that the body is of instrumental or incidental value and not essential value, and if mental life could survive outside the body, then the body would have no moral significance.<sup>3</sup> Its value only exists in relation to the human person being an embodied being. Once the person is removed, the body is just a shell that can be potentially used for other goods. This view employs an extrinsic value to the physical body, as the person-orientation view. Others disagree, and consider the body as something much more. It is our person and soul and relates to our moral self. The body has a value that extends beyond the individual as a means of establishing social identity and social behaviours.<sup>4</sup> Our psychology links itself to the body both in terms of self-agency (control over the physical self) as well as self-coherence (preservation of the non-fragmented self as an integrated whole), both of which are considered necessary attributes of a healthy psychology.<sup>5</sup> This intrinsic value to the body view employs sacredness or an intrinsic value to the physical body in a socio-political order, which extends to its natural, biological order<sup>6</sup> as the body-orientation view.

Respect for bodily dignity and integrity can be viewed from two diverse views- the person-orientated and the body-orientated view. Western bioethics gives more weight to the person-orientated view, which is based on respect of persons and autonomy.<sup>7</sup> The body-orientated view refers mainly to duties to one's own body rather than others. As a result, it can conflict with the person-orientated view, in that it is not always consistent with personal autonomy and self-determination. This intrinsic value to bodily integrity implies that our body is not entirely owned by us and that we are prohibited in doing certain things to our body that violate its dignity. This body-orientated approach is found mainly in religious doctrine such as the monotheistic traditions of Judaism, Christianity and Islam, and can also be found in classic Greek and Roman thought, as well as in the works of philosophers such as Aquinas, and Kant.<sup>8</sup>

Most of the literature on the body-orientated view can be categorised under two general approaches to bodily integrity<sup>9</sup>.

**1. The biological approach to bodily dignity** – This refers to the functional body as an integrated whole, made from anatomical and physiological parts. Violation of the bodily integrity in this view refers to two notions;

(i) *The intactness view*– this includes any form of physical injury, mutilation or removal of organs. Even if the functioning of the body is not compromised as a result, such a procedure requires justification.<sup>10</sup> The dead body, therefore, also possesses this integrity, which demands respect. In contrast to the living, invasive procedures on the dead body require greater justification. The reason for this is that invasive procedures on the living may be justified in preserving the well-being of the person, which is not the case for the dead.<sup>11</sup> Islamic literature refers to this as mutilation (*tamthīl*) of the body – The human body (*al-jasad*) is not to be physically mutilated and unjustly tampered with. Excision or procurement of an organ from an individual's body, where there is no benefit for him, is considered mutilation (*tamthīl*).<sup>12</sup> This act is a violation of that which belongs to God, and serves no purpose or benefit to the one whose body is violated. The offence of mutilation extends to the dead corpse also, and both the dead and alive are equal in *ḥurma*. The Prophet Muhammad said, “Breaking the bones of the dead is a kin to breaking the bones of the living,”<sup>13</sup> and, “causing injury to a dead believer is similar to causing him injury when he is alive.”<sup>14</sup> There is a general consensus amongst most contemporary scholars that such an act is strictly prohibited (*ḥarām*) or at least disliked enough to be impermissible (*makrūh*)<sup>15 16</sup>. Al-Shaukāni<sup>17</sup> comments regarding the former *ḥādīth*<sup>18</sup>, that this *ḥādīth* identifies the caution required in ensuring that due care is taken in performing the ritual bath, shrouding, burial and other related acts, and that this applies to both Muslims and non-Muslims. He further states:

... if sin is committed against the cadaver, then there is no doubt that this is impermissible (*fī tahrīm*). And if there is injury, then, just as it is prohibited to cause injury to the living, it is prohibited to cause injury to the dead.<sup>19</sup>

The Ḥanbali jurist, Abu al-Khaṭṭāb<sup>20</sup> refers to this *ḥādīth* in context only to bones and not the flesh. He specifies that this *ḥādīth* relates only to prohibition and not the degree of prohibition.<sup>21</sup>

To excise or remove an organ or tissue from the living and equally in the dead is considered a violation of this dignity according to this description.

(ii) *The functional view*– this view permits invasive procedures and the removal of organs or body parts as long as bodily function is not compromised. This is the more universal bioethical view related to harm considerations<sup>22</sup>, which may permit the transplantation of non-vital organs from the living, depending on the balance of harms. Modern day thinkers make claim that the extent of violation of bodily integrity depends on how replaceable the organ is, and on how functionally dependant the body is on that organ.<sup>23</sup> Islamic literature refers to this as functional harm (*ḍarar*) to the body – Life is a gift from God and no one has the authority to destroy it without a justified cause acceptable to God. The functional component of our bodily integrity is what preserves life, and if the *ḥurma* of this functional component of our bodily integrity is harmed, then our life will suffer. God states in the Qur'ān, “Do not kill yourselves, for God is Merciful to you,”<sup>24</sup> and, “do not put yourself into destruction by your own hands”<sup>25</sup>. Suicide or any direct attempt to harm self is therefore prohibited, as this violates the dignity, *ḥurma*, of the human body. Allowing others to harm self, when there is no benefit for self or others, is also prohibited, because the bearer of life cannot authorise to destroy self without the behest of the originator of life; Almighty God.<sup>26</sup> The importance of preserving the functional component to bodily integrity is evident in the many concessions (*rukḥṣa*) that *sharī'ah* grants in difficult circumstances.<sup>27</sup> An example of such a concession is the permissibility of dry ablution (*tayammum*), as a prerequisite to the performance of daily prayers, instead of the obligatory wet ablution (*wuḍū*). This is in cases where water is scarce or harmful, and serves the purpose to prevent potential detriment to health. Another example is the concession given to the frail, the pregnant and the ill, in keeping obligatory fasts, so as to preserve health and prevent harm. It is considered permissible for individuals to consume wine, to the extent necessary to avert harm. This is for the one who is choking whilst eating, if no other drink is available. Other concessions are given for those who are weak and ill in performing their obligatory prayer and pilgrimage, and for the ill to consume unlawful medication when alternate forms of therapy are unavailable. All these concessions are granted in the *sharī'ah* to preserve the functional component of our

bodily integrity.<sup>28</sup>

This interpretation of bodily integrity is in line with the functional component of the body-orientated view, where to harm any part of the living body is prohibited. Distinctions exist between the intactness component and the functional component of human bodily integrity, in that the dead do not have a functional component, because their body has ceased to function in the worldly sense. This suggests that the functional component is specific only to the living. Another distinction is the strength of the functional component in comparison to the intactness component<sup>29</sup>, in that the violation of the intactness component to bodily integrity (mutilation) is tolerated to preserve the functional component to bodily integrity, on medical grounds, if it is proven to be of benefit to the individual.<sup>30</sup>

## 2. The objectification approach to bodily integrity –

Ethical concerns about body objectification are not about whether bodies can be objectified, because bodies are objects and objects cannot be objectified.<sup>31</sup> Rather, the ethical concern of objectification of bodies is in treating bodies as mere objects in terms of their use and their value. This would suggest that the body has attributes (in use and value), that are beyond other objects for them to deserve such respect in contrast to other objects. These attributes are the result of the intimacy that exists between body and the person. A living person's body demands greater value than that of the dead person's body. This, however, does not deny value in a dead person's body, but attributes a value, in so far as the respect accorded to the person who was, and whom that body belonged to, or in religious contexts that value the body possesses in its connection to a 'life after death'.<sup>32</sup> Violation of bodily dignity, in terms of objectification of the human body or parts, therefore, can refer to two broad views;

(i) *The Instrumentality view*– This view refers to the treatment of organs or body parts as mere tools. This view may be represented as a subjective view of an irreducible self as an integrated whole. It does not consider removal of organs a violation of bodily integrity, but considers their instrumental use in the transplantation process problematic, in terms of integrating something that belongs to one, into another as a means.<sup>33</sup> Transgressing rigid boundaries of self and others<sup>34</sup> as well as significantly physically changing the body, threatens and disrupts bodily integrity<sup>35</sup>. Islam describes this as objectification of the body<sup>36</sup> – The entire universe has been created for the benefit of mankind. Within reason man can use its resources to his benefit. "Indeed, We honoured mankind"<sup>37</sup> and "It is He (Almighty God), who created for you, all that which is on the earth"<sup>38</sup>. It would be contrary to this, if man's body or body parts were used, other than what God had ordained, as this would violate human bodily honour and sanctity.<sup>39</sup> Ibn Nujaym<sup>40</sup>, states that,

...it is not permissible to sell or make use (intifāʿ) of human hair. This is because man is honoured (mukarram) and he is not to be defiled (mubtadhal). Therefore it is not permissible that any part of his body is objectified in an undignified way (muhānan mubtadhalan).<sup>41</sup>

The Muslim jurists describe the violation of the human bodily sanctity in this sense as a form of objectification, which can be interpreted in two ways; (i) instrumentality, and, (ii) fungibility.

### *Instrumentality*

The human body is moulded in the best of physical forms<sup>42</sup>, and every human body part has its natural form and purpose. This natural form and purpose must not be altered at will, but rather, it should be preserved in respect of bodily sanctity and dignity.<sup>43</sup> The Holy Qur'ān states:

He Who created you, then brought you in due proportion, then perfected you. In whatever form He wills, does he put you together.<sup>44</sup>

...[satan says:] I will lead them astray and tempt them with false hopes. I will command them and they will slit cattle's ears. I will command them and they will alter God's creation.<sup>45</sup>

Manipulating or changing our body in its form and use, from its natural or purposeful state, is a violation of bodily dignity. This is because it defiles the creation of God (taghayyar fī khalq Allāh).<sup>46</sup> Such an act considers the human body or its parts as instrument(s) that can be manipulated in form and use in accordance to our own fancies. The dead body and its parts should be buried as soon as is possible, as anything other than this is to misuse and thus dishonour it.<sup>47</sup> This instrumentality of the human body can be interpreted as a violation of the objectification component of the body-orientated view, which prohibits the misuse of human bodily parts as an instrument or for cosmetic purposes.

(ii). *The Fungibility view*– Fungibility is when a person is treated as replaceable with another similar or identical person or thing. It would be a violation of dignity to consider a person fungible, because a person is beyond price.<sup>48</sup> Whatever has a price can be replaced by something else as its equivalent; on the other hand, whatever is above all price, and therefore admits of no equivalent, has a dignity.<sup>49</sup> The dead body or parts can therefore also be interpreted as having a dignity, sanctity and integrity just as the living body, because they symbolise mankind.<sup>50</sup>

The human body is not fungible it is not interchangeable and has no price. To place a price on a human body part is to devalue it, because it is above price (māl ghair mutaqaawam). Therefore to sell a free man or his body parts, dead or alive, is prohibited. Body parts are

not interchangeable for monetary gain. They are not a commodity, and to consider them so, is to devalue them and to violate their dignity.<sup>51</sup> Ibn ‘Ābidīn<sup>52</sup> states:

Man is lawfully honoured even if he is an infidel; [making him the subject] of a contractual profit, abusing him therewith and attaching him to the inanimate is humiliation to him; in other words it is prohibited.<sup>53</sup>

If the corpse of a non-believer is considered honoured and cannot be objectified, as is stated in the ḥadīth, “there should be no sale involving the corpse of a non-believer,”<sup>54</sup> then it follows that the same would apply to the corpse or body parts of a believer. This fungibility of the human body can be also be interpreted as a violation of the objectification component of the body-orientated view, which prohibits the commodification of human bodily parts. Fungibility is a notion which is more apt under the bearing of human body as property, and bodily rights.

The objectification component of ḥurma holds great moral value, but not to the degree of the functional component, depending on degree of harm. Violating the objectification ḥurma is only permissible in the state of necessity (darūra)<sup>55</sup> for the Shafī‘ī jurists and some of the Malikī and Ḥanbalī jurists.<sup>56</sup> For most of the Ḥanafī jurists the objectification component of ḥurma holds relatively greater value, even in the state of necessity. This is evident in the situation of eating the flesh of the dead, where the Ḥanafī jurists consider it impermissible to eat the flesh (a body part) of the dead, even in situations where the omission of such an act threatens life. To consider a body part a consumable, a purpose which is contrary to its nature, violates its dignity- whilst in the case of human milk, also considered part of the body, its consumption for infants, or indeed adults<sup>57</sup>, is permitted with conditions. Similarly blood, also considered a body part, can be transfused in another in cases of necessity, because they both serve a purpose the nature for which they were created. Their dignity is therefore not violated, or at least, is tolerated.<sup>58</sup>

How the contemporary jurists identify this ḥurma of objectification related to the human body and how the principle of necessity fares in such considerations is considered the most challenging part of the debate on organ transplantation.

## Conclusion

The two primary sources of the sharī‘ah<sup>59</sup> do not provide detail on the issue of human organ use. For this reason, a lot of the contemporary literature by contemporary Muslim scholars relate human organ use to a number of traditional cases. These cases serve as a basis for analogical reasoning. The traditional cases describe actions vis-à-vis the human body and their rulings, as viewed by the classical Muslim jurists. They therefore provide some understanding of the

limits to the ḥurma of the human body in relation to other moral considerations. Muslim scholars and academics should articulate human dignity using these prime descriptions<sup>60</sup> of the violation of human bodily dignity, in context to these traditional cases. This will not just allow for a more nuanced approach to understanding the kinds of bodily dignity but also the limits to what degree such dignity can be compromised in cases of medical need and necessity such as in organ transplantation, cadaveric autopsy for research and teaching purposes, as well as use of human body tissue for other medical reasons such as stem cell research.

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54. al-Baihaqī, Aḥmad ibn al-Hussain (d. 364 A.H.), *al-Sunnan al-Kubrā*, (Hyderabad, Dār al-Ma‘ārif al-Uthmāniya, 1940) vol. 9, p. 133.
55. *Ḍarūrah*, in its technical sense, refers to a state of duress where one is compelled to act contrary to what Almighty God has prohibited in the primary Islamic sources to preserve what the sharī‘ah considers of greater importance. In other words, a lesser right of Almighty God is waived to one of greater priority. Ibn Nujaym, *Zayn ud-Dīn bin Ibrāhīm* (d. 970 A.H.), *al-Āshbāh wa al-Nazā’ir ‘alā Madhhab Abī Ḥanīfah al-Nu‘mān*, (Beirut, Dār al-Kutub al-‘Ilmiyya, 1999), p. 73.
56. Contemporary Muslim scholars must cite the authentic works of recognised classical Muslim jurists of the past in support of their view and their ascribed school of legal jurisprudence. Majority of the Muslims in the UK ascribe to the sunni school of thought, and space does not permit me to refer to other schools other than the four most accepted sunni schools- namely, the Ḥanafī, Malīkī, Shāfi‘ī and Ḥanbalī schools.
57. Jurists permit blood transfusion on the basis that human milk is also a body part and can be benefitted from by other individuals. See: Shafi‘, *Islam on grafting and transplanting*, pp. 36-40.
58. This would explain why it is permissible in the sharī‘ah for a woman to breast feed children other than her own. Shaykh al-Nīẓām, *al-Fatāwā al-Hindiyya*, vol. 4, p. 112; Ibn ‘Ābidīn, *Hāshīā*, vol. 7, p. 264; Jurists permit blood transfusion on the basis that human milk is also a body part and can be benefitted from by other individuals. See: Shafi‘, *Islam on grafting and transplanting*, pp. 36-40.

59. The Holy Qur'ān and the Sunna are considered the primary sources of the sharī'ah, where the sunna refers to the second level of legal proof after the Holy Qur'ān. See: Kamali, M. H., Principles of Islamic Jurisprudence, pp. 61.

