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Contents

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JBIMA Editorial

Prof Sharif Kaf Al-Ghazal, Editor in Chief

Assalamo Alaikom all,

The first few months of 2025 have been challenging for us as healthcare professionals; whilst 2024 was not easy, it seems that this year is just as difficult. Resilience is the byword, and when thinking about our individual journeys into medicine, it is worth us trying to find those reserves of resilience that have served us so well, and to continue our trust in Allah, our protector.

By the time you'll be reading this, it is likely that there will be clarity on the direction of the assisted dying bill, which has been delayed to give MPs on all sides more times to consider changes. Huge concerns remain about the bill however, and we at BIMA have not been shy in expressing these concerns. But beyond our stance as Muslim healthcare professionals, others have been upfront with their apprehension over this bill. More recently, more than 100 women from Christian, Muslim, Jewish and Sikh groups have warned in an open letter that the bill has "insufficient safeguards to protect some of the most marginalised in society, particularly women subjected to gender-based violence and abuse by a partner". Moreover, charities involved in the advocacy of victims of domestic violence has raised further concerns that this bill could put vulnerable women in danger and that there was a "significant risk" that coercion could potentially play a part in some cases of assisted dying. Within the bill, there is provision for doctors to proactively suggest assisted dying to patients that have not even raised it themselves which raises alarm bells about the idea of the NHS becoming a "state death service" as Shabana Mahmood, the Justice Secretary has stated.

The assisted dying bill has arguably become even more susceptible to abuse as the legislation has been weakened rather than strengthened. The judicial safeguard element which was part of the original bill has been removed so instead of judges signing off on assisted deaths, this will be the responsibility of panels with which lack investigatory panels, lack the ability to summon witnesses and can't hear evidence under oath. There is no obligation on assisted suicide providers to notify families that their relative is about to die which is inhumane, and just as worrying, no routes for relatives to raise concerns about coercion of a vulnerable and unwell family member.

MPs have repeatedly criticised the bill and there is still very little detail on costs of the service as well as any impact assessment. But beyond this, the ethico-legal dimension of assisted dying shifts the paradigm of what it means to be a doctor. We work to try and make the unwell feel better; to treat the root cause of a disease; to ensure that those who visit the hospital leave it in a state physically and mentally better than when they entered. The concept of assisted dying stands against all of this, and even arguments about "dignity in death" don't stand up to scrutiny. How is it dignified to be made to feel that you should die because you feel like a burden to those around you who you love?

Whilst we think about assisted dying in the UK, we cannot forget those dying in Gaza, who have been facing an ongoing genocide for over 500 days. Complicity in the killings of innocents goes far beyond Israel as this point; the international community must bear significant blame for repeatedly turning a blind eye to recent events. As healthcare professionals, we are especially concerned about reports that paramedics in Gaza – non-combatants and humanitarian workers – were shot by the Israeli military with intent to kill according to the Red Crescent. Video forage demonstrated that they were clearly seen in ambulances, but apart from a few simple statements of condemnation, the international community's response to Israel has been muted. Furthermore, the media have been partly to blame as on many occasions, having either ignored the ongoing massacres or presented a skewed narrative.

Muslim countries and the rest of the international community have just been giving lip service to the plight of the people of Gaza. As the massacres continue, the world has become desensitised to the daily horrible images coming out of Gaza every day proving that an immediate ceasefire has to be implemented.

The very recent news from the Supreme Court that the legal definition of a woman is based on biological sex in the Equality Act is has potentially far reaching consequences and is worth monitoring. It will mean that in hospitals and clinical settings, single sex spaces will accommodate only those whose biological sex aligns with said space, and the clarity is welcomed by many. It means that transgender women who hold a gender recognition certificate don't fit the legal definition of a woman under the Equality Act and means that single sex spaces are protected by the law. There will likely be more discussion in this space as people digest the news and its consequences, but for female patients and health-workers, this clarity is a positive step forward. We are publishing in this issue an interesting article written by Dr Saman Khan which is going to touch on this topic.

We ask Allah to guide us and put Baraka in our time. We ask Allah to protect the people of Gaza and grant them strength and resilience.

Wassalam.

Prof. Sharif Kaf Al-Ghazal
JBIMA, Editor in Chief

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Gender Dysphoria and Islamic Perspectives: Navigating Faith and identity

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Abstract

Gender dysphoria is an increasingly recognized global phenomenon, yet its prevalence remains underreported due to stigma and lack of research, particularly in Muslim-majority societies. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) estimates that gender dysphoria affects 0.005% to 0.014% of individuals assigned male at birth and 0.002% to 0.003% of individuals assigned female at birth, though these figures likely underestimate the true prevalence. Within Islamic contexts, discussions on gender identity are often shaped by religious, legal, and cultural perspectives, leading to varied responses ranging from acceptance to complete denial.

This paper explores gender dysphoria through both medical and Islamic lenses, addressing biological, psychological, and sociocultural factors. It examines the complex interplay between faith and identity, highlighting how Islamic jurisprudence has historically acknowledged intersex individuals while showing ambivalence toward transgender identities. Key fatwas and legal rulings from different Muslim-majority countries illustrate the diverse approaches taken by Islamic scholars and governments regarding gender-affirming medical interventions.

Additionally, the paper discusses the significant stigma faced by transgender individuals in Muslim societies, where they often encounter discrimination, violence, and socioeconomic marginalization. While Western nations have made strides in legal protections and medical support for transgender individuals, the Muslim world grapples with reconciling traditional religious teachings with contemporary understandings of gender identity.
Ultimately, this article underscores the need for a nuanced approach that integrates medical advancements with theological considerations. Encouraging informed discussions within Muslim communities can foster greater awareness, reduce stigma, and ensure compassionate care for individuals experiencing gender dysphoria.

Introduction

Gender dysphoria is a condition characterized by a deep and persistent discomfort or distress due to a mismatch between an individual's assigned sex at birth and their experienced gender identity. Often the term transgender is used as well, this relates to a person who has taken on the gender identity not corresponding to their registered sex at birth. Gender dysphoria is recognized in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as a condition that can lead to significant psychological distress, social

difficulties, and emotional struggles. While gender dysphoria itself is not classified as a mental disorder, the distress it causes can have profound mental health implications, including anxiety, depression, and suicidal ideation if left unaddressed.

In recent years, discussions surrounding gender identity have become more prominent globally. The prevalence of gender dysphoria is estimated to be between 0.005% to 0.014% for individuals assigned male at birth and 0.002% to 0.003% for individuals assigned female at birth, this figure from the DSM-V only reflects those who have attended a clinic and have been given a diagnosis of gender dysphoria. Hence these figures are likely underreported (Zucker et al 2017). In a 2016 CDC (Centre for disease control) survey found about 0.6% of U.S. adults identify as transgender. There has been a shift in approach since the DSM-5's rewording from "Gender Identity Disorder" to "Gender Dysphoria a move to help reduce stigma.

In the Muslim world, however, gender dysphoria remains a largely underexplored topic due to sociocultural stigma, legal restrictions, and religious debates. Many Muslim-majority societies hold strict gender binaries, which can create significant challenges for individuals experiencing gender incongruence.From an Islamic perspective, the discussion around gender and identity is deeply rooted in religious teachings, cultural traditions, and jurisprudential interpretations. Islam traditionally recognizes two primary sexes, and religious obligations, inheritance laws, and social roles are often structured around this binary framework. However, Islamic scholars and jurists have also acknowledged individuals who do not fit into these binary categories, such as intersex individuals (khuntha) and effeminate males (mukhannathun), and have historically provided legal and social guidelines for their integration into society.

The discourse surrounding transgender identity and gender dysphoria in Islam is complex and varies across different Islamic schools of thought. While some scholars argue that gender-affirming interventions contradict Islamic teachings on preserving one's natural form, others support medical transitions in cases of biological and psychological necessity. Countries such as Iran, Pakistan, and Egypt have issued religious fatwas permitting gender reassignment surgery under certain conditions, while others, like Saudi Arabia and the UAE, strictly prohibit such procedures for transgender individuals without intersex conditions.
This paper aims to explore the intersection of gender dysphoria and Islamic perspectives, focusing on the medical, psychological, and theological dimensions of the issue. It will examine Western medical treatments, analyse Islamic jurisprudential views, and discuss the challenges faced by transgender individuals in Muslim-majority societies. The goal is to provide a nuanced understanding of how gender dysphoria is perceived, treated, and debated within the framework of Islamic faith and identity.

Stigma

While theological interpretations and legal frameworks shape the discourse on gender identity in Islam, the everyday experiences of transgender individuals in Muslim-majority societies tell a different story. Beyond religious doctrine, deeply ingrained cultural stigmas, social exclusion, and systemic discrimination create significant challenges for those navigating gender dysphoria. In many communities, public discussion on gender variance remains taboo, leading to marginalization, limited healthcare access, and heightened mental health struggles for affected individuals. Understanding the impact of stigma and societal attitudes is crucial to grasping the full complexity of gender dysphoria within the Muslim world.

Data from numerous contemporary western studies have shown that transgender individuals have been abused, stigmatized, bullied and have been victims of prejudice both overtly and covertly. The 2011 National School Climate Survey conducted in the USA reported that as many as 90% of the transgender students had suffered harassment, and 25% had experienced physical assault merely because of their gender expression. However, gender dysphoria awareness is growing in Western countries. They are opening up to transgender individuals and talking about the issues that transgender communities face. Western societies have begun instituting rapid sociopolitical reforms in favour of transgender rights and medical assistance is freely accessible to those opting for gender-affirming surgery in line with their gender expression (National Gay and Lesbian Task Force 2008, Reisner et al. 2015a).

Although gender dysphoria has been contested globally, it is challenged to a greater extent in the Muslim world and is a culturally sensitive topic. Juristic debates aside, the lived reality of transgender individuals in Muslim societies is shaped by social attitudes and stigma. A literature review carried out by Taslim et al (2021) discovered that social and economic statuses of transgender individuals are a cause for concern in some

Muslim countries such as Malaysia, Indonesia, and Pakistan. They are marginalised, stigmatised and live in poverty. They are victims of violence, neglect and lack of education, healthcare and employment opportunities (Gibson et al. 2016, Saeed et al. 2018, Shah et al. 2018). Furthermore, transgender individuals in Pakistan reported depression, isolation, violence, and rejection in families and from society and their communities. Such experiences raise their lifetime risk of anxiety, depression, and suicidal ideation to higher levels than in the general population (Faiza et al 2024). Research has demonstrated familial rejection as one of the largest stressors, most of the transgenders are rejected or kicked out of their homes, thereby becoming homeless and economically helpless (Brennan et al., 2017). There is minimal or no representation of transgender individuals from Arab nations or the rest of the Muslim countries indicating avoidance or lack of attention on transgender matters in these countries.

Additionally, high prevalence of human immunodeficiency virus and other sexual transmitted diseases among local transgender individuals in these developing countries further stigmatises them and is also a major public health issue that has raised international concern (Akhtar et al. 2012, Wong 2012, Gibson et al. 2016, Barmania&Aljunid 2017, Vijay et al. 2018, Akhtar et al. 2020, Robbins et al. 2020)

Scientific Explanations of Gender Dysphoria

Beyond societal perceptions, scientific research has sought to understand the origins of gender dysphoria through biological, genetic, and psychological lenses. While stigma and cultural opposition persist, emerging evidence from neuroscience and endocrinology suggests that gender identity is influenced by complex biological and environmental factors.

The aetiology of gender identity remains elusive. There are no definitive extrinsic or intrinsic stimuli or motivators identified that can fully explain why transgender individuals are as they are.This uncertainty about transgender aetiology has caused scepticism about its legitimacy and is the root cause of the universal debate and controversy that surrounds it. However, transgenderism has gained huge media attention, public interest, and awareness over the last 2–3 decades, at the global level. During this time, academic literature and multi-disciplinary research output on this subject have also increased exponentially to highlight the social, economic, behavioural, and health aspects of the transgender community.

Biological factors

The presentation of gender dysphoria has been considered as a complex interaction of genetic, hormonal, and environmental factors. There may also be some evidence of differences in brain development and physiology. Twin studies have implicated a genetic role in the formation of gender identity with additional environmental contributors. In a large-scale CBCL study of Dutch twins (N=23,393) aged 7 and 10 (Coolidge et al, 2002), monozygotic (MZ) and dizygotic (DZ) twins were compared; genetic factors contributed to 70% of cross-gender behaviour (as assessed via the two CBCL gender items). Another study of 314 monozygotic (MZ) and dizygotic (DZ) twins (mean ages 9.4 and 10.1 years, respectively) roughly replicated this finding, with genetic factors contributing up to 62% of the variance on a DSMIV-based gender dysphoria scale (Coolidge et al, 2002). In animal studies, where prenatal hormones can be manipulated, the strong effect of prenatal testosterone on gender role behaviour is clear (Hines, 2011). Individuals with a disorder of sex development may be exposed to high levels of prenatal testosterone, and individuals with two X chromosomes with congenital adrenal hyperplasia (Merke& Bornstein, 2005) do have higher rates of gender dysphoria and cross-gender identification (Pasterski et al, 2015). However, the majority of female-raised individuals with congenital adrenal hyperplasia (CAH) (95%), appear to develop a female gender identity (Dessens et al, 2005). Other evidence for the importance of prenatal testosterone comes from studies in XY individuals with complete androgen insensitivity syndrome who lack the receptors necessary to respond to endogenous testosterone. The vast majority of these patients develop a female gender identity, suggesting that downstream testosterone signalling may be important for the development of a male gender identity (Hines, 2015). Some have noted that these patients were reared unambiguously as females and that social factors may have played a strong role in their female identity formation (Hines, 2009). Some studies have shown that those with complete androgen insensitivity syndrome have lower scores on female identity scales (Richter-Appelt et al, 2005) and there are case reports of gender dysphoria ultimately leading in these patients to gender affirming surgeries (T'Sjoen et al, 2011). This could be secondary to the psychological stress of learning about the diagnosis, as well as the possibility of undetected functional androgen receptors (Steensma et al, 2013a). Overall, studies of gender identity in individuals with disorders of sex development, while implicating androgens in the development of gender identity, have yet to show a direct relationship.