60. Arguably, there are other prime descriptions related to the violation of human bodily dignity, such as bodily modesty ('awrah)- ensuring the private parts of the body are always covered, but these descriptions have not been considered in the debate on organ transplants because such violation can be easily overcome with due care and attention, and it does not hold direct relevance to the subject.

# The Issuing of (Medical) Fataawa in the UK - Time for a Multi-Disciplinary Approach

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## Abstract

A major challenge faced by contemporary Muslim scholars is to be able to give religious rulings in their proper context to novel issues which have not been encountered by previous generations while maintaining continuity with the Islamic legal heritage, and also to be able to modify legal rulings of old to modern circumstances, considering current scientific knowledge. Sunni Muslims in the world do not have a supreme judicial-religious authority to give legal religious rulings (fataawa, singular fatawa) in such circumstances and individual Muslim jurists are free to issue legal religious rulings. This can be problematic if the individual Muslim jurist has not fully grasped the correct understanding of the reality of the subject matter in question. This article focuses on 3 such examples from the UK to highlight this problem.

## Introduction

In the major Sunni sect of Islam and to a lesser extent in the Shia minority sect, there is no overall figurehead as there is in the Catholic Church. Due to the absence of such an authority, different rulings may be issued for a particular problem by individual Muslim jurists, known as the fuqaha (plural of faqih) or muftis, or by regional organisations. When there is no clear-cut ruling in the religious texts the Muslim jurists use independent legal reasoning (called ijtiḥad) to derive a religious ruling. Individual religious scholars are free to issue legal rulings on all matters affecting the conduct of the followers of their Faith from such diverse issues such as the start and end of the month of fasting, which medical interventions break one's fast, the permissibility of certain medical procedures such as organ donation, the permissibility of cryptocurrency, and so on, in fact, virtually in every aspect of religious and social life.

Many such matters, either because they have not been encountered by previous generations or because of a new set of circumstances, require a great deal of background

specialist knowledge. It is not possible for one individual to acquire adequate knowledge of such matters as it requires a great deal of investigation and often understanding of novel concepts which one may not be accustomed to doing. Without such background knowledge, that is to say, without the correct understanding of the reality of the subject matter in question, any subsequent legal ruling (referred to as fatawa<sup>a</sup>, the plural being fataawa) on the subject is likely to be erroneous and hence, problematic for the followers of the Faith over time as it becomes apparent that the original fatawa was not constructed on a firm footing.

To illustrate this principle we shall examine three cases, although there are a lot more which could be cited, where a lack of deliberation with appropriate experts has led to the issue of legal rulings which has left the UK Muslims either in confusion and doubt or they have simply not taken the ruling on board.

<sup>a</sup> A fatwā is a legal opinion on a particular issue from a Islamic law perspective given by a qualified jurist called mufti or faqih

## Case 1

On the 28th of December 1986, 21 Muslim scholars signed a declaration under the title of “All Agreed Decision of New Moon” to follow Saudi moonsighting announcements so that the dates for start of Ramadan and the two Eids would be based on the Saudi hilal<sup>b</sup> sighting announcements from Riyadh. Although the intention of those involved in signing the declaration was sincere their methodology of not involving any experts in the field of astronomy in the decision-making process has to be questioned. All the signatories of the 1986 agreement were religious scholars, many were just mosque imams. The end result of the 1986 declaration has, unfortunately, split the UK Muslim community into two camps. So at a time of joy and celebration there are feelings of confusion, doubt and embitterment. Had experts been involved during the decision making process they would have informed the religious scholars that the criteria used to construct the Saudi Umm al-Qura<sup>c</sup> calendar is not based on actual moonsighting. For the majority of the months of the year the Umm al-Qura calendar is at least a day ahead of the actual moon being sighted, and this expectation of hoping to see the new moon crescent as predicted by the pre-calculated Umm al-Qura calendar leads to frequent false sighting of the new moon crescent in the Kingdom of Saudi Arabia. This fact of frequent false sightings has been confirmed by a recent article published by Saudi astronomers in The Observatory Journal (T. Alrefay, 2018)<sup>1</sup> which looked at 27 years of moonsighting reports from the Kingdom of Saudi Arabia.

## Case 2

In 1995 the Ministry of Health (UK) approached the Muslim Law (Shariah) Council UK regarding organ transplantation, who subsequently issued a fatawa stating that organ donation is allowed in Islam. 25 years later the Muslim community is still debating the same issue. Why was the fatawa not accepted by the general Muslim community in the UK? The Muslim Law (Shariah) Council UK did summon a group of scholars and other experts to discuss the matter in detail before issuing their fatawa but there were a number of problems with their approach. The group of scholars who got together did pay a visit to Queen Elizabeth Hospital in Birmingham to try to understand what is involved in organ donation and presumably brainstem death as well because they issued a fatawa on the latter issue as well. It is interesting to note that of the 18 names mentioned in the final ruling, besides the head of the group Dr. M.A. Zakai Badawi most were religious scholars of which 6 were imams from UK mosques and 3

were barristers. The area of specialisation of the 3 barristers is not mentioned nor of any of the Islamic scholars. There were no names of any Muslim medical experts in the field of transplantation mentioned nor brainstem death, and it is difficult to conceive what role the barristers would have played in the decision-making process. What was very disappointing was that the fatawa that was put out provided no details of the competing arguments nor any direct reference to other fatawa which had been issued in the Islamic world. Perhaps this was done so that no mention would be made of the fatawa issued by the Islamic Fiqh Academy of India in 1989 and the late and ex-grand mufti of Pakistan, Muhammad Shafii, both of whom had declared cadaveric organ donation to be impermissible from an Islamic perspective. Furthermore, some of the recommendations made by other notable Islamic institutions around the world, in the context of organ donation, may not have been politically correct to put in the final report. These recommendations include, amongst others, statements such as that organ donation should not be given to anyone who is at war (physically or intellectually) with Islam, and that organs should only be donated to righteous individuals.

The 1995 fatawa of the Muslim Law (Shariah) Council UK failed to win over the UK Muslims. When dealing with a mainly educated population such as the UK Muslims, some details as to how the final conclusion was reached was necessary. Furthermore, applying the principle of informed consent as practised in the NHS, competing arguments for and against organ transplantation must be put forward, rather than a simple final decision. It should also be pointed out that organ transplantation is not a single entity and a single fatawa covering the whole range of organ transplantation shows lack of knowledge of the complexity of the subject.

## Case 3

More recently over the past few years, many mosques and Islamic centres have started publishing information on their Ramadan timetables as to which things break the fast and which things do not. Once again it appears no specialist advice has been sought when compiling such lists with reference to modes of administration of medication and medical interventions. As a result, there is conflicting information on these Ramadan timetables, even though all the mosques involved follow the same school of jurisprudence (Hanafi fiqh)<sup>d</sup>. Some of the mosques and Islamic institutions involved are large and well known, but despite that, the information provided on their Ramadan timetables does not stand up to scrutiny. Some state that a

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<sup>b</sup> *hilal is the Arabic word for new moon crescent*

<sup>c</sup> *Umm al-Qura calendar is a pre-calculated calendar used in the Kingdom of Saudi Arabia and some other Muslim countries. A new lunar month starts if on the 29th day of a lunar month the geocentric conjunction (new moon birth) occurs before sunset and the Moon sets after the Sun*

<sup>d</sup> *One of the 4 Sunni Islamic schools of jurisprudence*

fast is broken by application of medication “to the anus”, “for women to apply medicine to the urinary organs”, “to inject anything into the body and using eyedrops”, “inserting medicine into the ears” and “inject medicine, place them on wounds which eventually gets in.” Other mosques state that these same acts do not break the fast. So, who is right? The problem is that those who have written these statements have not taken the time to try to understand the principles involved in how a fast is invalidated nor taken into consideration current medical knowledge about the human body, some have simply copy and pasted the rulings of classical Muslim jurists without appreciating the reasoning behind these rulings. The classical Muslim jurists outlined the principles in what invalidates a fast. In summary, they all agreed that if an invalidating substance is knowingly and deliberately taken, and it enters into a “cavity” within the body via a “passage” then the fast is invalidated. More details of this principle can be found at <http://bit.ly/medicalfastnullifiers>. However, these jurists disagreed as to what constitutes an invalidating substance, the definition of what a cavity (jawf) and whether the passage needs to be natural or it also includes any artificial passage.

The jurists of the Hanafi school defined an invalidating substance as any substance having a perceptible body and limited the definition of cavity (jawf) to the stomach. Many of the classical books on Islamic jurisprudence which are used as reference in this day and age were written several hundred years ago. Those Muslim jurists of old took into account medical knowledge available to them at their time. Many of those jurists believed that there was a passage from the vagina and from the female urethra to the stomach, and also that there was a passage from the auditory canal to the throat. As our knowledge of the human body has increased immensely over the last several hundred years, we can negate some of these false perceptions of the classical Muslim jurists. Had these classical Muslim jurists been alive today and had access to modern knowledge of the human body their rulings about which modes of administration of medication and which medical interventions invalidate the fast would have been different from their original rulings in many cases. It is sad that many Muslim jurists of our time are not prepared to consult appropriate specialists on such matters before publishing their guidelines for the public.

## Conclusion

We are living in an era where the amount of knowledge and complexity of matters cannot be assimilated by one individual. As the late Sheikh Mustafa al-Zaraqqa stated that individual ijihad by muftis was necessary at one time but now it has become a potential source for damage and should be replaced by collective ijihad. It may be partly naive on the part of individual jurists who either fail to or are reluctant to seek appropriate expert advice prior to issuing

a legal ruling, although there are several other reasons which may contribute to this reluctance. Many religious scholars may feel uncomfortable sitting with experts from other fields of knowledge, and in the vast majority of cases the religious scholars’ knowledge is confined to religious texts, and many are not comfortable discussing matters in the English language. Of course, there is no compulsion on such scholars to issue any fatawa. Individual religious scholars should refrain from issuing fatawa on complex contemporary issues, it should be a multi-disciplinary approach, whereby detailed discussions with appropriate experts is undertaken before any ruling is issued. The source of that expert advice should be clearly stated so that the strength of the fatawa can be assessed by those in a position to do so.

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## Arab-Islamic Origin of Modern Medicine

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### Introduction

Arab-Islamic influence on Western civilization in Medicine is a fascinating aspect of the history of Medicine. In-depth research (over a 24 year-period: from 1986 to 2012) revealed the extent and magnitude of such colossal influence and its reflection on medical terminology and its ramifications in European vocabulary. This research was crowned by publication of 1500 pages 'Paradise Dictionary', the first dictionary in the world for English words of Arabic origin, with emphasis on medical terms of Arabic etymology.

There are myriad routes for Arabic influences namely: Translation of Greek books into Arabic and reversed translation of Arabic books into Latin; Islamic presence in Europe with cultural influence via Andalusia (Spain) for 8 centuries (710-1492) and in Mediterranean islands (Sicily, Cyprus, and Malta) for more than 5 centuries. European presence in the Levant through Crusader wars for 200 years (1095-1291) provided a direct contact with Arabs in their homeland. Trade led to adoption by Europeans of many features of Islamic culture. British Empire interest in spices trade provided a medium of contact with its Muslim colonies (much of Europe's livestock had to be slaughtered before each winter, spices were used to preserve meat in cold winter). Cultural influence can be studied according to 3 phases of evolution of Arabic Medicine:

### I. Phase of Translation (from Greek into Arabic)

Abbasid Caliphs acquired Greek books from Romans and offered the equivalent weight of the translated book in gold. The famous Doctors of the time: Jurjis Ibn Jibrail, Yuhannah Ibn Masawayh and Hunayn Ibn Is'haq Al-Ibadi, at special request of successive Caliphs in Baghdad: Abu Ja'afar Al-Mansoor (754-775 AD), Haroun Al-Rashid (786-809 AD) and Al-Mamoon (813-833 AD) respectively, undertook the commitment of translating all Greek books into Arabic on an unprecedented scale.

### II. Phase of Arab Original and Creative Contributions

In Anatomy the assertion that Islam forbids dissection is untenable; Qur'an states: "And in yourselves, Can ye then not see? "Al-Thari'at, verse 21. Monkeys were dissected by Yuhannah Ibn Masawayh in 830; deers by Ibn Tufail in 1185; dead pregnant mothers and dead foeti were dissected by Rhazes and Albucasis. Dead human bodies were dissected by Avicenna (circa 1020) and by Ibn Al-Nafis (1288).

Dissection by Ibn Tufail as revealed in his book "Hai Ibn Yakthan" (1185) was translated into Latin as "Philosophus Autodidactus" by Mirandola (1494) and Pocock (1671). Dofoe's "Robinson Crusoe", Kipling's "Jungle Book" and Burroughs' "Tarzan" are corruptions of Philosophus Autodidactus.

Arabs left indelible imprints in Anatomical terms e.g. nucha (from Arabic nucha'a, pertaining to spinal cord), saphinous (safin, the conspicuous), cephalic and basilic veins (al bazili, the draining) and cephalic vein (kafil, the sponsoring), cornea (carania), and ass (asst), mesentery (mesareeq), cornea (cara'nia), abdomen (albadan/albatan), pupil, eye, and blind (bila Ain).

In Physiology, Systemic blood movement was described by Haly Abbas Al-Majusi (prior to 994) 6.5 centuries before Harvey's description in 1628. Capillaries discovery by Haly and Ibn Al-Quff (1233-1286) 4 centuries prior to M. Malpighi's discovery in 1661. Pulmonary circulation was described by Ibn Al-Nafis (1211-1288) three centuries before Michael Servetus report in 1553).

In chemistry and pharmacology there are camphor, myrrh, senna, syrups, juleps, lozenges, alcohol (alghol, mind suppressor), alkali (or kali rich in potassium, hence symbol K stands for Potassium derived from kalium), natron salts (symbol Na stands for Sodium derived from Natrium), sherbet, borax (from Arabic borac), elixir (exeer, a rejuvenating essence), talc (talq, a body powder), henna (a hair dye) and odour (ottor, a perfume). They also manufactured special cabinets for drug safekeeping and

Indeed the word drug is derived from Arabic (deriaq or teriaq). Arabic numbers, fractionation and decimal system facilitated the drug dosage communication.

In Food, Nutrition, and Health there are plethora of Arabic names such as guava, dates, banana, apricot, orange, tangerine, lemon, sultana. They discovered soap (from Arabic sapon), coffee (qahwa), sugar (sukkar), candy (qand), amber (amber), saffron (za'afiran, a food colouring), carthamus (or bastard saffron), cumin, coriander, rice, aubergines, artichokes, cotton, and wood.

In Medicine and Surgery, Arabs manufactured many instruments e.g. catgut, cautery, catheter, gauze, and Leather bulb syringe used for rectal enema. The word catheter is derived from Arabic Catha Tair, bird's quill a hollow tube with attenuated end used for writing); gauze (from Arabic Gazza where it was manufactured); bandages made of various textile materials for wound dressing or as a tourniquet in snake bites; wicks were also used in abscess cavities. Leather bulb syringe (from Arabic Zarrag, a goat stomach wrapped on silver tube) was used for rectal enema. Proctoclysis was invented by Avenzoar (8 centuries before J Murphy in 1908) for preoperative feeding of soup and yogurt infused via rectum with the aid of an invented enema ; urethral dilator, sound and lithotrite used by Albucasis; gypsum (from Arabic Gyps, a powder hardened by water was first used by Arabs in fractures, splints were also made of pomegranates tree wood); snares (from Sinnara for removal of nasal polyps, enlarged tonsils, varicose veins and piles); tracheostomy (first mentioned by Rhazes, performed by Avenzoar on goats and executed by Albucasis on one of his maids successfully); oesophageal intubation with narrow silver tubes was used by Avenzoar for feeding; vaginal speculum and obstetric forceps (anticipate Chamberlain's); and glasses and optics. Command of anatomy, anaesthesia, antiseptics and instruments made abdominal surgery and caesarian section feasible events. Indeed, Black gown of graduation from Medical colleges derived from black Abbasid Aba'.

In Microbiology, Islam considered leprosy and plague as infective diseases and advised quarantine principle for plague control. When Rhazes was asked to locate the newly founded Al-Mu'tadidi Hospital (after Caliph name), he hanged peices of meat in various corners of the city and the place the meat last to become rotten was selected for the hospital foundation.

Arabs named common cold an influenza (from Arabic Anf-alanza or goaty runny nose); they used the crushed rotten bread for Tonsillitis, thus unwittingly discovered antibiotics before Alexander Fleming. Methods for skin cleansing in trauma, in compound fracture and prior to surgery included the use of Alcohol (discovered by Rhazes); soap and water (Initially, Arabs discovered cleaning power

of frothy Christ's thorn leaves with water); cotton, rose oil and egg white for compound fractures (before reduction); and the use of Water and Honey.

"Arabian Nights" (Sir R. Burton) contains reference to anaesthesia by inhalation. Theodoric of Bologna (1206-1298) whose name is associated with the 'Arabic soporific anaesthetic sponge' got his information from Arabic sources. The sponge was steeped in aromatics and soporifics and then dried; when required it was moistened and applied to lips and nostrils. The Arabic innovation entails the immersion of the so-called 'anaesthetic sponge' in a boiled solution made of water with a unique mixture of hashish (from Arabic hasheesh), opium (from Arabic afiun), C-hyoscine (from Arabic cit al huscin, the beautiful lady), with Zo'an (Arabic for wheat infusion) acting as a carrier for active ingredients after water evaporation and within sponge interstices. Poppy seeds infusion liquid and paste were used orally in surgical procedures e.g. dental extraction, and ice was manufactured and used for local anaesthesia.

### III. Phase of Reversed Translation (from Arabic into Latin)

Gerard of Cremona (1114-1187); and Faraj Ibn Salim (Moses Farachi) who in 1279, started translating Rhazes "Liber Continens" (23 Volumes) during his lifetime. During Renaissance period, most medical knowledge was available only in Arabic texts. Circa 1400, professor Mondino of Bologna influenced by Arabs, risked church excommunication for suggesting that a better knowledge could be obtained from human dissection than reading Galen's books!

Andreas Vesalius(1514-1564), father of modern anatomy dissected human cadavers. Fluent in Arabic, he wrote "A Commentary on the fourth Fen of Avicenna", followed by his baccalaureate thesis, "Paraphrase on the Ninth Book of Rhazes" in 1537 long before his masterpiece, "De Humani Corporis Fabrica Libri Septem in 1543.

On May 25, 1085, Alfonso VI of Castile took Toledo and established direct personal control over the Moorish city. The Toledo School of Translators, that had commenced under Archbishop Raymond of Toledo, continued to bring vast stores of knowledge to Europe by rendering great academic and philosophical works in Arabic into Latin.

Religious intolerance of Spanish Reconquest/ Inquisition Tribunals (in 1492) burning thousands of Arabic books, followed by Humanists movement aimed at purifying Medicine and Science by casting out all Arabic terms.

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## Ibn Tofayl and his 12<sup>th</sup> Century Medical Poem “Urjuzah fi Tibb”

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The 11th century was a period of great change in the Muslim world. On the one hand, the Islamic West witnessed the gradual fall of Sicily to the Normans in 1146 C.E. and, on the other hand the end of Omeyyad rule in 1031 C.E. This was followed by nearly sixty years of neglect and stagnation of progress under the Petty Kings (1031-1086 C.E).

However, with the arrival of the Al Moravid dynasty (1085 C.E), Muslim Spain once more caught up with development and advances in the scientific realm. There was then a period of compiling into books of whatever was still salvageable from decay. Subsequently it became a task of recording all vital information from recent research in matters of agriculture, literature, architecture, medicine etc. Plant cultivation, instead of being for private gardens of local rulers, was being taught to students, as well as botany and chemistry. New architectural edifices were erected all over the country. Students attended specialised schools and education was improved and transformed. Learning centres appeared in all walks of life and revolutionary discoveries were made. Scholarship was spreading, with training and practical colleges giving rise to new studies and experiments hitherto unheard of. Consequently, 150 years after the famous Omeyyad physician Az-Zahrawi (d.1013 C.E) who in his time complained that “medical science had regressed to the extent that no longer was anyone acquainted with anatomy let alone surgery”, the new state of education was evidenced in the erudition of the scholar Abu Bakr Muhamed Ibn Abdel Malik Ibn Tofayl Al Qaisi (d.1185 C.E).

In his role as a minister to the Al Mohad dynasty in Marrakech and Seville, Ibn Tofayl had both the perception and experience that facilitated a rare insight into many spheres. His work was always achieved through a process of incessant investigation that drew on several disciplines. His philosophical oeuvre “Hayy Ibn Yaqdan” reveals the creative thinking of a genius. It appraises the role of Ibn Tofayl’s empiricism and enlightenment in provoking a paradigm shift from philosophy to science and thereby made him open the door of ‘scientific reasoning’. He

draws attention to sciences and arts with examples and representations, where he does not limit himself to models, but rather he deploys a new theory based on practical and operational knowledge of nature. It gives a view on spectacular changes in the world of science from the 12th century, how it opened the line of experiment and demonstration of things discovered in the body and in nature; the evidence is based on demonstration and proof.

This philosophical work stimulated European mainstream thinkers from the 13th to the 19th century evoking discussions for more than 700 years after the writer’s death. The other useful work for an appraisal of Ibn Tofayl is his 7,700-verse medical poem “Urjuzah fi tibb” written in simple rajaz verse. This work surpasses Ibn Sina’s “qanun” canon that had hitherto been the standard Muslim medical work of reference. This literary legacy defined a new methodology of approach that medical students learnt by heart to detect the symptoms, discern the causes and prescribe cures for disease. It is the most thorough and complete of all medieval medical works, since it adopts techniques of logic and rational thinking. Here the encyclopaedic scholar Ibn Tofayl demonstrated a high degree of pre-occupation with man’s health and wellbeing, indicated by his awareness of the importance of a dietary treatment.

Furthermore, according to Dr M. Mellouki<sup>1</sup>, the topographical manner in which Ibn Tofayl set out his observations revealed his detailed knowledge of anatomy and physiology, illustrating how he must have derived this information from pertinent dissection as described in his works. The poem follows the presentation “minal qarn ila qadam” (from head to toe) method where each chapter is devoted to one illness, where the name of the illness is mentioned followed by its symptoms, its causes and the appropriate diet protocol. It lists treatments type by type: anti-inflammatory, antispasmodic, antiseptic, sedative, tonic, diuretic, febrifuge, salt free, appetiser etc. Ibn Tofayl underlines in this work the dimension of nutrition. Therefore in his time (12th century), nutritherapy was considered to be the second medicine after plants.

Furthermore he uses food as a diagnosis tool to confirm the physician's diagnosis. For example, in his clinical diagnosis of renal tumours he prescribes foods with anti-inflammatory, anti-spasmodic, muscular-relaxing and diuretic properties, knowing that these of themselves will have no effect upon the tumour. He distinguishes different tumour localisations: facia, kidney and ureter. This emphasises his good knowledge of anatomy, whereby he insists on eliminating the presence of pus, bearing in mind that a super-infection can occur and complicate an existing tumour. Hence this bears witness to the extent of his medical knowledge in which he relates clinical markers that are described nowadays to indicate urological tumours: haematuria, fever etc. He identifies the chorion, which is made of connective tissue and rich in nerve fibres as confirmed in modern works. Ibn Tofayl, for instance in a nosological study of urology, in the relevant chapter lists seven sections:

- Renal diseases
- Renal tumours
- Renal lithiasis
- Dysuria
- Urinary incontinence
- Burning without dysuria
- Haematuria: classification and treatment

He evokes a differential diagnosis: pathology of the colon showing the topographic differences between the colon and the kidneys or, topography of the bladder and the pubic area. He also suggests a topographical method for classifying tumours:

- Tumours of the envelope (renal fascia)
- Tumours of the urinary tract
- Tumours of the actual kidney

Ibn Tofayl's paradigm in medicine is the model that is used to explain events such as the understanding of the environment and the evolution of the human body. Thus his medical reasoning is designed to train physicians to seek underlying causes of a disease rather than simply suppress the symptoms. Dr Mellouki revealed in his work that Ibn Tofayl practiced postural physio-therapy techniques to help displace kidney stones towards an eventual extraction<sup>2</sup>.

Dr O. Benhar<sup>3</sup> studied the chapter of Ibn Tofayl's poem on the digestive system. He found a valid match between today's semiology and Ibn Tofayl's description of the following symptoms:

- Colonic obstruction, jaundice, cholera, splenomegaly, dyspepsia hepatomegaly, liver failure and liver tumours, ileus etc.

In his more recent work, on the chapter on ophthalmology, Dr Benhar<sup>4</sup> lists several eye diseases and their various treatments:

-Pterygion, cataract, conjunctivitis, hemeralopia, glaucoma, ulcer of the cornea, leukocoria, amaurosis, intraocular infection etc. several conditions with different types of eye drop for various symptoms.

Obviously from current dissection practices Ibn Tofayl knew about the different layers of the eye and their nerves. The preparation of medicines by sublimation and distillation caused a whole range of new drugs to become available based on vegetal and mineral products. The Islamic Agricultural Revolution, through which plants were coming from all parts of the known world, formed a new material medica which is reported in the works of his famous compatriot Ibn Baytar (d.1248), pharmacist, botanist, physician and scientist.

The Urjuzah was a literary legacy of the history of medicine and therapeutics in the 12th century. It demonstrates the high degree of competence that Ibn Tofayl had reached in the medical art. The details that he gave of the function of the organs effectively made him the first recorded physiologist.

Furthermore, he described blood circulation, thereby preceding its discovery by Ibn Nafis (d.1285C.E.) by a whole century. This poem was devoted to the promotion of health, the cure of diseases and the spread and diffusion of medical knowledge. It shows that from Ibn Tofayl's description he had his hand inside organs to describe them and demonstrate their physiological aspect. Precise geographical and topographical location of each organ illustrates his frequent dissections either when he was a student of medicine or in his time as a teaching physician. In his time the institution of pharmacy was created and developed allowing the composition of pharmacological treatises on new drugs and chemicals amongst them Indian hemp and other anaesthetic products in liquid or inhaled. Furthermore the invention of a new distillation apparatus permitted Ibn Tofayl to use a variety of pharmaceutical preparations in forms of essential oils, elixirs, tinctures, ointments, inhalants etc.

The physician was admonished to use his sense of smell, sight, hearing and touch to help in his diagnosis. The Urjuzah poem was used as a medical reference instead of Al Razi or Ibn Sina works as it remained the authority until 1934C.E when the French Protectorate Authority decided to close the Bimaristan (built in 1260C.E) in Fes and turn it into a market.

Finally we described the time of Ibn Tofayl, the encyclopaedic scholar, physician, poet, philosopher, politician and prolific writer. His works show the re-interpretation and reformation of the classical heritage. The results of this transmission of knowledge to Northern Spain, Southern France and Sicily are proven in the schools of Salerno and Montpellier. As for the East, the

best example could be gauged by the philosophical and medical works of Maimonides (Ibn Maymoun) who left Fes for Egypt in 1165C.E loaded with copies these revolutionary discoveries.

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## Keeping Communities Healthy: The Islamic Paradigm

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**Keywords:** Islam, Health, History

### Health: A blessing from Allah

Health is a precious gift, a blessing from Allah (SWT) which should be protected and enhanced. Without good health, we would not be able to live up to our physical potential as His Khalifah (vicegerent) on earth to undertake *amar maaruf nahi mungkar*, to enjoin good and to forbid evil and to pursue the communal quest for *adl wa ihsan* (justice with fairness and mercy), the preservation of public interest (*maslahah amah*), mutual benefit (*masalih mushtarakah*) and protection from harm (*dar' al mafasid*).

Unfortunately, this blessing is often forgotten or not prioritized by many amongst us. This was alluded to by the Prophet Muhammad (SAW) when he said;

*“There are two blessings which many people do not appreciate, health and leisure time”*  
(Muslim & Bukhari)

### Quranic verses of healing

And although the Quran is primarily a book of *hidayah* (guidance), it nonetheless makes reference to health and healing. Six verses in the Quran have been described as verses of *shifaa'* (healing).

One of these verses, in surah As-Shu'ara, 26:80, describes Prophet Ibrahim's (AS) recognition of his Ultimate Healer;

*“And when I fall sick, He heals me”*

And to the Jewish community during the time of Prophet Isa (AS), where the healers were held in high esteem, Prophet Isa (AS) was sent with medical miracles (*mu'jizat*), emphasizing the need to be at the cutting edge of medical sciences:

*“... And I cure the blind and the leper, and I give life to the dead - by permission of Allah ...”*  
(Ali-Imran, 3:49)

### Health within the context of the Maqasid Shari'ah

The cardinal purposes of the Muslim's individual, community, national and global life experiences have been comprehensively defined by the *Maqasid Shari'ah*, the higher objectives of Islamic jurisprudence (1). The wellbeing of the community is protected by the preservation of the five essentials (*daruriyyat*) in human life, namely faith and morality (*deen*), life (*nafs*), intellect (*'aql*), progeny (*nasl*) and wealth (*maal*).

Allah says in Surah Al-Maidah, 5:32;

*“And if anyone saved one life, it would be as if he had saved mankind entirely”*

Three of the priorities of the Maqasid Shari'ah are directly related to health whilst the first (*deen*) and the fifth (*maal*) essentials in the hierarchy, though indirect are intimately associated. Thus, the objectives of the healthcare system are to nurture a community which is healthy and morally upright, prevent premature and inappropriate deaths, protect against intellectual and physical disabilities, promote safe reproduction and proliferation of the human seed through the utilization of health intervention programs which are cost-effective.

### A bias for preventative health strategies

A pervasive thread in the Islamic paradigm, whether in economic, social or health matters is the emphasis on preventative strategies. The prevention of diseases and the preservation of wellness are pillars of best practices in medicine. Apart from the injunctions in the Quran and authentic hadiths, it is based on a principle of jurisprudence, closing all avenues of destruction.

Several principles of health care practises and interventions can be summarized as follows (2):

- The Prophet Muhammad (SAW) said,

*“Cleanliness is half of faith (iman)”*  
(Muslim)

This hadith which connects cleanliness with belief is a cornerstone in Islam’s advocacy for optimal health.

- The Quran advocates healthy eating and encourages the believers to eat only permissible and good food

*“O mankind, eat from whatever is on earth [that is] lawful and good and do not follow the footsteps of Satan. Indeed, he is to you a clear enemy.”*

(Al-Baqarah 2:168).

There are numerous statements that have been recorded in both the Qur’an and the hadith of the Prophet (SAW) encouraging Muslims to be moderate in eating and drinking.

*And eat and drink and be not extravagant; surely He does not love the extravagant.*

(Al-A`raf 7: 31)

*“No human ever filled a container more evil than his belly. The few morsels needed to support his being shall suffice the son of Adam. But if there is no recourse then one third for his food, one third for his drink and one third for his breath.”*

(Ahmad and At-Tirmidhi)

- The prophet (SAW) in various hadiths enjoined his companions to exercise. He said,

*“A strong believer is better than a weak believer”*  
(Muslim)

Thus, a Muslim is enjoined to be not only strong in faith and character but also in physical strength and fitness through regular exercise.