Psychosocial factors

There have been no proven psychosocial factors in the development of gender identity. Mothers of gender dysphoric boys have been noted to have higher scores on the Beck Depression Inventory and the Diagnostic Interview for Borderlines (Marantz & Coates, 1991), but these higher scores might be due to external pressures placed on these parents by unaccepting social environments and such studies cannot determine the direction of causation. One study noted that gender dysphoric boys were rated as more feminine and "beautiful" by blinded college students (Zucker et al, 1993), while another study of gender dysphoric girls showed that these girls were rated as less "cute" (Fridell et al, 1996), raising the question of whether perceived physical appearance and resultant social treatment may contribute to gender incongruence.

Cultural factors

Culture plays an important role in the gender determination of patients with atypical somatic sex development (Kuhnle&Krahl, 2002; Meyer-Bahlburg, 1998). Cultural influences may contribute to patients with Disorders of Sexual Development (DSD) and their families' acceptance or rejection of their assigned gender, to the psychosexual development of the patient, and medical management. There are reports from several countries such as Saudi Arabia (Taha, 1994), Turkey (Özbey, Darendeliler, Kayserili, Korkmazlar, & Salman, 2004), and Egypt (Zainuddin and Mahdy 2016) that indicate increased rates of assignment to the male gender regardless of karyotype, gonadal makeup, and fertility potential, because the male gender has a dominant role in society and is thus the preferred sex. In India and Pakistan, DSD children are more likely to be raised as males simply in order to ensure a better future for these children when they grow up (Warne & Raza, 2008). Even if they are infertile as males, they are more likely than infertile females to achieve economic independence.

Gender identity and Autism

People who do not identify with the sex they were assigned at birth are three to six times as likely to fall on the autistic spectrum compared to cisgender (denoting or relating to a person whose gender identity corresponds with the sex registered for them at birth) individuals according to the largest study yet to examine the connection (Warrier et al 2020). Gender-diverse people are also more likely to report autism traits and to suspect they have undiagnosed autism. A number of studies show that autism spectrum disorder (ASD) symptoms are over-represented among transgender individuals. Autistic females seem to experience this more than Autistic males (Cooper et al 2018). The rate of ASD among the general population is estimated at around 1% (Lai et al, 2014). Clinical level rates of ASD symptomatology in transgender adults have been reported in 5-20% (Jones et al, 2012; Pasterski et al, 2014; Pohl et al, 2014). Although to date definitive findings have not been shown.

Gender Identity and Islam

As scientific research continues to uncover the underlying mechanisms of gender dysphoria, these findings raise important theological and ethical questions. How do Islamic teachings reconcile the existence of gender dysphoria with religious doctrines on gender and creation? The following section explores how Islamic scholarship has historically addressed gender variance and how contemporary scholars interpret these developments.

Historically, Middle Eastern, North African and European cultures recognized and had terms for transgender individuals. This includes "hijra" in subcontinent, "Mukhannath" in Islam and Arabic cultures, "Phrygia" in ancient Greek, and "Cybele" in ancient Roman. These individuals were often intersex people or natal males castrated for religious or other reasons. It is important to note that the recognition did not necessarily protect these individuals from stigma and marginalization, and in some places like the subcontinent, Hijras, although believed to have power to remove a "bad spell" from newborns, were highly stigmatized. Meanwhile there have been new movements to support and protect transgender individuals in this region. The Rights of Transgender Persons Bill, which provisions anti-discrimination and employment for transgender individuals, was introduced in 2014 in India; it may result in positive changes in the future.

The traditional gender binary constitutes an integral aspect of Islamic social ethics, which has a pivotal role in shaping religious obligations, legal proceedings, and interpersonal judgments within Muslim communities. Within the familial sphere, this gender binary underscores fundamental responsibilities encompassing parenthood, filial duties, and inheritance rights.

Unlike gender dysphoria, intersex individuals have a clearer standing in Islamic law. Intersex are individuals who have reproductive or sexual anatomy that doesn't fit

into an exclusive male or female classification. Out of every 1000 to 4500 births, approximately one case involves the presence of atypical genitalia, previously referred to as ambiguous genitalia (Congress House Report, 2023). Besides ambiguous genitalia, other disorders of sex development (DSDs) also include genetic conditions such as Klinefelter or Turner syndrome that rarely present ambiguous genitalia (Nowotny&Reisch, 2023). DSDs are not restricted to medical discussions, but their psychosocial aspects have also attracted much attention from gender and sexuality researchers, who have also investigated the religious aspects, such as in the field of Islamic jurisprudence

It is agreed that the Quran unequivocally states that there exist two biological sexes. This distinction is fundamental to the Shariah, permeating various aspects of life and articulated in the chapters of Islamic juristic texts from the chapter of cleanliness (taharah) to matters of inheritance (mirath), each gender carrying its own set of rights and responsibilities. It is essential to understand that gender dysphoria, the feeling that one's biological sex does not align with their gender identity, is recognized in Islam as a valid emotional experience. Within these variations, one can categorize individuals. as intersex (khuntha), effeminate (mukhannath), or masculine women (Mutarajjilah). Notably, Islamic jurisprudence (fiqh) literature addresses these distinctions by assigning distinct legal regulations to each of these categories (Haneef, 2011) Shariah respects the complexity of human emotions and identities but underscores the significance of adhering to established gender roles and distinctions, recognizing that human beings are multifaceted and that not every feeling should lead to action (Fiqh Council of North America, 2022). In fiqh, the matters concerning intersex and transgender individuals are typically considered exceptional cases, as they involve atypical sexual development and ambiguity in biological sex recognition, which fall outside the norms and generally perceived notions discussed in the Quran and ḥadith.

Further exploration of how these were described and managed historically are found in the following definitions. Khuntha (hermaphrodite/intersex) refers to an individual who either does not have male and female genitalia or has both (Al-Kasani, 1986). Al-Nawawi (1991) classified hermaphrodites into two distinct groups: (1) those with ambiguous or problematic genitalia (khunthamushkil) and (2) those with non-problematic or unambiguous genitalia (khuntha ghayr mushkil). The latter group includes individuals with both male and female genitals, yet their social/legal gender assignment is typically based on the genitalia with more predominant functionality. In contrast, the former group includes individuals who do not conform to the conventional binary gender classification because their genital organs may be either fully functional or non-functional, but they have an alternative anatomical structure for excretion.

In a report from Sunan al-Darimi, Ali ibn Abi Talib, companion of the Prophet (PBUH) and the fourth Caliph, was asked about the inheritance rights of an intersex person, specifically regarding whether their inheritance should be determined based on their male or female characteristics. His response was, "according to how they urinate" (Book 21, Hadith 2880). This tradition appears to have fixed the benchmark of social/ legal gender assignment in the case of khuntha. Classical Muslim jurists recognized the social/legal gender of Khuntha based on the functioning of urinary orifices and also by the signs of puberty as a secondary option.

Additionally, in cases where no conclusive biological indicators were present, these jurists considered feelings or sexual attraction as a means to determine social/legal gender (Collier et al 2013). Following progress in medical technology, the above-mentioned criteria of social/legal gender assignment have been updated and “the distinction today should be between a ‘real hermaphrodite’ (who has both testicles and ovaries) and a ‘pseudo-hermaphrodite’ (khuntakadib), who is born with either ovaries or testicles but has external sexual characteristics that are different from those expected when looking at the gonads” (Tolino, 2018, p. 233). With the aid of modern medical tests and scientific advancements, it has become possible to recognize the biological sex of intersex individuals with greater precision. This can be achieved through examinations to identify the presence of internal structures such as testicles or ovaries, sex chromosomes, the womb, fallopian tubes, and other characteristics that may not be externally visible.

Social/legal gender assignment of intersex individuals can also be based on psychosocial studies, which demonstrated that some disorders of sex development arising from specific genetic conditions predispose individuals to identify more predominantly with one particular gender. For example, in the case of individuals with 46, XX CAH (congenital adrenal hyperplasia) with Prader stage 4 or 5, assignment to the female gender at birth appears justified even in severely masculinized cases whereby the intact and functional clitorophallus is commonly surgically reduced, because of a much higher incidence of serious gender identity problems among

those raised as males compared to those raised as females (Dessens et al., 2005). Nevertheless, for such individuals raised as females who develop gender dysphoria later in life, as reported by the case study of Zainuddin and Mahdy (2017), gender reassignment may be considered. For individuals with 46, XY CAIS (complete androgen insensitivity syndrome), assignment to the female gender at birth is justified by the relatively low incidence of gender dysphoria (1.7%) among those raised as females (Babu& Shah, 2021), even though the testes may be fully functional but are often removed. By contrast, for individuals with 46, XY 5-alpha reductase deficiency who were raised as females, there was a significantly higher incidence of gender dysphoria (53%), which made gender assignment at birth much trickier (Babu& Shah, 2021).

Mukhannath (effeminate male) is indirectly referred to in the Quran by the term ghayr uli al-Irbah (This term also refers to old men and those with low IQ who have lost any sexual desire) which literally means “male attendants free from sexual desire” in Surah al-Nur: 31 (al-Qurtubi, 2003). Mutarajjilah is the corresponding term to Mukhannath which refers to a masculine woman. Efeminate male (Mukhannath) refers to those who are anatomically male but exhibit female traits like gait, speech, dressing, and posture (Haneef, 2011). The masculine woman (Mutarajjilah) is vice versa. Regarding Mukhannath, a ḥadith reported by Ummu Salamah gives some important insights. She said, "When the Prophet (PBUH) was with her, there was an effeminate man in the house. The effeminate man said to Ummu Salama's brother, ʿAbd Allah ibn Abi Umayyah, if Allah should make you conquer Taif tomorrow, I recommend that you take the daughter of Ghailan (in marriage) for (she is so fat) that she shows four folds of flesh when facing you and eight when she turns her back. Thereupon the Prophet (PBUH) said (to us), this (effeminate man) should not enter upon you (anymore)" (Al-Bukhārī, 1987). This ḥadith portrays two aspects of the treatment of Mukhannath. Firstly, Mukhannath was identified along with their distinctions, generally accepted in so far as they were permitted to mingle with females in a society where gender segregation was a predominant social norm (Mohamad Rusli&Azmi, 2021).

It must be the Prophet (PBUH)'s tacit approval for mukhannath as a special case, giving them freedom of interaction with women (Tolino, 2018). But, once they were noticed as describing women with intimate details that were likely to arouse erotic feelings in a man, they were banished.

Contrasting Healthcare Approaches: West vs Islam

Available treatments

Given the diverse Islamic perspectives on gender identity, the question of medical intervention remains a subject of debate. In Western contexts, gender dysphoria is typically managed through a combination of psychological support, hormone therapy, and surgical options. However, these treatments raise theological and ethical concerns within Islamic discourse, particularly regarding bodily modification and the notion of altering God's creation.

The approaches to treating gender dysphoria in the West and the Islamic world differ significantly due to variations in medical, psychological, socio-cultural, and religious perspectives. The West has developed a structured medical framework for gender-affirming care, whereas Islamic perspectives, influenced by religious jurisprudence, show a spectrum of responses ranging from acceptance to prohibition.

In Western societies, treatment for gender dysphoria has evolved into a multi-faceted approach that includes medical, psychological, and surgical interventions. Psychological therapy plays a critical role in supporting transgender individuals before and after transitioning.Gender identity clinics offer counselling, voice training, and peer support to help individuals cope with dysphoria.Social transitioning, such as changing names, pronouns, and appearances, is encouraged as a non-invasive step.

Medical interventions for gender dysphoria range from hormonal treatments to moreinvasive surgical procedures. Oestrogen is given to transgender women to induce feminization.Testosterone is given to transgender men to induce masculinization. Hormonal interventions have been linked to improvements in mental health and quality of life, reducing depression and anxiety. Puberty blockers were previously used to delay puberty for transgender youth, allowing them time to explore their identity before making irreversible changes. This has been severely restricted in the UK pending safety reviews since 2024due to concerns over safety and long-term outcomes, but is still available in some parts of the US and Europe.

Lastly, surgical interventions include top surgery which involves breast removal for trans men or augmentation

for trans women and bottom surgery which involves genital reconstruction surgeries such as vaginoplasty or phalloplasty. Other procedures are facial feminization/masculinization which involves procedures to alter facial features.The effectiveness of surgeries in improving quality of life is debated, with some studies showing improvements while others highlight risks such as regret or medical complications.

Evidence So far

A growing body of evidence suggests that medical interventions can significantly improve mental health outcomes for gender dysphoric individuals. Studies show notable improvements in anxiety, depression, and overall quality of life (Costa & Colizzi, 2016; Nguyen et al., 2018; Rowniak et al., 2019).Hormone therapy has been linked to better psychosocial well-being and mental health resilience. Surgical procedures have been found to enhance quality of life, particularly for transgender men (Defreyne et al., 2017; Passos et al., 2020) and transgender women (Zagami et al., 2019).Most studies indicate no immediate post-operative mental health improvements, but significant benefits emerge after more than six months.Some research suggests a ceiling effect, where prior hormonal therapy already improves mental health, limiting the additional gains from surgery. The quality of studies varies from medium to weak, often due to small sample sizes, high risks of bias, and lack of control for confounding factors (Baker et al., 2021; Dhejne et al., 2016).There is a lack of qualitative research capturing the personal experiences of gender dysphoric individuals before and after medical interventions.