- Islam recognises the existence of contagious diseases and the Prophet (SAW) commanded us to avoid such diseases. He said:

*“Run away from the leper same as you would from a lion.”*

(Bukhari and Muslim)

- Islam also introduced the concept of quarantine in the event of an infectious outbreak. The Prophet (peace be upon him) said:

*“If you hear that a land has been stricken by plague, do not approach it, and if your land is stricken by plague, do not leave it”.*

(Sahih al-Bukhari)

## Health professional training versus quackery

The believers are urged to seek medical treatment when they are ill. And when a cure is available some scholars would even suggest it as being mandatory. The Prophet (SAW) said:

*“Seek medical treatment, for truly Allah does not send down a disease without sending down a cure for it. Those who have knowledge of the cure know it, and those who are ignorant of it do not.”*

(Musnad Ahmad)

The Prophet (SAW) is also reported to have said:

*“He is not one of us who is not kind to children or does not respect our elders, or denies our learned people the esteem they deserve”*

(Abu Dawud, Al-Tirmidhi)

The two earlier hadiths also illustrates Islam’s high regard for people who are experts and highly trained in their specialty and Muslims are enjoined to seek treatment from these health professionals.

This hadith is especially instructive and relevant in this modern world of information and communication technology where individuals and groups claim to be overnight experts in medicine by simply accessing information from the internet.

An incident which happened during the time of the Prophet Muhammad (SAW), further emphasizes the importance of authentic knowledge and specialty training. When a man fell ill, the Prophet (SAW) said,

*“Summon the physician of the tribe so and so for him.”*  
(Ahmad)

It also shows the Prophet’s (SAW) criticism of the ignorant who blindly practise the art of healing without the pre-requisite medical knowledge and skills.

## Code of medical ethics

The early physicians who worked in the medieval Muslim hospitals were required to follow a strict code of ethical practices. Ishaq bin Ali al-Rahawi’s (854-931 AD) *Adab al-Tabib* (The conduct of a physician), is the earliest known Arabic treatise dedicated to medical ethics. Rahawi considered physicians as “guardians of souls and bodies” and in this treatise he spells out all the deeds and acts a Muslim physician must observe.

He also described the process of licensing physicians, when he wrote:

“...the physician was not allowed to sit for treating patients until after he passes the generally aforementioned tests and examinations...”

This was later enforced into law during the Abbasid Caliphate whereby all doctors were required to pass an examination before being allowed to practice medicine. This physician licensure became mandatory after the Caliph Al-Muqtadir, in 931 AD, was informed of the death of one of his subjects due to a physician's error.

## Individual autonomy versus community interest

The ethical principle of autonomy highly respects and values the individual (or parents or legal guardians) as the one who makes the self-defining choices upon which he then acts and for which he is accountable.

This however needs to be considered within the context of the wider public interest and benefits (*maslahah ammah*). This is defined by the Islamic legal maxim (*al-Qawa'id al-Fiqhiyyah*) which stipulates:

“individual rights may have to be sacrificed in order to protect the public interest.”

In the domain of healthcare, medical interventions such as global immunization programs, which have been proven to promote and protect the general health and wellbeing of the community, have priority over the considerations of the individual interest.

## The early Muslim hospitals

The Prophet's mosque in the city of Madinah held the first Muslim hospital service in its courtyard. During the *Ghazwah Khandaq* (battle of the trench), Muhammad ordered a tent to be assembled to provide medical care to the wounded soldiers. Among those who attended to the injured soldiers was the first Muslim nurse, *Rufaida al-Aslamia*. The prophet Muhammad (SAW) used to order all casualties to be carried to her tent so that she might treat them with her nursing and medical expertise. This later evolved into the many *bimaristans*, a Persian word meaning “house of the sick”, during the early Islamic rule. The Umayyad Caliph Al-Walid ibn Abd al-Malik is often credited with building the first *bimaristan*, in Damascus in 707 AD.

Many of these early hospitals were built with charitable endowments, *waqf* (3). They were staffed by salaried physicians who did regular ward rounds. Pharmacists dispensed medicines from the well-equipped dispensaries. There were separate wards for men and women and wards

were segregated according to the type of illnesses. Patients were nursed until they have fully recovered and upon discharge were given a sum of money for their immediate personal needs. There is good reason to believe that the Christians were impressed by the hospitals they overran during the crusades. A network of hospitals later spread across Europe which were influenced and modelled on the famous Islamic hospitals in Cairo and Damascus.

## Search for cures and the first clinical trials

Abu Hurairah (RA) narrated that the Prophet (SAW) said:

“There is no disease that Allah has created, except that He also has created its remedy.”  
(Bukhari)

In this and several other hadiths, the Prophet (SAW) advocated research into the finding of cures for ailments, thus urging the believers to be at the frontiers of medical research.

This inspired the likes of physician, Al-Razi (854 – 925 AD) who carried out the earliest known example of a clinical research trial on the effectiveness of bloodletting in the treatment of patients with meningitis by employing a control group. This demonstrates Al-Razi's commitment to evidence based medical science. (4).

Ibn Sina (980 – 1037 AD) in his magnum opus, *Al Qanun Fi Tibb* (The Canons of Medicine) outlined 7 principles before a medicine can be considered to be effective (5). Among others he emphasized that trials which were successful in animal models must be replicated in human subjects. And that the results of the trials should be reproducible in other similar research.

In this respect, the Wakefield claim of the link between the MMR vaccine and autism has never been reproduced in other studies. On the contrary, this claim has been debunked in at least 67 different studies. (6)

## Health status in Muslim countries

There are over 1.8 billion Muslims living in 57 Muslim majority countries. The health of the Muslims communities can be benchmarked against a set of 8 Millennium Development Goals (MDG), from the baseline statistics in 1990 up to 2015. (7)

MDG 4, 5 and 6 are directly related to the health of the communities whilst the health sector is an important stakeholder in the other five MDGs.

MDG 4 calls for a 2/3 reduction in the mortality of children under 5 years old by 2015. 1 in 12 children die in Muslim countries compared to 1 in 18 in world. Many of these under five deaths are preventable with the introduction of

basic public health interventions which include, access to safe drinking water, good nutrition, breastfeeding, hygienic sanitation and immunization. (8)

MDG 1 calls for the eradication of extreme poverty and hunger and among others targets to halve the proportion of people who suffer from hunger. Nearly half of the under-5 children in some Muslim countries are underweight and stunted. And one of the major risk factor for under-5 deaths is malnutrition. Thus the close relationship between the economic status of communities, rates of malnutrition of its mothers and children and a health indicator as in MDG 4.

MDG 5 calls for improvement of maternal health, through  $\frac{3}{4}$  reduction of maternal deaths. Many Muslim countries are not on track to achieve MDG 5. In Afghanistan 1 in 6 pregnancies results in death, in Africa 1 in 15 as against the global average of 1 in 74 pregnancies. This is due to the high fertility rates, low average age of pregnancies,

illiteracy, lack of antenatal care, lack of access to skilled obstetric care and complicated by the compromised social and economic status of women in these communities.

Some Muslim countries have however made considerable progress in their health programs. Maldives and Iran have reduced their maternal mortality ratios by more than 80% and were on target for MDG 5.

The under-5 mortality in Malaysia has been significantly reduced from 16.8 to 7.7 per 1,000 live births from 1990 to 2012. Malaysia's child mortality rates are comparable to rates in high-income and life, particularly in the first 28 days (neonatal). There is high immunisation coverage of the one-year olds for measles, mumps and rubella. The remaining issues under this goal are to address perinatal and neonatal mortality, the non-health determinants of child death, the needs of vulnerable children and the persistent high rates of child mortality amongst Orang Asli (indigenous people); and also to improve medically certified deaths (9). The maternal mortality ratio declined from 44 to 25.6 per 100,000 live births from 1991 to 2012. The challenges for Malaysia to be on track for MDG 4 and 5 is to enhance health care providers' knowledge and skills, provision of family planning services for high risk mothers, expansion of the Integrated Management for Childhood Illness Program and prevention of childhood injuries. (10)

Progress in the health status of other Muslim communities have been hampered by natural disasters, economic crises, political instability, armed conflicts, rural urban migration, breakdown of basic social structures and ultra-conservatism of some of its religious scholars.

## Reclaiming the lost heritage and moving forward

History will testify that the early Muslim scientists dominated virtually most aspects of knowledge and research from 600 – 1700 AD. Az-Zahrawi (930-1013 AD), the father of modern surgery, was pioneering new surgical instrumentations when Europe was restricted by a religious edict in 1163 AD which ruled:

*“All forms of surgery must be stopped in all medical school by all surgeons”*

Is it any wonder that Martin Kramer, an American historian wrote (11):

*“Had there been Nobel Prizes in 1000, they would have gone almost exclusively to Muslims.”*

Somehow, Muslim communities have lost it along the way and have lagged behind in developing their health systems which they once led and inspired the world during the glorious days of Islamic civilization.

Religious conservatism, has undoubtedly been one of the contributory factors to the decline and stagnation of the pursuit of science and the spirit of enquiry and research in the Muslim world today. In the eradication of smallpox, the last few cases were from Bangladesh and Somalia. And the Global Polio Eradication Initiative (GPEI) targets 2018 to end polio and three Muslim countries are still polio endemic, namely, Afghanistan, Nigeria and Pakistan. (12) We should never lose sight of the compassionate and humane nature of Islam as exemplified in surah al-Hajj, 22:78:

*“And strive for Allah with the striving due to Him. He has chosen you and has not placed upon you in the religion any difficulty.”*

And an authentic tradition further fortified this concept as narrated by Aisha (RA):

*“If given an option between 2 actions, the Prophet (SAW) would surely choose the easier one, as long as it is not sinful.”*  
(Bukhari)

When deliberating the permissibility of the Oral Polio Vaccine (OPV) which is manufactured using porcine-based trypsin, at the 11th Session of the European Council of Fatwa & Research (ECFR) from 1-7 July 2003, in Stockholm, the ECFR concluded; (13)

*“The Council urges Muslim leaders and officials at Islamic Centers not to be too strict in such matters that are open to considered opinion and that bring*

*considerable benefits to Muslim children, as long as these matters involve no conflict with any definite text.”*

And we firmly believe this spirit and approach pervades the corpus of the jurisprudence of facilitation (*Fiqh Taysir*). At no point in time does it blemish the belief nor practice of the faithful because scholars have anticipated the challenges of modernity and have reiterated;

*“Allah will bless the believer who recognises and engages with the new world, yet remains true to his religious values.”*

Investments in the health and education of Muslim communities should be among the major priorities of our political and economic leaders.

The caliphs of the early Islamic era took a very keen interest in the building of health infrastructure. In the early tenth century, Caliph al-Muktafi (died 907), called upon al-Razi to decide on the selection of a site for the new hospital. Al-Razi hung up pieces of meat in various districts of Baghdad and advised the site where the meat decayed the least to be selected. This is the first scientific observation of unknown particles (germs) in air which led to air borne diseases! Caliph al-Muqtadir (ruled from 908-932 AD), his successor, built several more hospitals and staffed them with the best physicians, many of them Christians and Jews; and filled the libraries with the latest books and writings. Hospitals were also found in the other large cities in the Islamic empire, notably Cairo and Cordoba, whilst Europe was still trapped in the “Dark Ages”.

We hope and pray to Allah (SWT) that our Muslim communities would be governed by similarly enlightened political and socio-economic leadership. In this context, it is worthwhile considering the wise words of Pervez Hoodbhoy, a Pakistani physicist, who wrote; (14)

*“With well over a billion Muslims and extensive material resources, why is the Islamic world disengaged from science and the process of creating new knowledge? Common sense and the principles of logic and reason (are) our only reasonable choice for governance and progress. Being scientists, we understand this easily. The task is to persuade those who do not.”*

We also hope and pray to Allah (SWT) that our countries would be similarly blessed with peace, security and protected from major natural disasters. And that as a community we would be inspired by the following hadith, to catch up on lost ground and rejuvenate our quest for leadership in the medical sciences and other aspects of scientific scholarship in the continuous process of *islah* (transformation) towards the community’s health and well-being.

*“A word of wisdom is the lost property of a Muslim. He should seize it wherever he finds it.”*  
(At-Tirmidhi)

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## Al-Hijama in the UK

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### Abstract

Hijama is a traditional form of therapy which is becoming increasingly popular in the United Kingdom, as well as USA, Canada and Australia. It is generally practiced by people with limited clinical training and clinicians will need to discuss this form of therapy with their patients when advice is sought. This brief review discusses issues that are likely to arise during such a consultation.

### Introduction

Hijama is a form of preventive medicine and clinical treatment with a long history. Its use by the Muslim community was recommended by the angels during the Night Journey. It was already an established practice at the time and its origins may well be linked to that of acupuncture. Both forms of treatment are applied at comparable points on the body and there is a form of acupuncture where cutting needles are used. Outside of the Muslim community the procedure is known as wet cupping. It consists of raising an area of skin using suction, making multiple small superficial scratches on the skin with a blade and then reapplying suction so as to draw blood over a period of 15 to 30 minutes. Nowadays, the cups used are usually plastic and disposable and suction is obtained using a small pump. Traditional therapy used glass cups or horns and suction was obtained through heating the inside.

Support for use of hijama includes a report by Bukhari which states: “*There is healing in cupping.*” (Book No. 71 Hadith No. 600)

During the last 10 years its use in the United Kingdom has become widespread. It is often referred to as “the lost Sunnah” and advertisements appear on the Internet and in many small shop windows. An increasing number

of Muslims have sought such treatment. It is likely that both patients and acquaintances will be considering this approach to care, but unlikely that they will readily mention it during a clinical consultation. For patients with chronic disease many of the advertisements advocate its use in preference to allopathic treatments and quote dramatic responses in the form of patient histories.

The questions facing clinicians include:

1. What is the evidence base for this form of treatment and how effective is it?
2. What advice should be given to patients considering its use?
3. Is this a form of therapy which I should consider practicing?

### What is the evidence base for this form of treatment and how effective is it?

In 2010 Cao et al (1) published a systematic review of 550 studies of cupping between 1959 and 2008. It included 73 randomised controlled trials, although their standard was poor according to Cochrane criteria. (2)

Amongst the conditions in which cupping was commonly employed were pain (70 studies), herpes zoster (59 studies), cough or asthma (39 studies), acne (29 studies),

cervical spondylosis (19 studies), lumbar sprain (19 studies), mastitis (14 studies), facial paralysis (13 studies), headache (13 studies), soft tissue injury (10 studies), arthritis (10 studies), neurodermatitis (10 studies) and sciatica (7 studies). In this period only 2 additional RCTs were conducted outside of China. (1) During the last forty years I have been unable to identify any published studies concerned with treatment of major conditions such as cancer, cardiovascular disease or dementia. (3). Nevertheless, its use has been promoted for such conditions in a number of advertisements on the internet.

There have been a limited number of studies which consider the mechanisms by which hijama could work, but, in general, they do not meet the rigorous standards required for laboratory-based studies. In contrast, in the comparable area of acupuncture there is a growing body of work using dynamic imaging techniques which demonstrate potential modes of action. A major issue for studies on both the physiological mechanisms by which hijama works and its clinical effectiveness is the absence of adequate independent external funding for such research. Such funding could be provided by many philanthropic Muslim institutions and is particularly needed at this time.

### What advice should be given to patients considering its use?

In any discussion with patients concerning the use of hijama serious attention needs to be given to who will perform the procedure. Within the United Kingdom there are clinics in Birmingham, Sheffield, Leicester, London, Cardiff and Glasgow amongst other towns and cities. (3 and Table). In addition, there are many individual practitioners who offer mobile services or practice in their homes or even their garages. The central issue concerns the ability of practitioners to make a diagnosis. Hijama is a form of treatment and it is critical that a practitioner should know what he or she is treating. This knowledge cannot be achieved through an online course or during a day's training. Traditionally hijama was one form treatment offered by doctors or by therapists who had undergone a long training and been licenced by their mentor in the form of an ijazzah. Today in Saudi Arabia, United Arab Emirates and Oman, practitioners who are not medically qualified must practice under the direct supervision of qualified doctors.(4)

The need for such an approach in the United Kingdom is underlined by the fact that, on occasions, hijama is linked with ruqyah. Criminal prosecutions of such therapists have now happened in Leeds UK and Sydney Australia. Such cases have involved the need for appropriate psychiatric assessments and diagnoses as well as vulnerable adult and child protection issues. Whilst hijama remains a totally unregulated therapy more and more such cases are likely

to occur. In general, self-regulation of complementary therapies has proven ineffective, and there is a reluctance amongst hijama therapists to come together and set up such a register. In contrast those who are registered with the General Medical Council (or any other statutory regulatory body dealing with health care practitioners) need to include their hijama practice within their annual appraisal and their practice is regulated by the same rigorous standards applied to other aspects of their work.

### Is this a form of therapy which I should consider practicing?

Any clinician planning to take up hijama should:

1. Obtain appropriate training and supervision as in any other form of clinical practice.
2. Include their practice within their annual appraisal.
3. Keep careful records and use detailed consent procedures.
4. Give comprehensive and adequate explanations of the technique, its potential benefits, risks and limitations.
5. Consider setting up regional studies and trials

### Conclusions

Hijama is an old and recognised form of clinical treatment. In the UK it is now being promoted as “the lost Sunnah” and is generally practiced by people with no recognised clinical training. There is an urgent need to ensure that patients who wish to have this form of therapy are treated by qualified and competent clinicians with a contemporary knowledge of disease processes and mechanisms.

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## If You Drink Alcohol, Your Children May Pay The Price

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**Keywords:** Islam, Health, Alcohol

I see alcoholism as a punishment to human society since time immemorial. It continues to cost countless human lives, and causes terrible misery to millions throughout the world. Alcohol is the basic cause of many problems facing society. The statistics of soaring crime rates, increasing instances of mental illnesses and millions of broken homes throughout the world bear mute testimony to the destructive power of alcohol. Yet if you interview any alcoholic, they will tell you that they never started to drink alcohol to become alcoholic. They wanted to be a social drinker, but unfortunately some of them could not keep themselves on the steady but slippery slope of alcoholism.

According to the 2010 estimation of Alcoholism by the world Health Organisation, 4.1% of the population over 15 years of age, are the victims of Alcoholism worldwide. That comes to staggering 208 million people. [1][2]. In the United States alone, 7% (17 million) of its population suffer from Alcoholism. It is higher in Eastern Europe at 11%. [3][4]. Alcoholism directly resulted in about 139,000 deaths and a total of 3.3 million deaths (5.9% of all deaths in the world) are believed to be due to Alcohol, during 2013.[3][5]. It is estimated that it reduces the life expectancy by around 10 years and it costed about US\$224 Billion in 2006.[3][6].

According to the National Crime Victimization Survey Bureau of Justice (U.S. Department of Justice) in the year 1996 alone every day, on average 2,713 rapes took place. The statistics tell us that the majority of the rapists, were intoxicated while committing the crime. The same is true in cases of molestation. According to statistics, 8% of Americans commit incest i.e. one in every twelve to thirteen persons in America is involved in incest. Almost all the cases of incest are due to intoxication of one or both of the persons involved. One of the major factors associated with the spread of AIDS, the most dreaded disease, is alcoholism.

We have known for a very long time that an individual's environment plays a very important role in alcoholism. These environments include, peer pressure, psychological condition, failure in life or recreational drinking becoming

something more. However, we did not know about the genetic factors until recently. Environmental factors and genetics are two components associated with alcoholism, with about half the risk attributed to each. Heavy consumption of alcohol can also result in congenital anomalies [7]. Someone with a parent or sibling with alcoholism is three to four times more likely to become an alcoholic themselves.

*“Every response in the body is due to alterations in proteins. Binge drinking is an environmental trigger that negatively affects histones by altering the correct binding of DNA. The result is unnecessary replication in the copied structure”*

(says Shivendra Shukla, a professor at the University of Missouri School of Medicine). The National Institute on Alcohol Abuse and Alcoholism defines binge drinking as a pattern of drinking that brings a person's blood alcohol concentration to 0.08 grams percent or above.

When a person drinks alcohol heavily or when the binge drinking is done then a sequence of changes happens in the genetic system. One of these are epigenetics modification. The latest research shows that epigenetic modifications in histone structures occur within the liver as a result of heavy binge drinking.

Epigenetic changes are also brought about by histone modifications, as well as by the role that noncoding RNA (ncRNA) plays. Histones are highly alkaline proteins found in eukaryotic cell nuclei that package and order the DNA into structural units called nucleosomes. They are the chief protein components of chromatin, acting as spools around which DNA winds, and playing a role in gene regulation. Without histones, the unwound DNA in chromosomes would be very long. By acting on these epigenetic markers, environmental factors such as diet (including alcohol), stress, and prenatal nutrition (also alcohol consumption) can make an imprint on the genes that are active in different tissues and at various stages of life. Even more importantly, these alterations may be passed along from one generation to the next. The result

is that the influences from harmful environmental factors can be extended beyond the individual and passed to his or her offspring [8].

## Lets see what Islam says:

The Glorious Qur'an prohibits the consumption of alcohol in the following verse:

*“O ye who believe! Intoxicants and Gambling, (dedication of) stones, and (divination by) arrows, are an Abomination – of Satan’s handiwork; eschew such (abomination), that ye may prosper.”*  
[Al-Qur’an 5:90]

The Prophet of Islam Muhammad (peace be upon him) said:

a. In Sunan Ibn-I-Majah Volume 3, Book of Intoxicants, Chapter 30 Hadith No. 3371:

*“Alcohol is the mother of all evils and it is the most shameful of evils.”*

b. In Sunan Ibn-I-Majah Volume 3, Book of Intoxicants, Chapter 30 Hadith No.3392

*“Anything which intoxicates in a large quantity, is prohibited even in a small quantity.”*

Now from the above information, we have concluded that alcoholism is not only catastrophic to the consumer but it can potentially destroy the life of their children as well by potentially altering the offspring’s genes. Therefore, the children have to pay the price of their parent’s actions. That’s why the Holy Quran mentions the alcoholism as the Satan’s handiwork and the Hadith calls it as the mother of all evils.

## Conclusion:

1. All Alcoholics started as social drinkers.
2. Alcohol alters genes which causes the person to crave more alcohol.
3. The altered genes may pass to their offspring causing them to become four times more prone to become alcoholics themselves, even if they are removed from the alcoholic environment.
4. Heavy alcohol consumption during pregnancy could cause congenital abnormalities

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## Spirituality: The Neglected Field of the Global Health Agenda and What It Means for Muslims

Qasim Ali Javed

**Keywords:** *Islam, Health, Spirituality, Global health*

Spirituality as a concept and a practice has been a part of societies throughout history. Almost 90% of the world's population is involved in some sort of spiritual practice making it a prominent aspect in an increasingly globalised world (1). Although Global Health is inherently an interdisciplinary field, the relevance spirituality has is currently greatly underestimated, particularly with regards to mental healthcare provision. This is particularly discouraging from a Muslim perspective given its importance within Islam. Despite this, many Muslim nations have chronically underfunded mental health services and also overlooked the value of integrating spirituality within healthcare provision, something which arguably contradicts the Islamic tradition. Instead, in Islamic terms a great importance is placed on not only health itself, but also both spirituality and its links to mental well-being. I will begin by considering how spirituality can be viewed and employed as a coping mechanism for some people. This will demonstrate its use in psychiatric assessment and intervention, whilst perhaps also being utilised through social support networks and community healthcare delivery.

Spirituality is concerned with the human spirit or soul and one's transcendent connection to a divine being (2,3). Although traditionally this is associated with religion, the Bradford Care Trust suggest that spirituality can refer to "the essence of human beings as unique individuals" which has given scope to non-religious people practicing spirituality (4,5). Moreover, it is used as a coping mechanism across different cultures, for example, an American study of 330 hospitalised patients found that 90 percent reported they used spiritual beliefs and practices to cope at least a moderate extent (6). Similarly, amongst Muslim communities practicing forms of spirituality is encouraged as a method to improve coping and provide greater meaning to life (7). Spirituality has also been shown to have positive outcomes for depressed women with HIV in terms of both the quality of life and immunological function improvements (8). Thus, the increasingly wide spectrum of people engaging in spirituality, even using it

as a coping mechanism, warrants greater attention for what it means to people and their health.

From an Islamic lens, health is considered a virtue as humans are said to be "honoured" by Allah as well as having the right to live (9). In many ways, spiritual health is integral to this overall health and well-being. Indeed, many within the Islamic tradition would argue a strong association between the outward psychological issues people face and the diseases of the spiritual heart. This spiritual heart can be seen as the essence of man and some would even consider its diseases to manifest as mental health related issues (10). Regardless, there has traditionally been a definite link between spirituality and healthcare provision which is more practically seen through the *bimaristans* of the so called 'Islamic Golden Age' from the eighth century to beginning of the modern era.

The Persian word, *bimaristan*, means a place of disease and traditionally they performed the role of hospitals in the Islamic world in pre-modern times. Moreover, the concept of *bimaristans* in Islamic history can be traced as far back as the time of the Prophet Muhammad ﷺ when a mobile military tent was set up during battle (11,12). Indeed it is within the Prophet Muhammad's ﷺ teachings for Muslims to actively seek medical attention, and in one saying he said "[y]es, O you servants of Allah take medicine as Allah has not created a disease without creating a cure except for one. They asked which one, he replied old age" (13). In consequence, not only did *bimaristans* hold an important role within Islamic society to provide healthcare, but they also incorporated mental health services. For example, one of the early *bimaristans* with a specialised section for the mentally unwell patients was built in 872 AD in Cairo (14). Within this, disease severity was categorised and patients were separated accordingly. This pattern was repeated frequently in *bimaristans* and some buildings used iron bars to isolate aggressive patients and prevent harm to others (11). Evidently, within Islam spirituality and mental well-being can be viewed as integral to the virtue of health.

Whilst I have discussed the values of spirituality, it is also pertinent to assess its potential within psychiatric assessments and management. Psychiatry has previously distanced itself from religion and spirituality including Freud even linking religion with neurosis (15). This has steadily been changing as the Royal College of Psychiatrists has a specific group on Psychiatry and Spirituality, as well as the World Psychiatric Association establishing a section on Psychiatry and Religion. Despite this, more action is needed in the clinical setting such as including greater consideration of patients' spiritual needs during an assessment. For instance, going beyond simply knowing the denomination a patient belongs to and enquiring further into their spiritual beliefs can better assist healthcare providers in utilising the coping mechanism ideas suggested above. Likewise, understanding the patients' beliefs could in turn be helpful in understanding their mental health status and other health attitudes (16). Moreover, the role of spirituality in health attitudes and beliefs is very important in some cultures. This is illustrated by certain South Asian migrants within the western world who prefer traditional spiritual healing practices over western mental health care options (17). Hence, it is essential the psychiatric assessment and management of patients should better incorporate how important spirituality is to a patient to effectively address their needs.

In this regard, the structure of bimaristans during the Islamic Golden Age becomes salient as they sought to integrate mental health provision with an Islamic basis. Whilst most of European medicine saw the mind and body as separate entities, Muslim physicians in the Islamic regions did not see this division allowing for greater exploration of the human mind (18). For instance, physicians such as Ibn Sina understood "physiological psychology" in treating diseases which had a mental aspect to them, including using the pulse rate as means to measure stress response (19). Likewise Al Razi brought forward innovative discoveries and definitions of mental health symptoms as he looked to integrate psychotherapy within healthcare through his book titled 'El Mansuri' dan 'Al Tibb al-Ruhani' (20). In addition, the works of the Muslim scholar Al-Ghazali extend this idea as he argued that mental health itself can be somewhat encapsulated within spiritual health. For example, he viewed anxiety as a mental disease established within the spiritual heart, which itself mirrors the state of the soul with regards to its purity (21,22). Hence, in this regard, anxiety was viewed as a disease of the heart requiring purification through spiritual acts in the same way as other spiritual diseases such as anger, hatred, envy, sadness, pride and others. Thus, in Islamic terms both spiritual and mental health play key roles within the overall health and well-being of an individual. As a result, traditional medical practice in Islamic tradition allowed the physician to go beyond the physical realm and to evaluate the patient holistically with a multi-faceted approach.

Another key reason spiritual health warrants greater attention within Global Health is due to the social networks it exists within. One component of this is the mental and social well-being benefit patients can obtain by being a part of a community or spiritual group (2). In addition, faith groups or leaders could play a greater involvement in the mental healthcare patients receive. In relation to this, the Lancet called for development of human resources for mental health including diversifying and expanding the current workforce (23). Accordingly, this should include forming partnerships between mental healthcare teams and faith groups. To support this, there is evidence to suggest certain groups prefer to contact their clergy or faith group regarding mental health problems in comparison to psychiatric professionals (24). Hence, creating working partnerships would then better allow for patients to access healthcare professionals through their clergy and even have a more holistic management approach if they wish. Ultimately, the spiritual social networks already exist. Therefore, improving the community-based medicine strategies as suggested above will surely improve patient healthcare access and management plans.

Without doubt a key barrier to improving the inclusion of spirituality in Global Health is the underestimation of global mental health impact in general. There has been a growing understanding that mental health problems could be improved even in low-resource settings and more importance has been placed on mental health in the global discourse on development (25). However, this has not solved the issue as most low-income countries invest less than 1% of their health budgets in mental health services and fall below acceptable standards of provision (26). Implementation of spirituality can only take place alongside whole global mental health improvement.

In conclusion, I have discussed the overlooked yet key role spirituality has as a discipline within Global Health. As an interdisciplinary field, Global Health is neglecting spirituality, the importance it has in many patients' health beliefs and the potential benefits it has for these patients. The diverse engagement of spirituality across the world, particularly as a coping mechanism, should be given greater attention. Health care providers can only appreciate the importance some patients may place on their spiritual health if it is better implemented within their assessments. This will assist management options and could include integration of a community-based medicine approach with local spiritual leaders and networks. Likewise, including spiritual networks within the Global Health disciplines will improve access to healthcare and provide a more holistic management plan to those patients who require it. However, enhancing the role of spirituality in Global Health will take time and this is made more difficult due to the wider problem of mental health underfunding. The Global Health agenda must embrace these disciplines to be truly interdisciplinary and meet the needs of a vast

number of people. This is especially pertinent for Muslim healthcare providers with an interest in mental health services or Global Health fields. Evidently, the Islamic tradition promotes health and values spiritual and mental well-being. However, the extent to which this is integrated into healthcare provision is certainly below ideal standards. In this sense, great inspiration can be taken from the bimaristans and scholars of previous eras.