For some gender dysphoric individuals, medical interventions may not be necessary or available. Alternative interventions include gender-affirming psychotherapy. This provides a supportive environment to explore gender identity (Austin & Craig, 2015).Peer-support groups help individuals build resilience and reduce isolation. Other non-medical strategies can also help manage gender dysphoria, including:Breast binding (for transgender men), genital tucking (for transgender women), body sculpting exercises and voice and communication therapy. There is little research on the mental health impact of these non-medical interventions.No known systematic reviews examine their effectiveness in reducing gender dysphoria.
Even with medical and non-medical interventions, mental health outcomes for gender dysphoric individuals depend on broader social factors.Peer-support networks, community connectedness, and safe spaces play a critical role in mental health resilience (Matsuno& Israel, 2018; Pflum et al., 2015; Puckett et al., 2019). The use of chosen names by family members is associated with reduced depressive symptoms and suicidal ideation (Russell et al., 2018).Having role models and supportive online communities contribute to better mental health outcomes (Pilecki, 2015).Post-surgical psychosocial well-being improves when individuals receive strong social support (Schultz, 2002).Furthermore, recent research suggests that the presence of autism spectrum disorder (ASD) is higher among transgender individuals (Thrower et al 2020), raising questions about informed consent and decision-making capacity.

There is a need for high quality research and rigorous, prospective studies measuring pre- and post-intervention outcomes.Future reviews need to examine all types of interventions, including medical, psychotherapeutic, social, and adaptive strategies.Research should also focus on the relative effectiveness of different interventions on mental health outcomes.Addressing gender dysphoria alone may not be sufficient to improve mental health.Social, psychological, and structural factors must also be considered.

This evidence so far highlights the positive impact of gender-affirming medical interventions while emphasizing the importance of social support and alternative interventions. It also underscores the gaps in current research, particularly the need for higher-quality studies and qualitative research. A holistic approach that integrates medical, psychological, and social support systems is crucial for improving mental health outcomes in gender dysphoric individuals.

Islam

Islamic perspectives on gender identity are more complex and vary across different schools of thought. The approach to treatment largely depends on whether gender dysphoria is considered a valid medical condition or a social/religious issue.

Traditional Islamic texts recognize intersex individuals (Khuntha) and have legal frameworks for their social inclusion.The concept of transgender identity (Mukhannath) existed historically but was often linked to eunuchs or those with ambiguous biological traits.There is a clear divide in Islamic rulings:Permissive Stance (Shia View):Iran allows gender-affirming surgeries based on Ayatollah Khomeini's 1987 fatwa.The Iranian government provides financial aid for transgender individuals to transition.Restrictive Stance (Sunni

View):Countries such as Saudi Arabia, Egypt, and the UAE prohibit gender transition unless the individual has a disorder of sex development (DSD).Fatwas from Sunni scholars emphasize the immutability of biological sex, discouraging transitions based on gender identity alone. Lastly, there is the conditional stance (some Sunni scholars):Some scholars, such as Sheikh Tantawi of Egypt, have allowed surgeries if they are medically justified by a doctor.

Mental health support for gender dysphoric individuals is minimal due to stigma and a lack of medical recognition.Social rejection is high, with many transgender individuals facing economic hardship, homelessness, and violence.Unlike in the West, where gender clinics exist, Muslim-majority countries often lack formal institutions to support gender-diverse individuals.Hormone therapy is rarely provided unless medically justified by a diagnosed intersex condition.Gender reassignment surgery is mostly illegal or inaccessible, except in Iran.Alternative approaches include religious counselling and psychotherapy, often aimed at discouraging transition rather than affirming gender identity.

In managing Muslim patients with disorders of sex development (DSD), clinicians should not focus purely on the medical and psychological aspects, but also recognize the religious aspects in communities where religion plays a large part in the daily lives of the individual and the family (Al Jurayyan, 2011; Dessouky, 2001; Warne & Raza, 2008): “The clinician’s role is not to superimpose her/his cultural values on those of others, but to come to a decision that likely minimizes potential harm to the patient in his/her cultural environment” (Meyer-Bahlburg, 2001). The Muslim DSD patient may be living in a community where the Muslim culture is not dominant in which case the Islamic aspects of gender-related issues may not be recognized or considered unless the patient his/herself or the family or the clinician are aware of these and bring it up for consideration.

There is a disparity in Islam on how gender dysphoria and DSD are managed, it would make sense to include a religious authority in the multidisciplinary team that manages these patients in Islamic countries. As many decisions made in the course of the clinical management of individuals with gender dysphoria and DSD affect the religious aspects of life and, therefore, the outcome of the individual patient, their families, and the community. It will be helpful to consider both the religious authorities and medical experts to cooperate with and educate each other about the various aspects of care of the patient with gender dysphoria/DSD. The confidentiality of information exchanged with regard to the patients and their families is highly important, keeping in mind that the aim is the achievement of optimal outcome for the patient and families living in still quite stigmatising societies

Persistence of Gender Dysphoria from Childhood to Adolescence

A key consideration in the medical and religious discourse on gender dysphoria is whether the condition persists from childhood into adulthood. Some Islamic scholars argue that early signs of gender dysphoria may be temporary and, therefore, should not warrant irreversible medical interventions. However, longitudinal studies suggest that while some children may desist, others continue to experience gender incongruence well into adulthood

Follow-up studies have classified participants as either “persisters” or “desisters” with regard to gender dysphoria using various metrics (semi-structured interviews based on DSM criteria for gender identity disorder, dimensional scores on standardized questionnaires, etc.). A 10-year follow up study (Ristori and Steensma 2016) summarized and reported that the percentage of participants classified as persisters ranged from 2% to 39% (collapsed across natal boys and girls). In one study (Wallien& Cohen-Kettenis, 2008), the percentage of natal girls who were “persisters” was substantially higher than the percentage of natal boys (50% vs. 12%), but in two other studies from the same clinic the percentage was similar across natal sex (Drummond et al, 2008; Singh, 2012). A criticism of these studies is that either formal diagnostic criteria were not used or that subthreshold cases were included. These subthreshold cases may have included individuals with cross-gender interests or behaviours who did not actually identify as transgender. Hence these patients did not identify as transgender at follow-up. Some studies have found that threshold cases were more likely to be classified as persisters (Steensma et al, 2013b), but other have not (Singh, 2012).

It has also been suggested that more recent cohorts (after the year 2000) have found higher rates of persistence (12% to 39%) (Zucker& Bradley, 1995; Wallien& Cohen-Kettenis, 2008; Drummond et al, 2008; Singh, 2012) than older cohorts (2% to 9% prior to 2000) (Green, 1987; Zucker et al, 1999), suggesting that, as society becomes more accepting of these individuals,

fewer report "desisting," which may represent going back into the closet due to social pressures rather than a true desistence of cross-gender identification. Comparisons of persisters with desisters have found that the intensity of gender dysphoria (using dimensional metrics), older age at the time of assessment in childhood, a lower social class background, and having a female gender assigned at birth are associated with higher rates of persistence (Steensma et al, 2013).

Despite this work, it remains difficult to predict the likelihood of cross-gender identification persistence from childhood into adolescence for an individual child (Steensma et al, 2013). Persistence of gender dysphoria from adolescence to adulthood in contrast to the low rates of persistence from childhood into adolescence, it seems that the majority of transgender adolescents persist in their transgender identity (Cohen-Kettenis&Pfäfflin, 2003). In a study of 55 transgender adolescents receiving gender affirmative care, 100% continued to identify as transgender in young adulthood (deVries et al. 2014). Larger longitudinal studies such as this are needed. Childhood Gender Variant Behaviour and Sexual Orientation Childhood gender variant behaviour has been found to be a strong predictor of a same-sex sexual orientation in adulthood (using gender assigned at birth as a reference point). In a study of 879 Dutch boys and girls, gender variant behaviour was assessed using the Child Behaviour Checklist (CBCL) and sexual orientation was assessed 24 years later (Steensma et al, 2013c). It was found that the prevalence of a same-sex sexual orientation was, depending on the domain (attraction, fantasy, behaviour, and identity), between 8.4 and 15.8 times higher in the gender variant subgroup as compared to the non-gender-variant subgroup.

In summary, the current literature, though limited, suggests that the majority of gender nonconforming pre-pubescent children will grow up to endorse identification as cisgender individuals with either a bisexual or a same-sex sexual orientation (Wallien& Cohen-Kettenis, 2008; Singh et al, 2021; Green, 1987).

Two main contemporary fatwas that were issued to do with gender dysphoria.

The first one was by a Sunni Mufti of Egypt, Tantawi. This was following the case of a male patient who experienced gender dysphoria affecting his mental health. The psychologist treating him referred him for sex reassignment surgery. The surgeon referred him for a second opinion to another psychologist who concurred that he needed sex reassignment surgery to treat his depression. The patient then addressed herself as female.The medical university he was studying at didn't accept his new gender. This case was eventually brought to Tantawi. He satisfied all criteria in making an ijtihad, by first referring to the scriptures (Quran and Hadiths) before moving to the second stage: doing ijtihad through his opinion (ray) and analogy (qiyas) (Alipour 2017). As a Sunni scholar under the Shafii school of thought, Tantawi followed this legal school in resorting to ijtihad by only doing it if: a) one has sufficient knowledge and skill to first return issues into Quran, Hadiths, and a consensus of Muslims; when these sources are found not to deal sufficiently with certain topics, one may then return the cases involved to qiyas or analogy (Al-Shafii, 1938). Transwomen did not nominally exist during the Prophet (PBUH)'s time, hence resulting in this ijtihad decision. In Alipour's work, the explanation of the Tantawi fatwa is clarified: Based on Al-Tabari's understanding of the Hadith, Tantawi acknowledged that the Prophet (PBUH) did not forbid the hermaphrodite and mukhannath from entering the women's quarters until he heard them giving a description of the women in great detail. Tantawi thus concludes that the person who is naturally a hermaphrodite or a mukhannath is not to be blamed but, as s/he has a disease, s/he must be cured. Tantawi, however, excludes persons who are not mukhannath by nature.

The second main fatwa issued was by Khomeini. This was prompted again by a male who felt like a female and started dressing up like one. He personally took his case to Khomeini who then after consulting 3 medical doctors gave the fatwa. He did not cite the Quran or Hadith sources that influenced him in making his fatwa. However, he used a similar ijtihad method within the Shia context. He applied the ijtihad method of al-Qawaid al-Fiqhiyyah (Islamic legal maxims) and al-Usul al-Amaliyyah (procedural principles) because there is nothing in the scriptures, Quran, or hadiths that clearly refers to being transgender (Alipour, 2017). There are two legal maxims through al-Qawaid al-Fiqhiyyah that Khomeini used in making the decision. Firstly, the "principle of permissibility" (isalat al-ibahah) and secondly, the "principle of lawfulness" (isalat al-hillyyah), support the Shi'a belief that everything, or every action, that cannot be clearly regarded as being forbidden or permissible in Islam, is permitted and lawful (Alipour, 2017).These general maxims are also in line with the Islamic jurisprudence principle of "necessity overrides prohibition", as long as those things or actions are not clearly prohibited in conventional Islamic sources.

One of the points of difference between the fatwas is that Khomeini's fatwa on gender-affirming surgery was more insistent in getting a medical doctor's permission, it states "In the Name of God sex-reassignment surgery is not prohibited in sharia law if reliable medical doctors recommend it. Inshallah you will be safe and hopefully the people whom you had mentioned might take care of your situation" (cited in Alipour 2017).

Alipour concludes his explanation of Tantawi's fatwa when he states:"To sum up: It is permissible to perform the operation in order to reveal what was hidden of male or female organs. Indeed, it is obligatory to do so on the grounds that it must be considered a treatment, when a trustworthy doctor advises it. It is, however, not permissible to do it at the mere wish to change sex from woman to man, or vice versa (2017, p. 97)".

Both Tantawi and Khomeini, in issuing the fatwa, have explained the Islamic jurisprudence principle "necessity overrides prohibition", in which a gender transition through gender affirming medical intervention(s) can be accepted as it becomes permissible given the desperate need of transgender individuals as part of a medical remedy (Alipour, 2017; Barmania&Aljunid, 2017). In recent times, this has been extended to include social welfare to support freedom, human dignity and human fraternity (Al-Qaradawi, 1999), fundamental rights and liberties, economic development, as well as research and development in science and technology (Kamali, 1989). One view point for surgical treatment for gender dysphoria as stated by Sarcheshmehpour et al. (2018) in their conclusion: "they should not be prohibited according to Islamic ethics and their surgical treatment should not be considered as a manipulation of Allah's creation".

On the other hand, the Fiqh Council of North America (FCNA) has addressed the topic of transgender individuals in a comprehensive fatwa authored by Dr.YasirQadhi. The fatwa emphasizes the Quranic perspective that humanity is created from a male and a female, underscoring a fundamental gender binary. It acknowledges that while feelings of gender dysphoria might be beyond one's control and are not sinful if not acted upon, Islam distinguishes between feelings, actions, and identity. The fatwa explicitly prohibits cross-dressing and any deliberate attempt to appear as the opposite gender. Regarding gender reassignment, the FCNA deems it impermissible to actively attempt to change one's biological sex or gender through medical interventions, except in cases involving intersex individuals which has a clearer ruling.

Conclusion

The intersection of gender dysphoria and Islamic perspectives presents a complex and evolving discourse that requires careful consideration of medical, psychological, theological, and social factors. While gender dysphoria is now well-documented in medical literature and recognized as a legitimate condition requiring compassionate care, its acceptance and management within Islamic jurisprudence remain a subject of ongoing debate.

Islamic teachings uphold the binary framework of gender, which forms the basis for religious obligations, inheritance laws, and social roles. However, classical Islamic scholarship has historically acknowledged intersex individuals (khuntha) and effeminate males (mukhannathun), offering specific legal rulings for their inclusion in society. The more recent discourse on transgender identity has led to divergent fatwas, with some scholars permitting gender-affirming medical interventions as a form of treatment, while others strictly prohibit elective transitions as an alteration of God's creation.