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# Using Social Media/ Mainstream Media to Prompt Organ Donation/ Transplantation Education – Scientist Perspective on Chronic Kidney Disease (CKD)

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## Abstract

**Introduction:** The use of social media (SM) today provides unparalleled opportunities to provide and receive education, access to communication and engagement. SM/ mainstream media (MM) such as television, newspapers, magazines, and radio stations are also being used to prompt education surrounding specific Long-Term Conditions (LTCs). Certainly, use of SM is not limited by constraints of time and geography **Aims:** Three questions being proposed here: 1) Is there an Islamic stance on using SM/ MM to prompt organ donation/ transplantation education? 2) Can Muslims donate their organs? and 3) Does the Healthcare Scientist have a role providing the public education surrounding organ donation/ transplantation? Chronic Kidney Disease (CKD) will be used to provide a LTC example. **Review:** There is a need for multi-channel approaches so that the issue is a more widely known social norm in primary care, where healthcare scientists will know underlying pathologies. **Islamic Stance:** If a Muslim decides to donate an organ they must do so out of free will without being morally or socially forced and without economic pressures. If the deceased Muslim indicated during life (in a will) that they do not want to donate organs, then no one is authorized to do this on the deceased person's behalf. **The Healthcare Scientist's Role:** More educational campaigns via SM/ MM involving healthcare scientists and Muslim communities are required. **Discussion:** Bridging gaps in health literacy (HL) is also important. This is where healthcare scientists have an important role, to provide health science transparency where other health professionals are challenged. Clarity of terminology to help increase HL on topics relating to organ donation/ transplantation is now especially required owing to more time being spent online. **Conclusion:** 1) The Islamic stance on use of social media to prompt organ donation/ education has not been investigated. 2) Muslims can donate their organs, and 3) there is a role for healthcare scientists to provide education, however more research is required to shed light on what is the most effective approach for the healthcare scientist to become proactive.

## Introduction

With exception to individuals with severe learning difficulties and neurological illnesses (which of course are devastating in their own right), there has never existed a human being who has not been aware not only of his body but also of his individuality, both physical and spiritual (Mauss 1998). Human beings are consciously aware of their own lives and, it's through understanding that awareness of a consciously constructed self is identified (Dunn 1998). The use of social media (SM) today provides unparalleled opportunities to provide and receive education, access to communication and engagement. SM/ mainstream media

(MM) such as television, newspapers, magazines, and radio stations are also being used to prompt education surrounding specific Long-Term Conditions (LTCs). These forms of education have not been explored in detail to prompt organ donation/ transplantation education using SM/ MM. Certainly use of SM is not limited by constraints of time and geography (Eysenbach and Till 2001).

## Aim

Three questions are being proposed here:

- 1) Can Muslims donate their organs?

2) Is there an Islamic stance on using SM/ MM to prompt organ donation/ transplantation education?

3) Does the Healthcare Scientist have a role providing the public education surrounding organ donation/ transplantation? To answer these questions, the LTC, Chronic Kidney Disease (CKD) will be used to provide an example.

## Social Media and Health Education

Social Media usage has grown exponentially, now representing one in five minutes spent online (Dunn 1998; Eysenbach and Till 2001; Eaton 1994; Nutbeam 2018; O’Kane 2015; Protheroe 2009) and patients/ carers and the lay general public accessing information combining key issues relating to organ donation/ transplantation through Mainstream Media. Using Social Media perhaps has several gains with standard forms of Mainstream Media where healthcare is concerned (Dunn 1998; Eysenbach and Till 2001; Eaton 1994), but both have advantages with regards to reach, accessibility and prompting organ donation awareness/ education. Using Social Media versus Mainstream media to prompt organ donation/ transplantation education offers wider opportunity in ways as previously unrealized (Dunn 1998; Eysenbach and Till 2001; Eaton 1994).

A study conducted on college students in the US, demonstrated that social- based communication had the greatest impact for donor registration, and described that a social media campaign which used Facebook, and YouTube resulted in 9000 documented donor registrations. Within the student organisation, the organ donor registration was increased by 28% (D’Alessandro et al. 2012). Furthermore, whilst traditional online advertising offers the greatest message exposure, when combined with the use of social networking sites to promote donation, it resulted in an increase in request for organ donor cards and registrations (BBC News 2015). Thus, the use of social media alongside existing mass media donation campaigns can be seen to be highly effective in promoting organ donation. One LTC that surrounds organ donation/ transplantation quite heavily is Chronic Kidney Disease (CKD).

## What is Chronic Kidney Disease (CKD)?

CKD is a long-term irreversible clinical condition and has been described as the gradual, and usually permanent, loss of kidney function over time. Early in the disease process, individuals with CKD often experience no symptoms and for a long time, it has been an under-diagnosed condition (Cameron et al. 2013). Even in the absence of symptoms, CKD appears to add significantly to the burden of cardiovascular disease (CVD) and death (Cameron et al. 2013). The rate of CKD is increasing worldwide, leading to greater need for kidney transplantation (Stefanone

et al. 2012). Transplantation is not a cure; however, it is cost effective compared with Haemodialysis (HD) in the treatment of this long-term condition (LTC) and achieves higher prognosis and morality (BBC News 2012). Currently living kidney donation accounts for about one-third of kidney transplants performed in the UK, with deceased donation forming the main source of kidney transplantation (Sissons 2011). This high need but low supply among minority ethnic populations presents problems in achieving an optimal match of blood group and tissue type where these are less common among the majority population, resulting in patients from minority ethnic groups/ Muslim faith spending an increased time on the transplantation waiting list (Stefanone et al. 2012; BBC News 2012; Sissons 2011). Table 1 summarises stages of CKD.

## What is the Islamic Stance to surrounding organ donation/ transplantation Education?

From an Islamic perspective, organ donation/ transplantation is a more recent phenomenon and started to preoccupy the minds of jurists since the 1950s (Saaleh bin Fawzaan bin Abdullaah al-Fawzaan 2015; Eaton 2000). Available Islamic literature to date does not provide detail with any indication that organ transplantation took place during the lifetime of the Prophet Muhammad (Peace be Upon Him). However, early discussions have some implications used as starting points by ‘today’s’ Muslims. One condition is that if a Muslim decides to donate an organ he must do so out of free will without being morally or socially forced and without economic pressures (Saaleh bin Fawzaan bin Abdullaah al-Fawzaan 2015; Eaton 2000). If the deceased Muslim indicated during life (in a will) that they do not want to donate organs, then no one is authorized to do this on the deceased person’s behalf Saaleh bin Fawzaan bin Abdullaah al-Fawzaan 2015; Eaton 2000).

Although other sociocultural confounders are likely to influence the decision-making process for Black and Asian Minority Ethnicity (BAME) communities, religion is an important aspect of the decision-making process for most individuals. To this end, healthcare professionals and service providers should also look to explore/ take advantage of SM/ MM to help facilitate discussions, raising education and providing evidence-based understanding for ultimate solutions (Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013; Morgan et al. 2006). The use of SM/ MM would help 1) bring more rounded discussions to the organ donation/ transplantation debate, 2) help with prompting open dialogue with key faith authorities in positions of influence to generate a consensus for further all-inclusive frameworks/ guidelines, 3) prompt organ donation/ transplantation to specific diseases, 4) provide channels for engagement with individuals, families, and communities to discuss some of the most sensitive issues, and 5) encourage personal decision-making by intellectual effort.

This may be a challenging subject to converse, but it is an important one because it has the potential to promote organ donation among an approximate fifth of the world population (Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013; Morgan et al. 2006). Education surrounding organ donation/ transplantation thus needs to be enhanced through the very health professionals that support clinical decision making, the healthcare scientists. These health professionals need to provide a rounded perspective on this important topic where laboratory care and practice is concerned. However, what also needs to be highlighted is that this understanding requires discussion with Fiqh (Islamic Jurisprudence) (Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013; Morgan et al. 2006). For every disease, there is a cure (definition of which is ambiguous from human thought to Divine knowledge). However, those who do not believe in mercy or practice it cannot expect to be saved by it (Eaton 1994; Eaton 2000). In terms of strategies to promote organ donation/ transplantation, there is a need for multi-channel approaches so that the issue it is a more widely known social norm in primary care (Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013; Morgan et al. 2006). It is important that this subject area is linked to those LTCs that are indeed known to require organ transplantation for best prognosis/ health outcome (Morgan 2010; Department of Health 2008; Hostetter 2001). LTCs that healthcare scientists will know underlying pathologies.

## Islam and Definition of Knowledge (or Education)

Islam is commonly regarded as religion of 'Law', but above all it is the religion of knowledge. The Arabic meaning word for 'law' has the primary meaning for 'understanding' and thus relates to knowledge (Rispler-Chaim 2007; Ghaly 2008; Sheikh 2007; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). In Islam, knowledge, intelligence and understanding define man as such. Man is not defined as a good or strong creature, or even as one who loves, but can be defined as one who understands or has the capacity for understanding (Rispler-Chaim 2007; Ghaly 2008; Sheikh 2007; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). In other words, if man penetrates deeply into self – through all the layers of dreams and darkness – then comes out into the open and finds 'everything', that is knowledge. There are contentions but the question is then: who provides knowledge? It is Allah (God) alone and He alone deserves worship. In Islam, worship can also be defined as 1) Tawhid al-Rububiyah (or the unity of Allah's Lordship), 2) Tawhid al-'Ibadah or the unity of Allah's worship and 3) Tawhid al-Asma' Wa'l-Sifat or the unity of His names and attributes (Rispler-Chaim 2007; Ghaly 2008; Sheikh 2007; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). This is why the beloved prophet Muhammad (Peace be Upon Him) informed: 'He, who knows himself, knows his Lord'. Science for a long time has been a foundation for

establishing knowledge/ education. What does Islam say about science?

## Islam and Science

Islamic Science has always been holistic. This term, in which is of recent origin is ambiguous. Sometimes it refers only to the recognition of inter-independence between mind and body (Rispler-Chaim 2007; Ghaly 2008; Sheikh 2007; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). If theory relates to 'holism' with reference to the Islamic perspective, then really it can only refer to the governing principle of Islam (Tawheed – oneness of Allah) and the unity of that He has created (Rispler-Chaim 2007; Ghaly 2008; Sheikh 2007; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). It is through trials and tribulations, man matures and Allah (SWT)-willing, begin to face the reality of circumstances. Trials and tribulations free mankind from the illusions in which man seeks refuge (Rispler-Chaim 2007; Ghaly 2008; Sheikh 2007; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). Any attempt to study phenomena (i.e. organ donation/ transplantation) without reference to the Qur'an is destined to failure because it has fragmented a link with reality (Rispler-Chaim 2007; Ghaly 2008; Sheikh 2007; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). It is also quintessential to note that religious morality sets limits which do not change with passing public opinion (Rispler-Chaim 2007; Ghaly 2008; Sheikh 2007; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). If man denies the world around him as a self-evident truth, then man is also denying that Allah (SWT) is a self-evident truth. Science has limitations – it is time bound (not timeless) and thus for the Muslim, the Qur'an is also 'The Criterion' (Al-Furqan) teaching to discriminate, not only between good and evil but also between shades of grey, the misnomers which are apparent in daily life (Rispler-Chaim 2007; Ghaly 2008; Sheikh 2007; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). The Qur'an is multi-layered and multifaceted; it is distinct and is/ has always been (for the Muslims throughout history) a premise for decision-making.

## The Healthcare Scientist's Role surrounding Education for Muslim Patients

Muslims are the most ethnically diverse faith group in the UK (Sheikh 2007). The limited health data shows that Muslims are about twice as likely to self-report poor health and disability as the general population (Wakefield et al. 2001; Wakefield et al. 2011; Sharif 2012; O'Leary et al. 2015). Available Islamic literature to date does not provide detail with any indication that organ transplantation took place during the lifetime of the Prophet Muhammad (Peace be Upon Him). However, early discussions have some implications used as starting points by 'today's' Muslims (Wakefield et al. 2001; Wakefield et al. 2011; Sharif 2012;

O'Leary et al. 2015).

Within Islam there are varying schools of thought when it comes to organ donation/ transplantation (Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013; Morgan et al. 2006; Wakefield et al. 2001; Wakefield et al. 2011; Sharif 2012; O'Leary et al. 2015). Muslims in the UK believe that their religion prohibits organ donation despite efforts of outreach groups to dispel this myth (Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013; Morgan et al. 2006; Sharif 2012; O'Leary et al. 2015). In a study which asked the question: what are your thoughts on organ donation and transplantation? Most Muslim participants were unwilling to discuss organ donation with their families (Sharif 2012). The current emphasis in UK health education material would-be donors to 'tell' their relatives of their plan needs to be worded more sensitively to consider the shared nature of decision-making within Muslim families (Sharif 2012). Whilst these are some perceptions on organ donation and transplantation, they do not represent the wider Islamic world. There is no one faith that can claim privileged status regarding the complex and challenging questions of organ donation (Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013; Morgan et al. 2006; Wakefield et al. 2001; Wakefield et al. 2011; Sharif 2012; O'Leary et al. 2015). If policymakers want to see an increase in organ donation from the Muslim population and decision process, NHS Trusts need to accommodate Muslims in other ways (Sheikh 2007). Healthcare scientists could be proactive in this area of healthcare providing more informed understanding surrounding tests behind the scenes. Specifically, there has been more effort to understand Muslim perspectives but there needs to be further cohesion between those producing policy and Muslim involvement (Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013; Morgan et al. 2006; Wakefield et al. 2001; Wakefield et al. 2011; Sharif 2012; O'Leary et al. 2015).

An understanding of patient (or individual) attitudes toward self-management and technology could inform unbiased, patient-centered interventions. Moreover, literature informs that the use of SM, in particular (and perhaps more generally) provides a gateway for knowledge gathering and decision-making (Baker et al. 1999; Williams et al. 1998; Muhammad et al. 2015; Nutbeam et al. 2000). SM also influences technology adoption for health self-management and shaping the development for assessing the appropriateness of SM-mediated interventions for patients/ individuals where sharing experiences are involved. Overall, a greater education of SM on health, organ donation, transplantation can help both clinicians to leverage patient values and strategies for enhancing both important decisions making and prompting education since this technology is now almost 'everyday language' (Baker et al. 1999; Williams et al. 1998; Muhammad et al. 2015; Nutbeam et al. 2000). This work encourages health

professionals and policy makers to ensure there is wider coverage of sensitive issues such as organ donation and transplantation through SM/ MM so that the general public and those from the Muslim population can make more informed decisions under more challenging circumstances (Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013). Certainly SM applications have their place and it's important that such topics are discussed to encompass the Muslim population. In Islam, organ donation/ transplantation is allowed as Allah (SWT) informs that for every disease, there is a cure. More educational campaigns via SM/ MM involving healthcare scientists and Muslim communities are required. Those who do not believe in mercy or practice it cannot expect to be saved by it (Eaton 1994; Eaton 2000).

## Discussion

The Holy Qur'an and teachings of the Prophet Muhammad (Peace be Upon Him) inform that suffering in this life is short-term. Attachment (worldly life) is, at best a very brief, and Islam never condemns what is natural to the human creature. Attachment becomes a grave sin when it leads to forgetfulness of what is again, in the words of the Qur'an 'better and long-lasting' (Eaton 1994; Eaton 2000). Patients/ carers and the lay general public use the internet/ SM to access information relating to organ donation/ transplantation. Using SM perhaps has several gains compared to traditional forms of MM where healthcare education is concerned (Nutbeam 2018; O'Kane 2015; Protheroe 2009), but both have advantages with regards to reach, accessibility and prompting organ donation/ transplantation education. In relating, health literacy (HL) is also important (Baker et al. 1999; Williams et al. 1998; Nutbeam et al. 2000; Nutbeam 2018; O'Kane 2015; Protheroe 2009) thus bridging gaps in understanding of specific areas of health. This is where healthcare scientists have an important role, to provide health science transparency where other health professionals are challenged. Clarity of terminology to help increase HL on topics relating to organ donation/ transplantation is now especially required owing to more time being spent online (Nutbeam 2018; O'Kane 2015; Protheroe 2009). Using SM versus MM to provide wider education surrounding organ donation/ transplantation is still unique, however, healthcare scientists should seek opportunities to help raise more education surrounding this sensitive topic in this faith population (Nutbeam 2018; O'Kane 2015; Protheroe 2009).

## Conclusion

So, 1) Can Muslims donate their organs? Yes, Muslims can donate their organs. Whilst there are some perceptions on organ donation/transplantation where Muslims can't donate, these do not represent the wider Islamic world. A campaign promoting the need for increased blood and

organ donation from Black and Asian Minority Ethnicities (BAME) and Muslim faith was published (Muhammad et al. 2015). There is no one faith that can claim privileged status regarding the complex and challenging questions of organ donation/ transplantation (Department of Health 2008; Rispler-Chaim 2007; Ghaly 2008; Sheikh; Alkhawari et al. 2005; Sissons 2011; Rocklinsberg 2009). 2) Is there an Islamic stance on using SM/ MM to prompt organ donation/ transplantation education? The Islamic stance on use of either SM/ MM would be positive to prompt organ donation/ transplantation if this helps to increase life expectancy. If policy-makers want to see an increase in organ donation/ transplantation from the Muslim population and a more inclusive process, NHS Trusts need to involve Muslims to help inform practice (Sheikh 2007; Morgan 2008a; Morgan et al. 2008b Morgan et al. 2013; Morgan et al. 2006). Specifically, there needs to be further cohesion between those producing policy and Muslim involvement. 3) Does the Healthcare Scientist have a role providing the public education surrounding organ donation/ transplantation? The answer is yes, however more research is required to shed light on what is the most effective approach for the healthcare scientist to become proactive surrounding education for Muslim patients. The proliferation and wide usage of SM in combination to education of disease states via MM of over the past decade has created opportunities for healthcare scientists to seek wider opportunities to contribute and inform practice.

## Summary

Discussions need to be balanced to help to make informed decisions and healthcare providers to prompt the right choices in care plans (Black et al. 2010). At the same time, an increase in life expectancy is worthless if additional years do not lead to an increasing education of the Divine reality (Eaton 1999; Eaton 2000). Practice and research now need to identify novel ways to deliver sensitive education. Healthcare scientists could help provide education through SM/ MM groups like the Renal Patient Support Group (RPSG), for example. With over 8000 members, the RPSG is perhaps one of the best examples through SM where shared-decision making can become more informed; real-life stories are being shared (RPSG 2019).

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Table 1: Stages of Chronic Kidney Disease (CKD)

CKD Severity	CKD Classification
<b>Stage 1</b>	Kidney damage with normal or raised GFR (greater than 90 ml/ min/ 1.73m <sup>2</sup> )
<b>Stage 2</b>	Kidney damage with normal or raised GFR (60-89 ml/ min/ 1.73m <sup>2</sup> )
<b>Stage 3</b>	Moderately impaired GFR (30-59 ml/ min/ 1.73m <sup>2</sup> )
<b>Stage 4</b>	Severely impaired GFR (15-29 ml/ min/ 1.73m <sup>2</sup> )
<b>Stage 5</b>	End Stage Renal Failure or GFR (less than 15 ml/ min/ 1.73m <sup>2</sup> )

Table adapted from (*Chronic Kidney Disease in England 2012*)

Table 1: CKD is classified in five stages, according to the level of kidney damage and the ability of the kidneys to filter blood. The glomerular filtration rate (GFR) measures the amount of blood that passes through the tiny filters in the kidneys, called glomeruli, each minute. As the disease progresses, the GFR falls. Stage 3 is divided into two parts - stages 3A and 3B (but classification for these two subdivisions are not outlined here).

## Medieval Islamic Medicine

Peter Pormann and Emilie Savage-Smith, *Published in 2007*

**A brief commentary & review by:** Ahmed Ashour, MRPharmS, *PhD Fellow, University of Manchester, GPhC-Registered Pharmacist, [ahmed.ashour@postgrad.manchester.ac.uk](mailto:ahmed.ashour@postgrad.manchester.ac.uk)*

### Review

Historians and researchers' opinions on medieval Islamic medicine has always been split. While scholars such as the German Manfred Ullmann, have judged the advancements of Muslim physicians to being minimal and no more than an appropriation of the ancient Greek advancements and literature, others have lauded the impact medieval Islamic medicine had on the international and historical progression of this crucial body of knowledge and the systems, procedures and inventions that they introduced.

Tackling this extremely vast and at times, complex terrain, Pormann and Savage-Smith introduce this topic to the modern reader by splitting the contents of their piece not by time or location, but by themes and topics. They present 6 key themes in 6 chapters, namely: the emergence of Islamic medicine; medical theory; physicians and society; practice; popular medicine and afterlife; and by afterlife the authors speak of the afterlife of medieval Islamic medicine and not the afterlife in the sense of a human's life. Their book covers the time periods dating from the 7th to the 16th centuries, and a geographical range spanning from Spain in the west all the way to India in the east, suitably portrayed through a map at the start of the book.

This review is not meant as an overly scholarly critique of Medieval Islamic Medicine, but more of a layman's review and a brief survey, a synopsis, of this interesting piece discussing a time of real pride for the Muslim world, that has not always been recognised for its impact on western modern medicine. During the course of this review notable and influential individuals will be highlighted that have been discussed by Pormann and Savage-Smith and additional comments will be made on their impact and contribution to medical knowledge.

Chapter 1 starts by setting the scene to the beginning of this era. The authors provide a background to the various theories that were around at the time, and there were many of them. As well as highlighting the importance of the translation movement, that really saw a propulsion during

the Umayyad Caliphate, as the boundaries of the Islamic empire grew to encompass a number of cultures and languages, with Arabic becoming the official language of the state. But it is really in chapter 2 that the reader is first exposed to the giants of the medieval Islamic medicine world, and fittingly starts with a quote from Ibn Sina, known in the European world as Avicenna, in which he states: "Medicine is a science from which one learns the state of the human body with respect to what is healthy and what is not, in order to preserve good health when it exists and restore it when it is lacking". Pormann and Savage-Smith accurately report that this is the opening to Ibn Sina's Canon of Medicine, a five-volume encyclopaedia that became one of his most notable works. While Pormann and Savage-Smith do not delve into the life of Ibn Sina, it is most definitely worth a mention at this point. Ibn Sina, began writing his first book at the age of 21, and his work was seen as the chief guide to medical sciences within the European universities sphere since the 12th century. Even though Ibn Sina passed away at the in the first half of the 11st century, his canon continued to be taught in European medical schools more than 700 years later. Another physician of note first mentioned in this chapter is Abu al-Qasim al-Zahrawi, Latinised as Abulcasis. His contributions are mentioned in various chapters, but his most significant contribution can be attributed to his work in the area of surgery where he is considered the greatest surgeon of the Islamic Golden Age. His work included 200 illustrations of surgical instruments, a number of them invented by al-Zahrawi, and his legacy was felt far beyond his geographic area.

In chapter 3, the physician's role is introduced, and the authors begin describing the social status of physicians throughout the change of the centuries. However, most interestingly in this chapter, the reader is introduced to the hospital system established in this period of time in the Muslim lands. While during this era there were many large and advanced (for the time) hospitals, none were more impressive than the Mansuri hospital in Cairo. A graphic detailing the plan of this hospital is presented in the book but in summary it was an all-inclusive healthcare

establishment that looked after the rich and the poor alike, and even utilised innovative methods to deal with some ailments (e.g. music therapy for psychiatric patients). The Mansuri hospital was named after its founder, Sultan Al-Mansur Qalawun, who was quoted as saying: “This hospital shall be opened to the old and to the young, to the poor patients, male or female, in order that they may be treated and cared for until cured.”, a quote not mentioned by Pormann and Savage-Smith.

The fourth chapter in the book is arguably the most eye opening, discussing the great al-Razi and his incredible work in building experience and documenting it in the form of textbooks and case histories. There are key examples of physicians improving the knowledge of the Greeks regarding the anatomy of the heart (i.e. Ibn al-Nafis), the anatomy of the jaw (i.e. al-Bagdadi) and the use of certain operations and their safety (i.e. al-Zahrawi and tracheotomies). Even though Al-Razi, or Rhazes, is highlighted by Pormann and Savage-Smith, I believe it is important we give more context to this great titan of Medieval Islamic medicine. Al-Razi practiced in Baghdad, where he was the chief physician, at the time a very noble position, with great power. He is responsible for the authoring of over 56 medical works, of which was his “Kitab al-Hawi fi al-tibb”, translated to The Comprehensive Book on Medicine. This was a large private compilation of Al-Razi’s gathered knowledge regarding medicine from previous authors, supplemented with his own experience dealing with cases. He also used this as a platform to criticise the works of those whose theories did not match what he witnessed in practice, including Greek philosophers such as Aristotle, Plato and Galen. Al-Razi’s writings were not limited to clinical cases and knowledge, but he wrote extensively in issues such as the ethics of a physician and also, he wrote a hugely influential book titled “For One Who Has No Physician to Attend Him”. He dedicated this work to those who could not consult with a doctor for their medical needs due to poverty, travel or other reasons.

The book briefly mentions the use of popular and magical cures in its fifth chapter, and a mention is made of the topic of prophetic medicine. The authors do not however differentiate between Sunni and Shia evidences, and the book does not go into a great length of detail on this matter. Chapter 6 closes the book by superficially mentioning the afterlife of Islamic medicine (i.e. its transmission into Europe).

This review aimed to highlight some of the most influential players in the Islamic world to medicine, and how their contributions were far more widely reached and appreciated than as mere translators or caretakers of Greek knowledge. While not large enough to establish the medieval Islamic medicine movement on its own, it is a brilliant introductory surveying piece that is easy to

read and provides a comprehensive introduction to the area of medieval Islamic medicine and possibly most importantly, at the time provided a different view of the impact of medieval Islamic medicine on early modern medicine in western Europe. Its simplicity however is complemented by its accurate and appropriate referencing to more detailed writings for those wishing to pursue their reading to a greater depth. While this is an easy read for the general interested party, if you prefer to listen to some of the ideas mentioned in this book, Peter Pormann also produced a podcast series available through the University of Warwick website on this topic.

## 1001 Cures – A Message to the Muslim Medical Community in the UK

Prof. Salim T S Al-Hassani, *Emeritus Professor University of Manchester, President, Foundation for Science, Technology & Civilisation (FSTC), www.fstc.org.uk*

### 1001 Cures: Uncovering 1000 Years of Medicine and Health Care to promote Inter-cultural Respect and Appreciation

The content of many schools' curricula and popular books of science and medicine rarely mention any scientific or technological progress between the fall of the Roman Empire and the European Renaissance. Yet reliable history books tell us of a period lasting nearly 1000 years after 600 CE, where a vast amount of scientific and intellectual activity took place in non-European cultures particularly in the Muslim world.

Strangely, the neglect includes the contribution of Muslim Spain (Al-Andalus) despite it being European. Unfortunately, this public amnesia has led to a polarised world.

The Foundation for Science, Technology and Civilisation (FSTC) recognised the need for a new language based on the cultural roots of science to discover connections between cultures to foster social cohesion and inter-cultural respect. Looking at world history through the lens of science, we see examples of cooperation, homage and respect throughout humanity. FSTC endeavours to popularize the notion that the development of science, technology and medicine benefitted from all cultures. This is exemplified by the famous saying of Sir Isaac Newton: "If I have seen further it is by standing on the shoulders of giants".

Initiatives like the '1001 Inventions' exhibition and accompanying literature and films have been met with resounding success and popularity. Building on this success, FSTC has embarked upon a new initiative focusing on the history of medicine and healthcare. This is named 1001Cures. It is a global initiative aiming to deliver in the public domain high-quality publications, exhibits and educational resources, accompanied by a series of academic and cultural activities. The aim is to encourage the building of a better shared future by positively altering public attitude through re-perceiving of historical connections within a new space for dialogue: the cultural

roots of science. In this space, people will discover new knowledge to fill the gap and remove the 1000 years Dark and Middle Ages amnesia.

"1001" in Arabic is a poetic historic term used to mean "numerous". It is familiar in the Western world from the title of the classic folk-tale collection, 1001 Arabian Nights. In the title 1001 Cures, however, the word refers to the many scientific and cultural stories of inventions and innovations in medicine and all aspects of healthcare, that this initiative seeks to tell.

The wider content of the material so far collected is published in the portal [www.muslimheritage.com](http://www.muslimheritage.com). More extensive material pertaining to medicine and healthcare can be divided into eight zones. Each zone reflects a major area of medicine and health care offering themes such as Medicine of Ancient Civilizations (Mesopotamian, Egyptian, Persian, Indian, Chinese and Greek), Early Middle (5th – 8th centuries) and High Middle Ages (9th - 14th centuries). Subject to adequate resources the data will be sufficient to produce exhibits on: Preventative medicine, Hospitals, Quality control, Medical Education and licensing, Clinical Medicine, Experimental Methods, Anatomy and functional Anatomy, Surgery, Ophthalmology, Pharmacy, Psychiatry, Therapeutic Music, Women in Medicine and Hospitals.

The first publication of this initiative was launched on 14 March 2018 at the Royal Society London, entitled "1001Cures: Contributions in Medicine and Healthcare from Muslim Civilisation" with various chapters written by modern historians of medicine from around the world, edited by Prof. Peter E Pormann of the university of Manchester.

The next publication is by late Prof. Rabie Abdel Halim entitled "1001Cures: Introduction to the Islamic Medieval Medicine". In an interview with the author, he said: "one of the most inspiring lessons we learn from the history of medicine and the history of science is that these disciplines broaden our world viewpoint and outlook to life. A thoughtful study of the history of science is bound

to strengthen a unique feeling of brotherhood, unity and universality of mankind.”

So, through these initiatives, FSTC aims to bring the best scholarship to a much wider audience, and thus demonstrate that (a) the scientific tradition of non-European civilisations is both interesting in its own right and innovative in numerous ways, and (b) this heritage is very much part of the medieval legacy of ‘Western’ science as it developed in the universities of Europe during the middle Ages and the Early Modern period.

I hope the new Journal of the British Islamic Medical Association (JBIMA) will play a significant part in supporting this vision and help spread the message and highlight the great advancements in the history of Islamic medicine.

I congratulate BIMA and its members for publishing the first journal of its kind in the UK and look forward to it shining a light on Muslim scholarship that contributed to such stunning developments in the field of medicine over the years. There is no doubt that JBIMA will help aid the discovery of previously unknown progression in this subject.

## Humanitarian Medical Projects

Dr. Hany El-Banna OBE, *Founder of Islamic Relief, Chairman of Muslim Charities Forum and Zakat House, President of Humanitarian Forum*

‘O you men! surely We have created you of a male and a female, and made you tribes and families that you may know each other’ (Quran 49:13)

### Practical definitions of Islam

If we try to find a practical definition of Islam, we can say that Islam is the religion of the individual, the society and the nation. Islam is the religion of creating positive developmental changes in societies.