Across the Muslim world, transgender individuals continue to face social stigma, discrimination, and legal restrictions, leading to mental health struggles, economic hardships, and societal exclusion. Some countries, like Iran and Pakistan, recognize transgender rights to varying degrees, while others, like Saudi Arabia and the UAE, impose legal and religious barriers against gender transition. The lack of open discussion and safe spaces further exacerbates the challenges faced by those experiencing gender dysphoria within Islamic communities.

From a medical perspective, gender-affirming treatments such as hormone therapy and surgery have been shown to improve the mental health and well-being of transgender individuals. However, recent shifts in Western medical policies, particularly the increasing scrutiny of hormone therapy for minors, indicate that the field is still evolving. Islamic medical ethics must engage with these developments to ensure that any intervention aligns with both scientific evidence and religious considerations.

Moving forward, it is crucial for Islamic scholars, healthcare professionals, and policymakers to engage in compassionate, evidence-based discussions on gender dysphoria. A more nuanced, interdisciplinary approach, one that integrates faith, science, and mental health awareness, can help foster greater understanding, reduce

stigma, and provide practical guidance for those navigating gender dysphoria within the framework of Islamic beliefs.

Ultimately, as society continues to evolve, there is an opportunity for Islamic perspectives on gender identity to be revisited with greater emphasis on human dignity, justice, and compassion- principles that are deeply rooted in Islamic tradition

References:

1. Akhtar M &Bilour N: State of Mental Health Among Transgender Individuals in Pakistan: Psychological Resilience and Self-esteem. Community Ment Health J 2020; 56:626- 634. https://link.springer.com/article/10.1007/s10597-019-00522-5

2. Akhtar H, Badshah Y, Akhtar S, Kanwal N, Akhtar MN, Zaidi NU, Qadri I: Prevalence of human immunodeficiency virus infection among transgender men in Rawalpindi (Pakistan). Virol J 2012; 9:229. https://virologyj. biomedcentral.com/articles/10.1186/1743-422X-9-229

3. Alipour, M. (2017). Islamic shari'a law, neotraditionalist Muslim scholars and transgender sex-reassignment surgery: A case study of Ayatollah Khomeini's and Sheikh al-Tantawi's fatwas. International Journal of Transgenderism, 18(1), 91–103. https://doi.org/10.1080/15532739.2016.1250239

4. Al-Jurayyan NA. Ambiguous genitalia: two decades of experience. Ann Saudi Med. 2011 May-Jun;31(3):284-8. doi: 10.4103/0256-4947.81544 . PMID: 21623059; PMCID: PMC3119970.

5. Al Jurayyan NA. Disorders of sex development: diagnostic approaches and management options-an islamic perspective. Malays J Med Sci. 2011 Jul;18(3):4-12. PMID: 22135595; PMCID: PMC3216232.

6. Al-Kasani, A. M. (1987). Bada`i` al-Sana`i` fi Tartibal-Shara`i`. Beirut: Dar al-Kutub al-`Ilmiyyah.

7. Al-Qurtubi, A. al-H. A. bin K. bin A. M. bin B. al-B. (2003). SyarhuSahih al-Bukhari li Ibni al-Baththal. Maktabah al-Rusyd.

8. Al-Nawawi, A. S. (1991). Al-Majmu. Madinah: Maktabah al-Salafiyah.

9. Austin, A., & Craig, S. L. (2015). Transgender affirmative cognitive behavioral therapy: Clinical considerations and applications. Professional Psychology: Research and Practice, 46(1), 21–29. https://doi.org/10.1037/a0038642

10. Babu, R., & Shah, U. 2021. Gender identity disorder (GID) in adolescents and adults with differences of sex development (DSD): A systematic review and meta-analysis Journal of Paediatric Urology, 17(1), 39–47. https://doi.org/10.1016/j.jpurol.2020.11.017

11. Baker KE, Wilson LM, Sharma R, Dukhanin V, McArthur K, Robinson KA. Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review. J Endocr Soc. 2021 Feb 2;5(4):bvab011. doi: 10.1210/jendso/bvab011. PMID: 33644622; PMCID: PMC7894249 .

12. Barmania S &Aljunid SM: Transgender women in Malaysia, in the context of HIV and Islam: a qualitative study of stakeholders' perceptions. BMC Int Health Hum Rights 2017; 17:30. https://bmcinthealthhumrights.biomedcentral. com/articles/10.1186/s12914-017-0138-y

13. Brennan, S. L., Irwin, J., Drincic, A., Amoura, N. J., Randall, A., & Smith-Sallans, M. (2017). Relationship among gender-related stress, resilience factors, and mental health in a Midwestern U.S. transgender and gender-nonconforming population. International Journal of Transgenderism, 18(4), 433–445. https://doi.org/10.1080/15532739.2017.1365034

14. Cohen-Kettenis, Peggy. (2003). Transgenderism and Intersexuality in Childhood and Adolescence: Making Choices. 10.4135/9781452233628 .

15. Collier, Kate &Bos, Henny & Merry, Michael &Sandfort, Theo. (2013). Gender, Ethnicity, Religiosity, and Same-sex Sexual Attraction and the Acceptance of Same-sex Sexuality and Gender Non-conformity. Sex roles. 68. 724-737. 10.1007/s11199-012-0135-5.

16. Coolidge FL, Thede LL, Young SE. The heritability of gender identity disorder in a child and adolescent twin sample. Behav Genet. 2002 Jul;32(4):251-7. doi: 10.1023/a:1019724712983. PMID: 12211624.

17. Cooper, K., Smith, L.G.E. & Russell, A.J. Gender Identity in Autism: Sex Differences in Social Affiliation with Gender Groups. J Autism Dev Disord 48, 3995–4006 (2018). https://doi.org/10.1007/s10803-018-3590-1

18. Costa R, Carmichael P, Colizzi M. To treat or not to treat: puberty suppression in childhood-onset gender dysphoria. Nat Rev Urol. 2016 Aug;13(8):456-62. doi: 10.1038/nrurol.2016.128. Epub 2016 Jul 19. PMID: 27431339.

19. Defreyne, J., Motmans, J., &T'sjoen, G. (2017). Healthcare costs and quality of life outcomes following gender affirming surgery in trans men: a review. Expert Review of Pharmacoeconomics& Outcomes Research, 17(6), 543–556. https://doi.org/10.1080/14737167.2017.1388164

20. de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014 Oct;134(4):696-704. doi: 10.1542/peds.2013-2958. Epub 2014 Sep 8. PMID: 25201798.

21. Dessens AB, Slijper FM, Drop SL. Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. Arch Sex Behav. 2005 Aug;34(4):389-97. doi: 10.1007/s10508-005-4338-5. PMID: 16010462.

22. Dessouky, M. N. (2001). Gender assignment for children with intersex problems: An Egyptian perspective. The Egyptian Journal of Surgery, 20(2), 499-515. doi: 10.21608/ejsur.2001.376369

23. Dhejne C, Van Vlerken R, Heylens G, Arcelus J. Mental health and gender dysphoria: A review of the literature. Int Rev Psychiatry. 2016;28(1):44-57. doi: 10.3109/09540261.2015.1115753. PMID: 26835611.

24. Drummond KD, Bradley SJ, Peterson-Badali M, Zucker KJ. A follow-up study of girls with gender identity disorder. Dev Psychol. 2008 Jan;44(1):34-45. doi: 10.1037/0012-1649.44.1.34. PMID: 18194003.

25. Faiza, Mehreen& Atta, Huma &Ejaz, Asma &Shahzadi, Kiran &Sohail, Sadia. (2024). Mental Health And Transgender Identity: Exploring The Mental Health Challenges Faced By Transgender Individuals, Including Higher Rates Of Anxiety, Depression, And Suicide, And The Impact Of Gender Dysphoria On Overall Well-Being. International journal of social sciences. 2. 1311-1312.

26. Gibson BA, Brown SE, Rutledge R, Wickersham JA, Kamarulzaman A, Altice FL: Gender identity, healthcare access, and risk reduction among Malaysia's maknyah community. Glob Public Health 2016; 11: 1010-1025. DOI: 10.1080/17441692.2015.1134614

27. Green, R. (1987). Gender identity in childhood and later sexual orientation: Follow-up of 78 males. In S. Chess & A. Thomas (Eds.), Annual progress in child psychiatry and child development, 1986 (pp. 214–220). Brunner/Mazel. (Reprinted from the "American Journal of Psychiatry," 1985, Vol. 142, 339-341)

28. Haneef SSS. Sex reassignment in Islamic law: The dilemma of transsexuals. International Journal of Business, Humanities and Technology. 2011;1:98–107

29. Hines, M. (2009). Gonadal hormones and sexual differentiation of human brain and behavior. In D. W. Pfaff, A. P. Arnold, A. M. Etgen, S. E. Fahrbach, & R. T. Rubin (Eds.), Hormones, brain and behavior (2nd ed., pp. 1869–1909). Elsevier Academic Press. https://doi.org/10.1016/B978-008088783-8.00059-0

30. Hines M. Prenatal endocrine influences on sexual orientation and on sexually differentiated childhood behavior. Front Neuroendocrinol. 2011 Apr;32(2):170-82. doi: 10.1016/j.yfrne.2011.02.006. Epub 2011 Feb 17. PMID: 21333673; PMCID: PMC3296090.

31. Hines M, Constantinescu M, Spencer D. Early androgen exposure and human gender development. Biol Sex Differ. 2015 Feb 26;6:3. doi: 10.1186/s13293-015-0022-1. PMID: 25745554; PMCID: PMC4350266.

32. Hines M 2020, Human gender development, Neuroscience &Biobehavioral Reviews, Volume 118, 2020, Pages 89-96, ISSN 0149-7634, https://doi.org/10.1016/j.neubiorev.2020.07.018

33. Kamali, M. H. (1989) "SiyasahShar'iyah or the Policies of Islamic Government", American Journal of Islam and Society. USA, 6(1), pp. 59–80. doi: 10.35632/ajis.v6i1.2833

34. Kuhnle U, Krahl W. The impact of culture on sex assignment and gender development in intersex patients. PerspectBiol Med. 2002 Winter;45(1):85-103. doi: 10.1353/pbm.2002.0011. PMID: 11796934.

35. Lai, Meng-Chuan et al. Autism 2014 The Lancet, Volume 383, Issue 9920, 896 – 910

36. Marantz, S., & Coates, S. (1991). Mothers of boys with gender identity disorder: A comparison of matched controls. Journal of the American Academy of Child & Adolescent Psychiatry, 30(2), 310–315. https://doi.org/10.1097/00004583-199103000-00022

37. Matsuno, E., & Israel, T. (2018). Psychological interventions promoting resilience among transgender individuals: Transgender resilience intervention model (TRIM). The Counseling Psychologist, 46(5), 632–655. https://doi.org/10.1177/0011000018787261

38. Merke DP, Bornstein SR. Congenitaladrenalhyperplasia. Lancet. 2005 Jun 18-24;365(9477):2125-36. doi: 10.1016/S0140-6736(05)66736-0. PMID: 15964450.

39. Meyer-Bahlburg, H. F. L. (1998). Gender Assignment in Intersexuality. Journal of Psychology & Human Sexuality, 10(2), 1–21. https://doi.org/10.1300/J056v10n02_01

40. Abdul Rasydan Bin Mohamad Rusli and Ahmad Sanusi Bin Azmi (2021) "The Acceptance of Effeminates During the Prophet's Time According to the Ḥadīth", AL-BURHĀN: JOURNAL OF QURʾĀNAND SUNNAH STUDIES. Kuala Lumpur, Malaysia, 5(1), pp. 39–52. doi: 10.31436/alburhn.v5i1.200.

41. Nowotny HF, Reisch N. Challenges Waiting for an Adult with DSD. Horm Res Paediatr. 2023;96(2):207-221. doi: 10.1159/000527433. Epub 2022 Dec 6. PMID: 36473446.

42. Nguyen HB, Chavez AM, Lipner E, Hantsoo L, Kornfield SL, Davies RD, Epperson CN. Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition. Curr Psychiatry Rep. 2018 Oct 11;20(12):110. doi: 10.1007/s11920-018-0973-0. PMID: 30306351; PMCID: PMC6354936.

43. Ozbey H, Darendeliler F, Kayserili H, Korkmazlar U, Salman T. Gender assignment in female congenital adrenal hyperplasia: a difficult experience. BJU Int. 2004 Aug;94(3):388-91. doi: 10.1111/j.1464-410X.2004.04967.x. PMID: 15291874.

44. Passos, T.S., Teixeira, M.S. & Almeida-Santos, M.A. Quality of Life After Gender Affirmation Surgery: a Systematic Review and Network Meta-analysis. Sex Res Soc Policy 17, 252–262 (2020). https://doi.org/10.1007/s13178-019-00394-0

45. Pasterski V, Gilligan L, Curtis R. Traits of autism spectrum disorders in adults with gender dysphoria. Arch Sex Behav. 2014 Feb;43(2):387-93. doi: 10.1007/s10508-013-0154-5. Epub 2013 Jul 18. PMID: 23864402.

46. Pasterski V, Zucker KJ, Hindmarsh PC, Hughes IA, Acerini C, Spencer D, Neufeld S, Hines M. Increased Cross-Gender Identification Independent of Gender Role Behavior in Girls with Congenital Adrenal Hyperplasia: Results from a Standardized Assessment of 4- to 11-Year-Old Children. Arch Sex Behav. 2015 Jul;44(5):1363-75. doi: 10.1007/s10508-014-0385-0. Epub 2014 Sep 20. PMID: 25239661.