### Why volunteer?

- Offers the chance to give something back to the community
- Allows you to make a difference to the people around you
- Provides an opportunity to develop new skills or build on existing experience and knowledge
- Is challenging and rewarding

### Characteristics of a ‘Social Leader’

1. Not afraid to work where no one else does
2. Ensures the comfort of others and advocates for goodness that binds the hearts of everyone
3. Is able to compromise
4. Is humble, patient and a good listener to the people and the community
5. Always optimistic, proactive and brings forward new initiatives
6. Respects all those around him/her, without preferences or discrimination
7. Recognizes the achievements of those around him/her
8. Encourages everything that contributes to building the community and empowering community members to work harder

### Health Humanitarian Projects

Health projects should look after the community as a whole. They need to be simple and holistic, and should focus on building the capacity and the efficiency of health care services in the community. These can be achieved by giving attention to the following points:

1. Respecting the traditional medicines and the culture of the community by trying to integrate modern medicine with good practices that are present in society. We should create an awareness of the ethical and practical aspects of doing humanitarian and medical relief work so that we are more thoughtful and can develop awareness of the bigger picture of the needs of the community.
2. Highlight the role of community /religious leaders and the media in promoting good health practices and general public health programs. Care should be given to projects promoting ‘preventive’ medical programs, as prevention is better than cure.
3. Women’s health: giving priority to programs caring for women’s health and encouraging women to join the medical field as doctors, nurses and midwives.
4. Providing clean drinking water: contaminated water can transmit diseases such as diarrhea, cholera, dysentery, typhoid and polio. Health costs associated with waterborne diseases such as malaria, diarrhea and worm infections represent more than one third of the income of poor households in sub-Saharan Africa. (<https://www.who.int/sustainable-development/cities/health-risks/water-sanitation/en/>)
5. Impact: some health projects have relatively low costs, but have a big impact on the lives of the people and the society as a whole. An example of such project is the ‘Cataract operations’ or blindness prevention projects.

6. Innovation: transferring the medical knowledge and technology is important, however, we should also be innovative and continuously look for new ways of providing good health care.

7. Needs-driven: it is also very important to mention that we should not be driven by the will of donors. The needs of the community should determine the type of projects implemented. We should maintain a balance between emergency relief and long term developmental issues.

It is therefore imperative that the healthcare community in the UK engage with medical humanitarian projects and help those who are less fortunate, particularly in the developing world and disaster-hit areas.

## Health Advocacy Through Our Mosques

Harun Khan, *Secretary General, Muslim Council of Britain (MCB)*

Public Health England 2017 report “Guide to Healthy Living: Mosques” cites national data indicating that BAME groups often have poorer levels of physical activity, for example, only 11% of Bangladeshi and 14% of Pakistani women undertake the recommended amounts of physical activity per week compared to 25% in the general population.

With many BAME communities following the Muslim faith, the mosque as a hub and community centre is an ideal and largely untapped medium for the delivery of high-quality public health interventions to improve health outcomes of the over 3 million Muslims in the UK.

The methods could be numerous, from encouraging healthier food to be served at community meal events such as Iftars during the Month of Ramadan, to organising weekly group walks in a local park for elderly members of the congregation to subtle changes in the way Madrassah (Supplementary Schools) structure their lessons for pupils to introduce more physical activity.

The British Islamic Medical Association (BIMA) itself has been active in this space for many years, through its landmark annual LifeSavers programme with free CPR training, Ramadan Health Awareness talks and Cancer Screening Awareness campaign earlier this year where mosques are able to “Request A Speaker” from BIMA’s skilled and qualified health professional network.

And aside from physical health, mental health is just as important e.g. via the capacity building of Imams and Aalimahs, such as through the free Mental Health training courses offered by the grassroots voluntary Muslim charity Inspired Minds. This and similar programmes have the potential to upskills the thousands of spiritual leaders at our mosques across the UK if scaled up effectively.

Recommended Friday Sermons on health-related topics are another way to raise the healthy lifestyle agenda, and at the Muslim Council of Britain (MCB) we regularly share with our members template Friday Sermons and maintain a bank of them on our website ([www.mcb.org.uk/friday-sermons](http://www.mcb.org.uk/friday-sermons))

And we hope to continue to advocate for better awareness of health issues in mosques via the annual Our Mosques Our Future conference, which is next planned for October 2019 in the Midlands, as well as MCB’s Mosques & Health working group.

The 2017 Public Health England report was based on a regional pilot with 6 mosques in the West Midlands delivered in partnership with Birmingham City Council and KIKIT Pathways to Recovery.

The need for further regional projects to explore the most effective ways to harness faith-based institutions as conduits for community health improvements is much needed and requires collaboration from across the public sector, private sector and civil society.

## BIMA - Who Are We?

Salman Waqar, *General Secretary, British Islamic Medical Association*

### Unite. Inspire. Serve.

This is the vision of the British Islamic Medical Association (BIMA), established on the 22nd of June 2013 at the Markfield Institute near Leicester, where over 100 healthcare professionals from all over Britain gathered to revive efforts to organise the Muslim healthcare community. BIMA was formed to meet the growing and unmet needs of the hundreds of thousands of Muslim healthcare professionals and students in Britain, who are becoming increasingly visible and active in their work and communities.

We now have a fast-growing membership of over 2,500 healthcare professionals and are engaged in numerous projects and workstreams, including JBIMA - our academic journal to highlight issues facing Muslims in their health, care and wellbeing. As we embark on this journey to address the inequalities and opportunities facing our communities, it is a timely opportunity to take stock of our progress.

*Table 1 - The 6 aims of BIMA*

1. To promote better understanding and appreciation of principles and values of Islam amongst all healthcare professionals
2. To protect and promote the health of patients and the public by adhering to fundamentals of Islamic ethics and good clinical practice
3. To encourage professional and social interaction amongst Muslim healthcare professionals and with the wider clinical community in the UK
4. To promote research and education in the field of medicine, Islamic medical history and bioethics
5. To engage our professional skills in charitable activities locally and globally to help the needy irrespective of colour, faith or creed
6. To advise and support Muslim healthcare professionals and students in career development, orientation and other work-related issues

Organising busy healthcare professionals and medical students is no easy task, especially with the resources of a voluntary organisation. However, we have been blessed

with opportunities and abilities to make meaningful contributions in many facets of our professional, community and spiritual lives. BIMA has always valued our democratic principles, led by our membership in not only matters of policy, but also financially and operationally. We are proud to be an organisation that represents all professions, specialities, grades, ethnicities and geographies. At its heart BIMA is simply a collective of inspired individuals with purpose.

Effective representation and meaningful change comes from being rooted to the communities we serve. This is why the majority of BIMA outreach projects are organised nationally but delivered in partnership with local Muslim institutions. We are proud to be working closely with the Muslim Council of Britain (MCB), the Federation of Islamic Medical Associations (FIMA), and numerous other Muslim NGOs to achieve our vision. We have partnered with mainstream health institutions too: from national NHS bodies and governmental bodies, major international charities, and interfaith organisations to deliver for our members and communities.

We have engaged with hundreds of mosques and Islamic centres to deliver programmes on basic life support, cancer screening, diabetes, mental health, organ donation, and long-term conditions management. We have trained hundreds of young clinicians and provided career orientation courses and webinars. We have produced materials to make Ramadan a safer experience with education courses for prescribers and the public. We have lobbied the NHS bodies on the rights of Muslim women to observe hijab in theatres and improve dress code policies, and have petitioned the government to protect the vulnerable from doctor assisted suicide legislation. We are organising a medical relief mission in partnership with international NGOs. We have organised conferences, webinars, seminars and socials to meet the needs of professionals, patients and the community. This is by no means an exhaustive list, and more details of our achievements and projects can be found on our website and social media channels.

There is more to come – in sha' Allah, God willing. We hope you will join us on this journey.

## On the Harms of Alcohol Consumption and Prevention

Ihsan Karaman, *President, Federation of Islamic Medical Associations (FIMA)*  
*President, International Federation of Green Crescents*

As almost everybody knows, alcohol consumption, as one of three primary public health problems of the world, is the third basic reason for preventable deaths and injuries on global basis. Over three hundred thousand people between the ages 15-29 lose their lives for alcohol related reasons every year in the world. Apart from being an addictive substance, alcohol is a public health problem known as the reason for 60 different diseases and conditions, injuries, mental and behavioral disorders including digestive system diseases, cancers, cardiovascular diseases, immunity disorders, lung diseases, musculoskeletal diseases, gonadal dysfunctions, and increasing risk of premature and low weight births. In addition, alcohol is associated with many serious social and developmental issues, including violence, child neglect and abuse, and absenteeism in the workplace.

It is scientifically known that there is no safe level of alcohol use especially for young people. Many negative outcomes of alcohol consumption could be prevented by adopting meaningful alcohol policies. Practices in the world have shown that it is possible to decrease the harms of alcohol by evidence-based and cost-effective interventions. Though the positive reflections of these interventions to the economy, society and general health of the population have been observed on the basis of countries, there is still a need for global cooperation and solidarity to decrease the harm and solve problems. It will be a great gain for public health to start the work required for an “international alcohol control framework convention” to prevent the harms of alcohol.

It is a well-known fact that the alcohol industry targets young people and influences their drinking patterns. Exposure to alcohol marketing, advertising and sponsorships in young ages increases the early initiation of alcohol in their lives.

However, the WHO European Charter on Alcohol states that “All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and to the extent possible, from the promotion of alcoholic beverages”.

To avoid this industrial influence on youth, increasing the role of youth involvement in alcohol policy and raising awareness amongst youth against the influence of industrial advertisement are crucial.

In the efforts of reducing the harms of alcohol, we face new challenges such as technological innovation and virtual advertising that cross international borders. Since modern alcohol advertising knows no frontiers; strict controls on marketing, advertising and sponsorship of the alcohol industry are crucial to prevent the youth from negative consequences of alcohol use.

With regards to this, I would like to mention the alcohol policy law which was adopted in Turkey, in 2013, as an exemplary model.

Alcohol policy in Turkey was mostly based on the 4250 numbered law which was enacted in 1942 in the monopoly period for alcoholic beverages. This law adopts some rules on alcohol marketing regulation but mostly, away from contemporary public health principles.

At last, the Turkish Government has prepared a new draft law, numbered 6487 on alcohol policy within the framework of “The National Alcohol Control Action Plan”. The bill was proposed and prepared by the Ministry of Health and was approved in the Grand National Assembly of Turkey on 24th of May, 2013 and the law was started to be implemented throughout the country.

According to this law, campaigns, promotions or events that aim to encourage the use or sale of alcohol are limited especially for young people.

This regulation firstly limits the advertisement of alcoholic beverages in printed and visual media:

*All kinds of advertising and promotion of alcoholic beverages are prohibited,*

*Campaigns, promotions or events that aim to encourage the use or sale of these products will not be allowed,*

*Companies that produce, import or market alcoholic beverages will not be permitted to be sponsor for events by using the brand or logo of their products,*

*It makes obligatory to be placed warning labels and statements on the bottles of alcohol drinks.*

Secondly, the regulation limits the availability of alcohol drinks:

*The sale of alcoholic beverages will be banned between the 10 pm and 6 am.*

*Alcoholic beverages will not be sold to individuals under the age of 18.*

*Alcoholic beverages cannot be sold in motorway service areas, gas stations, gyms, and public institutions.*

*Individuals under the age of 18 will not be allowed to be employed in the production, sale and marketing of alcoholic beverages,*

*The shops selling alcoholic beverages will need to be at least 100 meters away from schools, universities, student dormitories and places of worship.*

Thirdly, it adopts heavy penalties for drink driving, and severe sanctions for the violations of these principles.

When we evaluate the alcohol law from a public health point of view, we see that the restrictions are in line with the guidelines of WHO and the other public health organizations. WHO and the public health community recommend reducing physical availability of alcohol, restricting or banning alcohol advertising and promotion, and raising the price of alcohol. These are all the most effective ways suggested by WHO to reduce the burden of harmful use of alcohol.

Unfortunately, this comprehensive alcohol law became a political instrument between the ruling and the opposition political parties in Turkey. The new law faced very strong objections from the secular segments of the society which believe that it deliberately restricts their freedom and it is an intervention into their lifestyle. Industrial involvement and lobbying increased the reaction against regulations. Industry propagates that the alcohol regulations are religion based and mostly violate people's freedom. However when the regulations are examined closely, the principles that were adopted with the law are the basic guidelines of WHO.

I strongly believe that, as physicians, health workers and civil society members, we should work to develop contemporary strategies for dealing with alcohol consumption and for the prevention of addiction by using evidence-based scientific methods. Our efforts should focus especially on carrying out preventive social and advocacy activities aiming to create public opinion and raise awareness of the decision-makers and the general public all over the world. This is a great social responsibility and global task for leaving an addiction-free world to our young generations.

## “To Cure Sometimes, To Relieve Often, To Comfort Always” – Reflections on the Challenges in End of Life Care for Muslim Patients and Physicians in the UK

Nadia Khan, *Consultant in Palliative Medicine*

The above aphorism from 19th century American physician Edward Trudeau encapsulates what the endeavour of medicine is about. The fact that those words are often attributed to Hippocrates is not accidental- physicians throughout the ages have recognised that the outcome of their efforts to stave off illness and suffering, would always require seamlessly integrating the science of understanding and managing disease, and the art of understanding and accompanying people in confronting the impact of illness on the human condition.

Nowhere does the truth of this maxim come into sharper focus, than at the end of life. The reality of this truth has been led to several specific complex challenges for patients, carers and health care professionals from the Islamic tradition who must grapple with end of life issues in the modern Western setting.

In the increasingly complex clinical scenarios where end of life is faced by patients, the concept of medical futility is often a prominent influencer of professional opinion and decision-making. The judgement of medical futility may hold even more importance in clinical end of life scenarios characterised by uncertainty in physiological outcome. However, the concept fundamentally rests on a subjective judgement of what makes life worthwhile, upon which a benefit-harm judgement of treatment value is made. Tension around decisions of treatment withdrawal often arise essentially due to a mismatch between what Muslim patients and carers, and secular healthcare professionals might perceive as a life worthwhile. This tends to be compounded by attitudes towards, and acceptance of, medical uncertainty.

Muslims are likely to view the intangible spiritual domain of life to be fundamental to what constitutes a life worth living. Often this means erring on the side of life-preservation in the face of clinical uncertainty about prognosis - even if this requires a sacrifice in physical quality of life. In contrast, based on a secular conceptualisation of a life worthwhile, the capacity of an individual to connect

to the sacred may be a much less important factor for non-Muslim healthcare professionals in judging the futility of medical intervention. In such a situation, insistence of Muslim patients and carers to continue treatments deemed by professionals as futile, may lead to subsequent mutual misunderstandings and misperceptions around values, beliefs and intentions. Often this may end in therapeutic relationship breakdown and even perpetuate mistrust and preconceptions which influence interactions in future, unrelated, clinical scenarios.

On the other hand, Muslim healthcare professionals must increasingly contend with the consequences of an increasingly prominent secular individualism philosophy shaping the myriad of ethical quandaries, narratives, and societal discourses around the physician assisted suicide debate.

This has been thrown once again into sharp focus, following a controversial planned survey outcome interpretation by the UK Royal College of Physicians, which weights towards the college moving to a ‘neutral’ position on proposed legislation to introduce physician assisted dying. Regardless of outcome, the issue is part of a wider task for Muslim physicians to understand, engage with and manage, yet not be morally compromised by the inevitable ethical quandaries that arise when dealing with the inherent uncertainty within medical decision-making at the end of life.

How then, both as providers and receivers of end of life care, might we start to face such a mammoth undertaking? An important starting point is to establish open, regular and shared critical thinking and discourse between mujtahideen (expert scholars in Islamic legal theory), care experiencers, and clinicians at the forefront of contemporaneous medical practice within different cultures is key. This will help ensure that scholarly guidance around end of life issues is relevant to the constantly evolving contextual reality whilst being firmly rooted in the timeless principles of our deeply compassionate Islamic tradition.

Consequently, this will allow Muslim physicians to create a credible, collective framework that can be used to help articulate moral positions and nurture shared understanding. On a personal and professional level, as Muslim physicians it is key that we actively engage in cultivating the practical wisdom (phronesis) that has traditionally defined our professional identity. A greater understanding and recognition of phronesis allow the embracing of a decision-making space that values the rich plurality of mindset- key for dealing with the clinical dilemmas at the end of life in a way that allows us to 'relieve often, comfort always'.

Whoever is granted wisdom has indeed been granted something tremendously beneficial; but none reflect except people of insight. [Quran 2:269]