47. Pflum, Samantha &Testa, Rylan & Balsam, Kimberly & Goldblum, Peter &Bongar, Bruce. (2015). Social Support, Trans Community Connectedness, and Mental Health Symptoms Among Transgender and Gender Nonconforming Adults. Psychology of Sexual Orientation and Gender Diversity. 2. 281-286. 10.1037/sgd0000122.

48. Pilecki, Andy 2015 Transitional space: the role of Internet community for transgender and gender non-conforming patients Psychoanalysis Online 1st Edition Imprint Routledge Page 14 eBookISBN9780429478840

49. Pohl, A., Cassidy, S., Auyeung, B. et al. Uncovering steroidopathy in women with autism: a latent class analysis. Molecular Autism 5, 27 (2014). https://doi.org/10.1186/2040-2392-5-27

50. Puckett JA, Matsuno E, Dyar C, Mustanski B, Newcomb ME. Mental health and resilience in transgender individuals: What type of support makes a difference? J Fam Psychol. 2019 Dec;33(8):954-

964. doi: 10.1037/fam0000561. Epub 2019 Jul 18. PMID: 31318262; PMCID: PMC7390536.

51. Reisner SL, Poteat T, Keatley J, Cabral M, Mothopeng T, Dunham E, Holland CE, Max R, Baral SD. (2015) Global health burden and needs of transgender populations: a review. Lancet. 2016 Jul 23;388(10042):412-436. doi: 10.1016/S0140-6736(16)00684-X. Epub 2016 Jun 17. PMID: 27323919; PMCID: PMC7035595.

52. Richter-Appelt, Hertha & Discher, Christine &Gedrose, Benjamin. (2005). Gender identity and recalled gender related play behavior in individuals with different forms of intersexuality. AnthropologischerAnzeiger; Berichtüber die biologisch-anthropologischeLiteratur. 63. 241-56. 10.1127/anthranz/63/2005/241.

53. Ristori J, Steensma TD. Gender dysphoria in childhood. Int Rev Psychiatry. 2016;28(1):13-20. doi: 10.3109/09540261.2015.1115754. Epub 2016 Jan 12. PMID: 26754056.

54. Rowniak, Stefan & Bolt, Lindsay &Sharifi, Claire. (2019). The effect of cross-sex hormones on the quality of life, depression and anxiety of transgender individuals: a quantitative systematic review. JBI Database of Systematic Reviews and Implementation Reports. 17. 1. 10.11124/JBISRIR-2017-003869.

55. Russell ST, Pollitt AM, Li G, Grossman AH. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. J Adolesc Health. 2018 Oct;63(4):503-505. doi: 10.1016/j.jadohealth.2018.02.003 . Epub 2018 Mar 30. PMID: 29609917; PMCID: PMC6165713.

56. Rusli Abdul Rasydan Bin Mohamad, BinAzmi Ahmad Sanusi (2021) "The Acceptance of Effeminates During the Prophet's Time According to the Ḥadīth", AL-BURHĀN: JOURNAL OF QUR'ĀN AND SUNNAH STUDIES. Kuala Lumpur, Malaysia, 5(1), pp. 39–52. doi: 10.31436/alburhn.v5i1.200.

57. Saeed A, Mughal U & Farooq S J 2018. It's Complicated: Sociocultural factors and the Disclosure Decision of Transgender Individuals in Pakistan. Homosex 2018; 65: 1051-1070. DOI: 10.1080/00918369.2017.1368766

58. Sarcheshmehpour Zahra, Abdullah Raihanah and Alkali Muhammad Bashir. Gender Change of Transexuals in Shariah: An Analysis Vol. 3 No. 1 (2018): Journal of Shariah Law Research

59. Sarcheshmehpour, Zahra 2019. The Legal and Social Aspect of Transsexuality Among Muslims; A Study in Muslim Countries with Special Reference to Iran University of Malaya (Malaysia) ProQuest Dissertations &Theses, 2019. 30597787.

60. Shah HBU, Rashid F, Atif I, Hydrie MZ, Fawad MW, Muzaffar HZ et al.: Challenges faced by marginalized communities such as transgenders in Pakistan. Pan Afr Med J 2018; 30: 96. DOI:10.11604/pamj.2018.30.96.12818

61. Singh D, Bradley SJ, Zucker KJ. A Follow-Up Study of Boys With Gender Identity Disorder. Front Psychiatry. 2021 Mar 29;12:632784. doi: 10.3389/fpsyt.2021.632784. PMID: 33854450; PMCID: PMC8039393.

62. Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clin Child Psychol Psychiatry. 2011 Oct;16(4):499-516. doi: 10.1177/1359104510378303. Epub 2011 Jan 7. PMID: 21216800.

63. Steensma TD, McGuire JK, Kreukels BP, Beekman AJ, Cohen-Kettenis PT. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry. 2013 Jun;52(6):582-90. doi: 10.1016/j.jaac.2013.03.016. Epub 2013 May 3. PMID: 23702447.

64. Taha SA. Male pseudohermaphroditism. Factors determining the gender of rearing in Saudi Arabia. Urology 1994; 43: 370–4

65. Taslim N, Ahmad S, Rehman SU, et al. A literature analysis of scientific research on gender incongruence in Muslim nations. Journal of Public Health Research. 2022;11(4). doi:10.1177/22799036221124054

66. Testa, R. J., Habarth, J., Peta, J., Balsam, K., &Bockting, W. (2015). Development of the Gender Minority Stress and Resilience Measure. Psychology

of Sexual Orientation and Gender Diversity, 2(1), 65–77. https://doi.org/10.1037/sgd0000081

67. Thrower E, Bretherton I, Pang KC, Zajac JD, Cheung AS. Prevalence of Autism Spectrum Disorder and Attention-Deficit Hyperactivity Disorder Amongst Individuals with Gender Dysphoria: A Systematic Review. J Autism Dev Disord. 2020 Mar;50(3):695-706. doi: 10.1007/s10803-019-04298-1. PMID: 31732891.

68. Tolino, Serena. (2018). (g) Transgenderism, Transsexuality and SexReassignment Surgery in Contemporary Sunni Fatwas. Journal of Arabic and Islamic Studies. 17. 223. 10.5617/jais.6116.

69. T'Sjoen G, De Cuypere G, Monstrey S, Hoebeke P, Freedman FK, Appari M, Holterhus PM, Van Borsel J, Cools M. Male gender identity in complete androgen insensitivity syndrome. Arch Sex Behav. 2011 Jun;40(3):635-8. doi: 10.1007/s10508-010-9624-1. Epub 2010 Apr 1. PMID: 20358272.

70. Vijay A, Earnshaw VA, Tee YC, Pillai V, White Hughto JM, Clark K, Kamarulzaman A et al.: Factors Associated with Medical Doctors' Intentions to Discriminate Against Transgender Patients in Kuala Lumpur, Malaysia. LGBT Health 2018; 5: 61-68. DOI: 10.1089/lgbt.2017.0092

71. Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. J Am Acad Child Adolesc Psychiatry. 2008 Dec;47(12):1413-23. doi: 10.1097/CHI.0b013e31818956b9. PMID: 18981931.

72. Warne GL, Raza J. Disorders of sex development (DSDs), their presentation and management in different cultures. Rev EndocrMetabDisord. 2008 Sep;9(3):227-36. doi: 10.1007/s11154-008-9084-2. Epub 2008 Jul 17. PMID: 18633712.

73. Warrier V, Greenberg DM, Weir E, Buckingham C, Smith P, Lai MC, Allison C, Baron-Cohen S. Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. Nat Commun. 2020 Aug 7;11(1):3959. doi: 10.1038/s41467-020-17794-1. PMID: 32770077; PMCID: PMC7415151.

74. Wong Y: Islam, sexuality, and the marginal positioning of Pengkids and their girlfriends in malaysia. J Lesbian Stud 2012; 16: 435-448. doi: 10.1080/10894160.2012.681267

75. Zagami Samira Ebrahimzadeh, RoudsariRobabLatifnejad, SadeghiRamin. Quality of Life After Sex Reassignment Surgery: A Systematic Review and Meta-Analysis Iran J Psychiatry Behav Sci. 2019 September; 13(3):e69086

76. Zainuddin, A. A., &Mahdy, Z. A. (2016). The Islamic perspectives of gender-related issues in the management of patients with Disorders of Sex Development. Archives of Sexual Behavior, Special Section: culture and variants of sex/gender: bias and stigma (pp. 1–8)

77. Zucker KJ, Bradley SJ, Sullivan CB, Kuksis M, Birkenfeld-Adams A, Mitchell JN. A gender identity interview for children. J Pers Assess. 1993 Dec;61(3):443-56. doi: 10.1207/s15327752jpa6103_2. PMID: 8295110.

78. Zucker KJ, Bradley SJ, Kuksis M, Pecore K, Birkenfeld-Adams A, Doering RW, Mitchell JN, Wild J. Gender constancy judgments in children with gender identity disorder: evidence for a developmental lag. Arch Sex Behav. 1999 Dec;28(6):475-502. doi: 10.1023/a:1018713115866. PMID: 10650437.

79. Zucker KJ. Epidemiology of gender dysphoria and transgender identity. Sex Health. 2017 Oct;14(5):404-411. doi: 10.1071/SH17067. PMID: 28838353.

80. https://www.voanews.com/a/despite-fatwa-transgender-people-in-iran-face-harassment/4402998.html

Appendix

Fatwa From Saudi Arabia

Al Jurayyan (2011), a Professor of Paediatrics from King Saud University, Saudi Arabia, presented a set of guidelines or recommendations on this issue based on the current Islamic fatwas put forward by the senior ulama council in Saudi Arabia and the experiences of medical practitioners in Saudi Arabia (Abdullah et al., 1991; Al Herbish et al., 1996; Al Jurayyan, 2011; Couch, 1987). These fatwas are translated as follows:

1. A sex change operation [in a non-DSD individual] is totally prohibited and considered to be criminal in accordance with the Holy Quran and the Prophet PBUH's sayings.
2. Those who have both male and female organs require further investigation and, if the evidence is more suggestive of a male gender, then it is permissible to treat the individual medically (i.e., with hormones or surgery) in order to eliminate the ambiguity and to raise him as a male and vice versa.
3. Physicians are required to explain to the child's guardians the results of the medical investigations and whether the evidence indicates that the child is male or female in order to keep the guardians well informed.

Al Jurayyan (2011) stated that the dominant role of the male gender in the Muslim community should not overrule Islamic laws, and he emphasized that these laws should not be ignored and be given due consideration.

Fatwa From Malaysia

There have been several fatwas produced by the Fatwa Committee of the National Council of Islamic Religious Affairs Malaysia regarding the permissibility of genital reconstruction surgery in patients with DSD.16 The most recent one from November 2006 is formulated as follows:

1. For those with 46,XX CAH reared male, gender reassignment surgery to get back to the previous gender that is female is permitted in Islam because it can be treated by hormone treatment and surgery.
2. For those with 46,XY AIS reared female, getting back to the male gender through surgery or hormone treatment is quite difficult. If the patient intends to undergo surgery, it is permitted, provided that the surgery does not harm the patient psychologically or biologically.
3. For those with 46,XY AIS reared female, but diagnosed only after the person has already grown up, the person can continue a normal life and the gender is recognized from his/her [body build] and the [appearance] of the genitalia. Surgery to remove the testes (if any) is permissible to prevent the risk of cancer. The marriage of a man with a female spouse who suffers from 46,XY AIS does not need to be dissolved.
4. Medical specialists should provide explanation and advice to Muslim individuals who are affected by CAH and AIS and their parents to undergo treatment in a way that avoids any difficulties with religious regulations.

Fatwa From Egypt

As Dessouky (2001), a pediatric surgeon from Egypt, states, "All juristic religious opinions (fatwas) concerning the change of sex in a totally feminine or masculine human being with no physical abnormalities in his body (only due to the refusal of the person to accept his natal sex, i.e., in a transsexual) state that it is a religious doctrinal crime, as it changes 'what God has created'." He continues that these fatwas decreed that if both masculine and feminine characters are detected in a person (such as in a person with a DSD), the doctors should determine which characteristics are dominant and remove any other characteristic that may cause "suspicion" to achieve the best outcome for the person. Dessouky points out additional important issues in the management of Muslim patients with DSDs that still require decisions from the religious authorities, including the following:

1. which characteristic, i.e., chromosomes, gonads, phenotype, or appearance and function of the external genitalia, is the best criterion to determine whether a person is male or female;
2. the legality of performing gonadectomies or hysterectomies in patients with partial AIS and wrongly assigned males with 46,XX CAH, especially after late diagnoses

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Amanah (trust) and Physician-Patient Relationship in Islamic Medical Ethics

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Introduction

Conscientious Muslim physicians remain concernedabout the centrality of a wholesome physician-patient relationshipin ensuring better health outcomes,while fulfilling their accountability to Allah swt. An Islamic conscience facilitates medical interventions aligning withIslamic and general medical ethics.This multifacetedrelationship is best understood through the Islamic concept of trust (*al-amānah*),which embodies integrity, trustworthiness[1] or honesty[2] to uphold justice and fairness.*Amānah*refers to fulfilling trust or responsibilities toward the one who grants it or depends on it.Nevertheless, how does this complex concept relate to a humane physician-patient relationship? Islamic ethics are derived and inferred from the Qur'ān, the Sunnah of Prophet Muhammad (saw), scholarly consensus (*ijmā'*), and analogy-based reasoning (*qiyās*). To understand *amānah* in this context, we turn to these sources, using the methodology of differentiation (*furūq*) - a rational-linguistic approach that examines a term's usage in Qur'ānic and Prophetic contexts[3]

Commonly rendered as 'trust'in its nominal form, the Arabic word *Amānah*(pl: *amānāt*) appears six times in the Qur'an: Allah bestowing the trust of obedience to humankind (Q33:72), warning against betraying mutual trusts (Q8:27), emphasising the duty to return a trust after mutual understanding (Q2:283), commanding belongings to be entrusted to those worthy of them (Q4:58), and highlighting a defining quality of believers - safeguarding their trusts (Q23:8, Q70:32).

At the heart of the term *amānah* is the triliteral Arabic root (ʾa-m-n) / أ-م-ن, which forms approximately 900 words in the Qur'an. The most common are the verbs "to believe, have belief" (*āmana-yu'minu*) appearing 537 times, 'believer' (mu'min) and its variants (e.g., *mu'minūn*) appearing 202 times, and "Islamic faith and belief" (ʾīmān) appearing 45 times. Classical linguist Ibn Manẓūr defined security (*amnun*) as the opposite of fear (*khawf*), trust (*amānah*) as the opposite of betrayal (*khiyānah*), and faith (*ʾīmān*) as the opposite of disbelief (*kufr*). The shared triliteral root of these words reflects their deep etymological and conceptual connections, which we will explore in relation to the physician-patient context.

Am nah and the Mu'min physician

Faith or belief (*ʾīmān*)is distinguished from a Muslim's submission(*islām*) sinceas explained by archangel Gabriel[4] (as) to the Prophet (saw): *ʾīmān*as the inwardbeliefs about Allah, His book and the unseen; *Islām* as outward religious rituals and *Iḥsān*as excellence in faith and submission. *ʾīmān*carries a deeper

[1] Shuhari et al 2019
[2] Islam and Samsuddin 2018
[3] Abdur-Rashid et al 2013, Lifting the veil: a typological survey of the methodological features of Islamic ethical reasoning on biomedical issues.

[4] One day while Allah's Messenger (saw) was sitting with the people, a man came to him walking and said, "O Allah's Messenger (saw). What is Belief?" The Prophet (saw) said, "Belief is to believe in Allah, His Angels, His Books, His Apostles, and the meeting with Him, and to believe in the Resurrection." The man asked, "O Allah's Messenger (saw) What is Islam?" The Prophet (saw) replied, "Islam is to worship Allah and not worship anything besides Him, to offer prayers perfectly, to pay the (compulsory) charity i.e. Zakat and to fast the month of Ramadan." The man again asked, "O Allah's Messenger (saw) What is Ihsan (i.e. perfection or Benevolence)?" The Prophet (saw) said, "Ihsan is to worship Allah as if you see Him, and if you do not achieve this state of devotion, then (take it for granted that) Allah sees you." Sahih al-Bukhari 4777, Book 65, Hadith 299. sunnah.com/bukhari:4777

connotation, as the Qur'ān reprimands[5]*Bedouin* Arabs for claiming "we have believed" (*āmannā*) whilst they had merelysubmitted (*aslamnā*), and had yet to truly believe (*lam tu'minū*).*Imān*is known to have seventy branches, including testimony of faith, modesty, moderation in speech, and removing harmful things from paths[6].Two direct Qur'anic mentions (Q23:8, Q70:32) of *amanah* come as prerequisites of *ʾīmān*and being a *mu'min*(one who possesses true faith, beyond mere submission).These indicatethe broad and profound nature of *amānah,*encompassing multiple aspects of what it means to be faithful and believing.A key characteristic of successful believers is fulfilling trust[7] (*al-amānāt*) whilst a lack of trustworthiness impliesweakness of faith[8].Breaking the trust[9] is a sign of hypocrisy.Allahbestowed *amanah* on humankind as a virtue,

"Indeed, we offered the *Trust*(*al-amānah*) to the heavens and the earth and the mountains, and they declined to bear it and feared it; but man [undertook to] bear it. Indeed, he was unjust and ignorant." Q33:72.

Among exegetes (*mufaṣṣirūn*), Aṭ-Ṭabarī related that this *trust*refers to acknowledging obedience to Allah, accepting His obligations, and exercising free will in fulfilling them, consequently opting for reward or punishment that none agreed to bear and carry out except for humankind.[10]Paying attention to the textual context (*siyāq an-naṣ*), Ibn Ashūr adds[11]that the subsequent verse[12] (Q33:73)explains why humankind is deemed unjust and ignorant:except for the believers, many would turn disobedient unable to render this *trust*.Fascinatingly, the noun believers (*al-mu'minūn*), derived from the verb "to believe" (*āmana-yu'minu*), is etymologically connected to the word *amānah.*

In the medical domain, Islam highly encourages medical treatment as a divine blessing as every illness has a cure with Allah's permission.[13]However, medical treatment requires rigorous training and research, and practising medicine without proper expertise is Islamically blameworthy.[14]Studying medicine is particularly demanding, requiring intellectual capacity, financial resources, and physical-emotional endurance, making it a challenge that not everyone can undertake.

For a *Mu'min* physician, medical knowledge and expertise are divinely bestowed *amānāt*gained through intensive study and training, using divine favours such as perceptive senses, intellect and physique.[15]It aligns with a prophetic invocation[16] in which beneficial knowledge is sought alongside good provision and acceptable deeds. Acquiring beneficial knowledge safeguards both material sustenance and spiritual fulfilment, as it contributes to human wellbeing and the upliftment of the *ummah*—fulfilling many branches of *ʾīmān*.

The opposite of this principle is embodied by Qārūn, a wealthy figure from Moses' time, whose arrogance led him to declare, "I was only given this because of my knowledge." His downfall serves as a cautionary tale against attributing success solely to oneself or one's

[5] "The bedouins say, "We have believed (*āmannā*)." Say, "You have not [yet] believed; but say [instead], 'We have submitted (*aslamnā*),' for faith has not yet entered your hearts. And if you obey Allah and His Messenger, He will not deprive you of your deeds of anything. Indeed, Allah is Forgiving and Merciful." Q49:14

[6] "Faith has over seventy branches or over sixty branches, the most excellent of which is the declaration that there is no Allah but Allah, and the humblest of which is the, removal of what is injurious from the path: and modesty is the branch of faith." Sahih Muslim 35b, Book 1, Hadith 60.

[7] "Certainly will the believers have succeeded …. and they who are to their trusts and their promises attentive." Q23:1,8

[8] "There is no faith for the one who has no trustworthiness, and there is no religion for the one who has no covenant." Ahmad 12567. dorar.net/hadith/sharh/119911

[9] "There are four characteristics, whoever has them all is a pure hypocrite, and whoever has one of its characteristics, he has one of the characteristics of hypocrisy, until he gives it up: When he speaks he lies, when he makes a covenant he betrays it, when he makes a promise he breaks it, and when he disputes he resorts to obscene speech … and if he has one of them, he has one of the characteristics of hypocrisy." Sahih Muslim 58, Book 1, Hadith 116. sunnah.com/muslim:58

[10] Ibn JarīrAṭ-Ṭabarī, Jāmi'ilBayān, Q33:72

[11]Ibn Ashūr, At-Taḥrīr wat-Tanwīr, Q33:73

[12][It was] so that Allah may punish the hypocrite men and hypocrite women and the men and women who associate others with Him and that Allah may accept repentance from the believing men and believing women. And ever is Allah Forgiving and Merciful. Q33:73

[13] There is a remedy for every malady, and when the remedy is applied to the disease it is cured with the permission of Allah, the Exalted and Glorious. Sahih Muslim 2204. Book 39, Hadith 95. sunnah.com/muslim:2204

[14] Anyone who practises medicine when he is not known as a practitioner will be held responsible. Sunan Abi Dawud 4586.Book 41, Hadith 93

[15]… and He made for you hearing and vision and intellect that perhaps you would be grateful. Q16:78, and also see At-Tirmidhī2417: "Man's feet will not move from their place on the Day of Judgment until he is asked about his life, in what he let it perish; about his knowledge, what he did with it; about his money, from where he earned it and on what he spent it on; and about his body, and how he wore it out."

[16] "O Allah, I ask You for beneficial knowledge, goodly provision and acceptable deeds". Sunan Ibn Majah 925, Book 5, Hadith 123. sunnah.com/ibnmajah:925

intellect and accomplishments"[17]Thus, a *mu'min* physician recognises intellectual capabilities as a form of *amānah* and uses them to acquire beneficial knowledge - another form of *amānah* - to serve humankind - another form of *amānah* to be discussed later.

Preservation and maintenance

Being a Muslim means refraining from harming others, while being a *Mu'min*requires being widely entrusted[18]. In Islamic finance, *al-āmanah*refers to a securitydeposit, business trust or confidentiality.Moreover, for a trustee, properly distributing entrusted resources from an owner's treasury is akin to giving charity.[19] In the Medinan Qur'ān (Q2:283), trust appears in the context of security deposits[20] where people entrusted with something (*fa in aminaba'ḍukum*) are urged to faithfullyrender trust.It's an innate human disposition, preserved in the heart and fortified by the Qur'ān and sunnah until its eschatologically destined depletionleads to rampant untrustworthinessand lossof faith.[21]

While mutual trust is encouraged, breaking it is not permissible irrespective of one party's distrustful conduct[22]. Entrustment can be material or immaterial; regarding financial deposits, Qur'ān (Q3:75) notes thatregardless of the amount entrusted, people act as per their trustworthinesslevels.[23]In an immaterial sense, prophet Yaʿqūb (as) admonished his elder sons for mishandling Prophet Yūsuf (as), which made him reluctant to trust them again (*lāta'mannā*)with Yūsuf's brother, Binyamīn.[24]

Based on the above, patients can be viewed as an *amānah* entrusted to Muslim physicians – a notion aligning with the deontological works Ishāq al-Ruhawi (circa 850–900 CE), whose *Adāb al-Ṭabīb*is one of the oldest surviving works covering ethical principles for physicians from Islamic perspectives[25]. Al-Ruhawi extensively discusses how physicianscould cultivate virtues[26] (*adāb*)in every interaction with patients because of a divinely bestowed responsibility. For a Muslim physician, *adāb*-based ethical principles complement *sharīʿah*-based medical obligations, ensuring adherence to Islamic medical ethics.[27] Medical *adāb*encompasses ethical-behavioural aspects and religious obligations of a Muslim, who is also a physician, "the physician's virtuous inner disposition and relationship towards patients" which reflects "the physician's morality and relationship with the divine".[28]In this light, a patient is an *amānah* entrusted to a Muslim physician, and honouring this trust reinforcesdivine connections.

Authority and Responsibility

Ibn al-Jawzī and al-Dāmaghānī[29] classified *amānah* into (i) obligatory matters (*farāʾiḍ*) - Q8:27 and Q33:72, (ii) deposits (*wadāʾiʿ*) - Q4:58, Q23:8 and Q70:32 and (iii)

[17] Q28: 76-77
[18] "The Muslim is the one from (the harm of) whose tongue and hand (other) Muslims are safe, and the believer is the one with whom the people trust their blood and their wealth." Jami at-Tirmidhi 2627, Book 40, Hadith 22. sunnah.com/tirmidhi:2627
[19] The faithful trustee who gives what he is commanded completely and in full with a good will, and delivers it to the one whom he was told to give it, is one of the two who gives sadaqah. Sunan Abi Dawud 1684, Book 9, Hadith 129. sunnah.com/abudawud:1684
[20] And if you are on a journey and cannot find a scribe, then a security deposit [should be] taken. And if one of you entrusts another, then let him who is entrusted discharge his trust [faithfully] and let him fear Allah, his Lord. Q2:283
[21] Allah's Messenger (ﷺ) narrated that trust was preserved in the roots of the hearts of men (in the beginning) and then they learnt it (trust) from the Qur'an, and then they learnt it from the (Prophet's) Sunna (tradition). He also told us about its disappearance, saying, "A man will go to sleep whereupon trust will be taken away from his heart, and only its trace will remain, resembling the traces of fire. He then will sleep whereupon the remainder of the trust will also be taken away (from his heart) and its trace will resemble a blister which is raised over the surface of skin, when an ember touches one's foot; and in fact, this blister does not contain anything. So there will come a day when people will deal in business with each other but there will hardly be any trustworthy persons among them. Then it will be said that in such-and-such a tribe there is such-and-such person who is honest, and a man will be admired for his intelligence, good manners and strength, though indeed he will not have belief equal to a mustard seed in his heart." Sahih al-Bukhari 6497, Book 81, Hadith 86. sunnah.com/bukhari:6497 Also see Sahih al-Bukhari 7276, sunnah.com/bukhari:7276
[22] "Pay the deposit to him who deposited it with you, and do not betray him who betrayed you." Sunan Abi Dawud 3535, Book 24, Hadith 120
[23] "… is he who, if you entrust him with a great amount [of wealth], he will return it to you. And among them is he who, if you entrust him with a [single] silver coin, he will not return it to you unless you are constantly standing over him [demanding it]…" Q3:75
[24] He said, "Should I entrust you with him except [under coercion] as I entrusted you with his brother before? But Allah is the best guardian, and He is the most merciful of the merciful." Q12:64
[25]Levey M. Medical ethics of medieval Islam with special reference to Al-Ruhawi's "Practical ethics of the physician." *Transactions of the American Philosophical Society*. 1967;57(3):1
[26]Arabic lexicographers trace the term Adāb to its root meaning "hospitality" or "virtuously inviting people to goodness."
[27] Sartell and Padela 2015. Adab and its significance for an Islamic medical ethics.
[28] Ibid pp 4-5
[29] Eggen 2006.

integrity (ʿiffa) - Q28:26. As for (i) obligatory matters, Allah says,

O you who have believed, do not betray Allah and the Messenger or betray your trusts while you know [the consequence]. Q8:27

Exegete ar-Rāzī relates (from Q8:26-28) that Muslims were warned not to betray the trust of Allah and His Messenger, as they had been blessed with Islam after a period of weakness and oppression, and they must not allow worldly trials (e.g., material possessions and children) to divert their attention.[30] Former people of the Scripture were *entrusted*[31] with divine guidance which they devalued and failed to fulfil obligations.

The verse Q4:58 was revealed during the Day of Victory (*yawm al-fatḥ*), when the Prophet (saw) opened the gate of the Kaʿbah, recited this verse, and handed the keys to ʿUthmān bin AbīṬalḥa (ra) as an entrustment[32]. This is an explicit command to render trust:

"Indeed, Allah commands you to render trust to whom they are due and when you judge between people to judge with justice. Excellent is that which Allah instructs you. Indeed, Allah is ever Hearing and Seeing." Q4:58

Ibn Kathīr clarified that these rulings are general (*faḥakamuhumā ʻāmmun*), applying not just to the historical context but to all trust-related matters between Allah and humankind, as well as mutual trust between people[33].Al-Qurṭubī further elaborated, referencing several companions (*ṣahabah*) and the plural form (*amānāt*) to indicate that this concept extends to everything (*al-amānatufīkulli shay*), including fulfilling religious obligations, i.e., prayer and fasting, even business transactions.[34]Although the verse is categorised under the deposit-related theme, it is immediately followed by Q4:59,which instructs to obey those in authority.[35]This is why aṭ-Ṭabarī interpreted this verse as referring to those in positions of authority entrusted to fulfil their trust.[36]. Thus, *amānah* in Q33:72, Q8:27, and Q4:58 is central to authority and responsibility.

In Greek (yunānī) medicine, physicians are termed the "wise one" (ḥakīm), a term that also signifies "he who delivers the ruling (ḥukm)". Physicians' health recommendations are to be closely followed by patients, who place their trust in them. Therefore, Muslim physicians with specialised knowledge hold a significant *amānah* and are entrusted to carry out their obligations.Abūʿ Ubayda ibn al-Jarrāḥ (ra), a prominent commander and one of the ten companions promised Paradise, was known for his trustworthiness. His reputation for authority and sincerity made him the ideal candidate for important missions, such as teaching Islam to a Christian delegation from Najrān after the Battle of Tabūk.[37]On asking the Prophet about governing position, a companion was reminded to consider these a type of *amānah,*which could lead to difficulties on the Day of Resurrection if unmeted.[38]Habitually entrusting power to the undeserving breaches the *amanah* and signals approaching of the Hour.[39]From this perspective, Muslim physicians carry a dual responsibility - as both authorities in their field and trustees of amānah - to uphold medical and Islamic ethics, which further strengthens the physician-patient relationship.

Trustworthiness and Confidentiality

Prophet Muhammad (saw) was universally acknowledged as the most reliableand honest person,which led to his honorific "the most trustworthy"(*al-Amīn*), a quality endorsed even by his enemies and non-Muslims. It is derived from the same triliteral root ('a-m-n / أ-م-ن), through the verb "to be

[30]Ar-Rāzī, Mafātīḥ al-Ghayb, Q8:26-28
[31] See Q5:44, 5:89 and 62:5
[32] Ibn JarīrAṭ-Ṭabarī, Jāmi'ilBayān, Q4:58
[33] Ibn Kathīr, Tafsīr al-Qur'ān al-'aẓīm, v4:58
[34] Al-Qurṭubī, al-jāmi' li-'aḥkām al-qur'ān, v4:58
[35] O you who have believed, obey Allah and obey the Messenger and those in authority among you. And if you disagree over anything, refer it to Allah and the Messenger, if you should believe in Allah and the Last Day. That is the best [way] and best in result. Q4:59

[36] Ibn JarīrAṭ-Ṭabarī, Jāmi'ilBayān, v4:58
[37] The people of Najran [Christians] came to Allah's Messenger (saw) and said: Allah's Messenger, send along with us a man of trust; whereupon he said: I would definitely send to you a man of trust, a man of trust in the true sense of the term. Thereupon his Companions looked up eagerly and he sent Abu Ubaida b. Jarrah. Sahih Muslim 2420a. Book 44, Hadith 84.
[38] Abu Dharr (ra) said to the Prophet (saw): O Messenger of Allah, will you not appoint me to a public office? He stroked my shoulder with his hand and said: Abu Dharr, thou art weak and authority is a trust. and on the Day of judgment, it is a cause of humiliation and repentance except for one who fulfils its obligations and (properly) discharges the duties attendant thereon. Sahih Muslim 1825, Book 33, Hadith 19. sunnah.com/muslim:1825
[39] "When honesty is lost, then wait for the Hour." It was asked, "How will honesty be lost, O Allah's Messenger (saw)?" He said, "When authority is given to those who do not deserve it, then wait for the Hour." Sahih al-Bukhari 6496, Book 81, Hadith 85. sunnah.com/bukhari:6496

trustworthy" (*amuna*) implying both the process of becoming trustworthy and acquiring this as a permanent characteristic. The Prophet's entrepreneurial career, spanning 40 years, reflected his traits and professional conduct, before the commencement of his 23-year mission.[40]

The Qur'ān hails archangel Gabriel (as) as "trustworthy spirit" (*al-rūḥ al-amīn*) due to their unfaltering obedience and for conveying revelations.Noble human beings like prophets were divinely guided towardsembodying trustworthiness, serving as exemplary figures for their followers and humankind. Prophet Hūd (as) referred to himself as a trustworthy advisor (*nāṣihunamīn*), while prophets Nūḥ, Ṣāliḥ, Lūṭ, and Shu'ayb (as) implored people for recognition as trustworthy messengers (*rasūlunamīn*).[41]Prophet Musa (as), before prophethood, impressed prophet Shu'ayb's (as) daughters with his integrity and unblemished character, leading one of them to recommend him for employment as a strong and trustworthy man (*al-qawī al-amīn*).[42]After prophethood, Mūsā (as) asserted his trustworthiness to Pharaohin delivering the Children of Israel[43].Prophet Yusuf (as)was appointed an advisorby an Egyptian king, noting his exclusive establishment and trustworthiness (*makīnunamīn*).[44]*Al-amīn* is also associated with non-human entities - a powerful *djinn* (*'ifrīt*)from prophet Sulaymān' (as)army claimed to be powerful and trustworthy[45] (*qawīyunamīn*) to fetch Queen of Sheba's throne in an eyeblink. Thus, the Prophet's honorific is historically significant as angelicor a reflection of the inherent trustworthiness of prophets.This was validated by the Arabs, who were very well-versed in literary excellence, alluding that the prophet upheld all aspects of *amānah*.

In the medical domain, physicians gain patients' trust for their knowledge and expertise, positioning them in a guardianship role - directly addressing many Qur'ānicrenditions of the term. Persian physician Abū Bakr al-Rāzī (d. circa 925 AD / 313 AH) argued that a patient's treatment outcome is tied to relying on a single trustworthy physician.[46]Due to the high level of trust, patients often confide their deepest issues, relying on physicians to maintain confidentiality[47], which is widely discussed across medical ethics[48]. Obtaining informed consent, protecting confidentiality and privacy concerns are the building blocks of a physician-patient relationship relating to trust[49]. Keeping a secret as *amānah* is the most generic understanding of *amānah* because of a prophetic saying defining it as such.[50]The most significant form of trust is not violating the secrecy of marital intimacy.[51]

Security and safety

*Amānah*is complemented by an *amānah*-relevantterm *amn/amān* (security), which extends to non-human entities due to the divine oath by the "secured city" (*al-balad al-amīn*).[52]The Meccans were enjoined to worship Allah, the owner of the Meccan Ka'bah because he made them safe and secure[53] from hunger and fear. This relates to Prophet Ibrāhīm's (as) supplication: "Make this a secure city" (*ij'alhādhābaladanāminan*), specifically for those who believe (*man āmanaminhum*), highlighting the etymological connection between security and faith.[54]The verb *āmana* (to make someone secure from something) is transitive, requiring two objects. A derivative of this verb is one of Allah's attributes, al-Muʾmin—the Bestower of faith and security[55]. Interestingly, the words believer

[40] Noted in the second revealed sūrah (SuratulQalam): "And indeed, you are of a great moral character." Q68:4
[41] Indeed, I am to you a trustworthy messenger. Q26:107, 125, 143, 161, 178
[42]"One of the women said, "O my father, hire him. Indeed, the best one you can hire is the strong and the trustworthy." Q28:26
[43] "Render to me the servants of Allāh. Indeed, I am to you a trustworthy messenger," Q44:18
[44] "And the king said, "Bring him to me; I will appoint him exclusively for myself." And when he spoke to him, he said, "Indeed, you are today established [in position] and trusted." Q12:54
[45] "A powerful one from among the jinn said, "I will bring it to you before you rise from your place, and indeed, I am for this [task] strong and trustworthy." Q27:39

[46] Ragab 2015
[47] Dunn and Hope 2004
[48] Muhsin 2021
[49]Chamsi-Pasha et al 2021. Patient-Physician Relationship: Islamic Views
[50] When a man tells something and then departs, it is a trust. Sunan Abi Dawud 4868, Book 43, Hadith 96. sunnah.com/abudawud:4868
[51] The most important of the trusts in the sight of Allah on the Day of judgment is that a man goes to his wife and she goes to him (and the breach of this trust is) that he should divulge her secret Ibn Numair narrates this hadith with a slight change of wording. Sahih Muslim 1437b, Book 16, Hadith 145. sunnah.com/muslim:1437b
[52] And [by] this secure city [i.e., Makkah]. Q95:3
[53] Let them worship the Lord of this House, who has fed them, [saving them] from hunger and made them safe, [saving them] from fear. Q106:3-4
[54] And [mention] when Abraham said, "My Lord, make this a secure city and provide its people with fruits - whoever of them believes in Allah and the Last Day." Q2:126. Also see Q3:97, Q14: 35-37, Q28:57 and Q29:67.
[55] He is Allah, other than whom there is no deity, the Sovereign, the Pure, the Perfection, the Bestower of Faith, the Overseer, the Exalted in Might, the Compeller, the Superior. Exalted is Allah above whatever they associate with Him. Q59:23

(*muʾmin*) and faith (*īmān*) originate from the same root, where *āmana* often means "to believe" in its most common Qur'ānic usage.

Renowned Islamic jurist ʿIzz al-Dīn ibn ʿAbd al-Salām (d. 660H/1243 CE) summarised the aim of medicine in his Qawāʿid al-Aḥkām as securing patient's benefit (*maṣlaḥa*) by ensuring safety, preserving and restoring health, reducing ailments, and protecting against harm. This principle strongly resonates with *amn*.The Qur'ān also presents security (*āmin*īn) as a state of being[56] in three distinct contexts, all involving groups of people feeling safe and secure.In Surat al-Ḥijr (Q15:46, 15:83), the righteous are invited to enter Paradise in peace and security (*udkhulūhābisalāmināmin*īn), contrasting with the false sense of security felt by the Thamūd in their mountain-carved homes (*buyūtanāmin*īn).Secondly, the term appears in four instances reassuring protection from fear or insecurity:Allah made travel between the ancient Yemeni cities of Sabaʾ safe (Q34:18).Prophet Mūsā (as), upon seeing a writhing snake, was reassured (Q28:31).The Prophet's (saw) peaceful entry into Mecca after the conquest (Q48:27).Prophet Yūsuf (as) welcoming his parents into Egypt safely (Q12:99).The term also appears as both a warning and an assurance - Prophet Ṣāliḥ (as) warned the Thamūd (Q26:146). In contrast, people of Paradise are reassured of their eternal safety (Q44:55).

Hence, *amn*is deeply intertwined with *amānah*, emphasising that human trustworthiness is complemented by divine protection. Drawing from Qur'ānic examples, the term reflects the profound connection between faith and protection, underscoring the ethical responsibility to safeguard and preserve well-being, whether in medicine or society.

Tranquillity and Assurance

In contrast to *amānah* (أمانة), a closeterm*amanah* (أمنة) denotes tranquillity and calmness[57] and has two Qur'ānicusages. During the battles of Badr (Q8:11) and 'Uhud (Q3:154), Allah sent down *amanah* (أَمَنَة) to relieve believers' hearts from drowsiness, confusion, distress, and satanic suggestions. This divine calmness was so comforting that everyone, except the Prophet, fell asleep.[58] Ibn Masʿūd (ra) noted that sleeping during battle signifies calmness from Allah, while sleeping during prayer is from Satan.[59]Ar-Rāzī added that this sleep reflected trust in Allah; otherwise, none could sleep on a battlefield.[60]

Assurance is also evident in the dialogue[61] between Allah and Prophet Ibrāhīm (as) regarding how the dead are given life. Ibrāhīm sought this demonstration so his heart "may be satisfied" (*liyaṭma'innaqalbī*), thereby strengthening his faith. Similarly, the disciples of Prophet ʿĪsā (as) requested a banquet, stating it would reassure their hearts (*wataṭma'innaqulūbunā*).[62] The verb "to satisfy or have tranquillity" (*ṭa'manah*) stems from a quadriliteral root (ṭ-ʾa-m-n / ط-أ-م-ن), sharing three letters with the triliteral root (ʾa-m-n / أ-م-ن). Both roots are conceptually linked, centring on the human heart.[63]The Qur'ān frequently references the reassurance of the heart with faith and security, highlighting the intrinsic connection between these concepts.[64]

An unnamed village (*qaryah*) enjoying a state of safety and security (*āminatanmuṭma'innatan* | ءامنةمطمئنة) was stripped of its blessings due to disbelief and denial of favours.[65] This narrative illustrates that denial and disbelief—the opposites of faith and belief—lead to the loss of safety and security. It underscores that faith and security are not only linguistically but also conceptually connected in a causal relationship. As seen in Prophet Ibrāhīm's prayer for Mecca's safety and provision, Allah

[56] In all instances, the word *āmin*īnappears as a circumstantial (hāl) adverb or clause, denoting a state of safety and security.
[57] Badawi, E and Abdel-Haleem, M. 2008, p. 52
[58] 'Ali (ra) said: I remember us on the night of Badr, there was none among us who were not sleeping, except the Messenger of Allah (saw) who prayed facing a tree and offered supplication until morning came … Musnad Ahmad 1161, Book 5, Hadith 574. sunnah.com/ahmad:1161
[59] Al-Waḥidī, at-Tafsīr al-Basīṭ, v8:11
[60]Ar-Rāzī, Mafātīḥ al-Ghayb, v8:11 and v3:154
[61] And [mention] when Abraham said, "My Lord, show me how You give life to the dead." [Allah] said, "Have you not believed?" He said, "Yes, but [I ask] only that my heart may be satisfied." [Allah] said, "Take four birds and commit them to yourself. Then [after slaughtering them] put on each hill a portion of them; then call them - they will come [flying] to you in haste. And know that Allah is Exalted in Might and Wise." Q2:260
[62] [And remember] when the disciples said, "O Jesus, Son of Mary, can your Lord send down to us a table [spread with food] from the heaven? [Jesus] said," Fear Allah, if you should be believers." They said, "We wish to eat from it and let our hearts be reassured and know that you have been truthful to us and be among its witnesses." Q5:112-113
[63] "Whoever is pleased with Allah as (his) Lord, and Islam as (his) religion, and Muhammad as (his) Prophet, then he has tasted the sweetness of faith." Jami' at-Tirmidhi 2623, Book 40, Hadith 18. sunnah.com/tirmidhi:2623
[64] See Q3:126, 4:103, 8:10, 10:7, 13:28, 16:106, 17:95, 22:11, 89:27
[65]Some exegetes believed it was Mecca while some said it was an example of a foregone civilisation.

threatened to punish those who disbelieved[66]. Similarly, in the case of the disciples of ʿĪsā, the sent-down banquet came with a warning against disbelief.[67] These instances demonstrate that safety and security, ensured through divine provisions, are subtle examples of trust meant to be preserved with sincere faith.

Ar-Ruhāwī stressed building relationships to understand patients' distress and being receptive to their responses.[68] In the physician-patient relationship, empathy is crucial for emotional responsiveness, effective communication, allowing time, and attentively hearing complaints.[69] This approach brings assurance and tranquillity to patients' hearts, reinforcing their trust in physicians - a culmination of faith (*īmān*), trust (*amānah*), and a sense of security (*amn*) in human hearts.

Conclusion: Implications for a secular healthcare system

The physician-patient relationship in Islamic medical ethics is fundamentally rooted in the concept of *amānah* (trust) and its relevant terms, which encompasses multiple layers and is intrinsically linked to faith.This trust mandates that physicians exhibit transparency, integrity, and honesty in both intention and conduct. *Amānah* manifests in two primary forms: as a divine endowment from Allah to humanity, and as a mutual responsibility between individuals concerning specific duties or obligations. Neglecting this trust can compromise one's faith and incur accountability on the Day of Judgement. The five themes explored converge to highlight that Muslim physicians working in secular contexts may reprise the Qur'anic understanding and the lost Sunnah of *amānah* and its related terms into their medical practice and ethics by embracing a holistic approach. This approach integrates faith-based accountability, cultural humility, and a commitment to ethical integrity, thereby fostering a healthcare environment that is both spiritually and morally congruent with Islamic teachings.

For Muslim physicians, a profound comprehension of *amānah* necessitates[70] the integration of Islamic cultural awareness into patient care[71], ensuring that medical practices align with Islamic ethical principles. Scholars have observed a decline in compassionate patient care, attributing it to the commercialisation and privatisation of healthcare[72], as well as the marginalisation of religious values in medical practice[73]. Al-Ghazal importantly notes: within Islamic medical philosophy, Allah is regarded as the ultimate healer, with physicians serving as instruments of His will. This perspective fosters a stronger physician-patient bond, grounded in the physician's accountability to Allah, contrasting with relationships influenced by materialistic or secular ideologies that may erode trust.[74]While al-Ghazal critiques Western materialistic cultures, the influence of profit-driven medical care is evident globally, including in developing nations where disadvantaged patients often rely on privatised healthcare systems managed by affluent doctors.[75] Physicians deserve more respect and fair compensation for their dedication; however, pursuing medicine primarily for wealth, social status hierarchy, or authority and entrepreneurial motivescan be a concern.[76] In certain regions, remnants of colonial legacies persist, where titles like "*doctor sahib*" reflect hierarchical dynamics reminiscent of colonial times.[77] In contrast to well-regulated healthcare systems in developed countries, where these colonial legacies are now extinct, privatised healthcare in underdeveloped areas can exacerbate power imbalances, leaving impoverished patients vulnerable and with limited options beyond placing implicit trust in their physicians. To mitigate this vulnerability, many families in developing countries strive to have at least one doctor among them, ensuring trustworthy medical

[66] And [mention] when Abraham said, "My Lord, make this a secure city and provide its people with fruits - whoever of them believes in Allah and the Last Day." [Allah] said. "And whoever disbelieves - I will grant him enjoyment for a little; then I will force him to the punishment of the Fire, and wretched is the destination." Q2:127

[67] Allah said, "Indeed, I will sent it [table with food] down to you, but whoever disbelieves afterwards from among you - then indeed will I punish him with a punishment by which I have not punished anyone among the worlds." Q5:115

[68] Levey 1967, p10

[69] Habbal and Arawi 2020. Physicians' empathy levels in a primary care setting: perceptions of patients and their physicians, a qualitative study

[70] Ahmed 2016

[71] Gatrad and Sheikh 2001, Medical ethics and Islam: principles and practice

[72] Chamsi-Pasha et al 2021

[73] Khan 2008

[74] Al Ghazal 2004. The Influence of Islamic Philosophy and Ethics on the Development of Medicine During the Islamic Renaissance. https://repository.library.georgetown.edu/handle/10822/987473

[75] Ghosh 2008. Rich doctors and poor patients: Market failure and health care systems in developing countries. https://www.tandfonline.com/doi/full/10.1080/00472330701546525

[76] Muula 2006. Medicine and money: Friends or foe? https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3190462/

[77] Kumbhar 2023. Doctor sahab: Doctors and the public in the 'golden era' of the Indian medical profession. https://onlinelibrary.wiley.com/doi/full/10.1111/1467-9566.13630

care during times of illness.Altruism is often cited as a motivation for entering the medical profession; however, this noble pursuit attains true altruism only when underpinned by a robust ethical framework, including religious principles and a sense of accountability to Allah. In the context of Muslim physician-patient interactions, the *adāb*(etiquette) component of Islamic medical ethics safeguards the *amānah* between physician and patient, thereby upholding the covenant between the Muslim physician and Allah.

Incorporating the Qur'anic concept of *amānah* (trust) into medical practice requires Muslim physicians to embody transparency, integrity, and honesty, recognising their accountability to Allah and their patients. This trust is foundational to the physician-patient relationship and is deeply intertwined with faith. By understanding *amānah* as both a divine trust and a social responsibility, physicians can navigate the challenges posed by commercialised and secular healthcare systems, ensuring that their practice aligns with Islamic medical ethics. This alignment recognises the ability and authority to provide care as an *amānah* itself, fosters a compassionate, empathetic approach to patient care, enhances the quality of care, strengthens patient trust, and fulfils their religious and moral obligations.For Muslim physicians, restoring this integrity aligns with key objectives of Islamic law (*maqāṣid al-sharīʿa*), specifically the preservation of religion and morality (*ḥifẓ al-dīn*) and the preservation of life and health (*ḥifẓ al-nafs*), as articulated by the exegete al-Qurṭubī.[78]

[78] Arawi et al 2019. The Journey of the Nafs and the Muslim: Physician: Moral Plasticity in Medicine, https://doi.org/10.1007/978-3-319-74365-3_181-1

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Serefeddin Sabuncuoglu: A Pioneer in Ottoman Medicine and Surgery

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Introduction

The Ottoman State witnessed significant advancements in thefields of science and art during the 15th century, with notable progress also occurring in the field of medicine. Among the prominent medical scholars of this period was Şerefeddin Sabuncuoğlu, who distinguished himself through innovative surgical practices and substantial contributions to the Turkish medical literature. Sabuncuoğlu left an indelible mark on Islamic medical history, with his influence extending beyond the Islamic world into Western medicine.

The Life of erefeddin Sabuncuo lu

Şerefeddin Sabuncuoğlu was born in 1386 in Amasya, an import antintellectual center of the Ottoman Empire (1). He hailed from a prominent medical family; his grandfather, Sabuncuoğlu Mevlânâ el-Hâc İlyas Çelebi Bey, was the chief physician of Çelebi Sultan Mehmed. It is believed that Sabuncuoğlu received his medical education at the Amasya Darüşşifa under the tutelage of Burhâneddin Ahmed en-Nahcuvânî (2). After practicing medicine there for fourteen years, he spent some time in Kastamonu, where he began writing his seminal works. Notably, after completing *Cerrâhiyye-i İlhâniyye*, he traveled to Istanbul to present the work to Sultan Mehmed the Conqueror. In his final work, *Mücerrebnâme*, written in 1468, Sabuncuoğlu mentionedthat he was 85 years old at the time, and he is presumed to have passed away shortly thereafter.

Despite his contributions, Sabuncuoğlu's name was not widely recognized within the Ottoman scientific community. His name first appeared in the historical record in the 1505 work *Alâim-i Cerrâhîn*by the surgeon İbrahim b. Abdullah. Additionally (3), Sabuncuoğlu's student Gıyâs b. Muhammed İsfahânî praised his mentor'smedical achievements in his book *Mir'âtü'ş-şıḥḥa*, which he dedicated to Sultan Bayezid II (4).

The Works of Serefeddin Sabuncuoglu

Şerefeddin Sabuncuoğlu's most renowned work is *Cerrâhiyye-i İlhâniyye*, which holds the distinction of being the first surgical text written in Turkish during the Ottoman period. This work not only reflects the level of Turkish surgery in the 15th century but also represents an adaptation of the surgical section of the Andalusian Islamic physician Abu al-Qasim al-Zahrawi's *Kitāb al-Taṣrīf*, with the addition of two new chapters, as well as illustrations of surgical instruments and patient treatments. *Cerrâhiyye-i İlhâniyye* is unique in medical history for being the first text to depict surgical interventions using miniature illustrations (5). Thetext's composition in straightforward and accessible Turkish further underscores its significant contribution to Turkish medical literature, and its reflection of the linguistic features of Anatolian Turkish makes it an essential resource for the study of Turkish grammar and phonetics (6).

Three known copies of the manuscript have survived to the present day. Two of these copies, housed at theBibliothèque Nationale in Paris and the Millet Library in Istanbul, were penned by Sabuncuoğlu himself. Amongthese, the Paris manuscript, which was presented to Sultan Mehmed the Conqueror and bears the seal of Sultan Bayezid II, is regarded as the most valuable. This manuscript consists of 205 folios, each containing seventeen lines of meticulously penned Turkish text, with red ink used to highlight key titles. The text offers

detailed descriptions of various treatments involving cauterization, surgical procedures, and the management of fractures and dislocations, all accompanied by a total of 138 miniature illustrations and depictions of surgical instruments. Notably, some of the points described for cauterization treatments have been found to coincide with acupuncture points (7).

Another significant work by Sabuncuoğlu is *Mücerrebnâme*, which details the preparation and usage of various medicines tested on animals, humans, and even the author himself (8). *Mücerrebnâme* is notable as the first monograph in Turkish medical history to describe a physician's own medicinal discoveries and treatment methods. The text is organized in a manner similar to modern case reports, with medicines categorized from most to least used.

Sabuncuoğlu also translated the "Akrâbâzîn" section of the *Ẕaḫîre-i Ḫârizmşâhî*, a Persian work by Ismail b. Hasan al-Jurjani, into Turkish at the request of Prince Bayezid in 1444. This work, known as *Akrâbâzîn Tercümesi*, provided detailed instructions on the preparation and application of various medications, significantly contributing to the development of Turkish medical terminology (2, 9).

Contributions and Innovations in Medicine

Şerefeddin Sabuncuoğlu made significant contributions to the field of surgery, leaving a lasting impact on the medical world. The innovations he introduced in *Cerrâhiyye-i İlhâniyye*, particularly in orthopedics, neurosurgery, urology, gynecology, and paediatric surgery, underscore his importance in medical history. For example, the techniques he developed for spinal surgery, neurological disorders, pain management, and anesthesia were widely adopted in subsequent periods (10, 11).

Sabuncuoğlu also introduced groundbreaking designs for surgical instruments, meticulously illustrating their use in his Works (12). These original contributions had a profound influence not only on Ottoman medicine but also on Western surgical practices. His detailed illustrations, created despite the technical limitations of his time, ensured that his works attained a universal quality (13).

Beyond surgery, Sabuncuoğlu made notable advancements in dermatology, ophthalmology, dentistry, orthopedics, andneurology. His work in these areas demonstrates his comprehensive medical knowledge and his ability to apply this knowledge effectively in practice. Particularly, his contributions to pain management and anesthesia laid the foundation for modern anesthetic practices (14).

In the field of obstetrics and gynecology, Sabuncuoğlu introduced innovative surgical techniques and designed specialized instruments, which he meticulously documented in his works (15). These advancements highlight his progressive understanding of medical science for his time.

Moreover, the detailed illustrations in Sabuncuoğlu's works played a vital role in medical education of the time, enabling surgical techniques to be disseminated more widely. His contributions represent a pivotal moment in Islamic medical history, establishing a foundation for the development of modern medicine.

Conclusion

Şerefeddin Sabuncuoğlu was a pioneering figure in thedevelopment of Ottoman medicine, introducing numerous innovations that have had a lasting impact on the field. His works are not only valuable for their medical content but also for their cultural and scientific significance. Understanding Sabuncuoğlu's life and contributions is crucial for appreciating the role of Muslim scholars in the foundations of modern medicine. Therefore, recognizing and preserving his legacy is of great importance for both medical and cultural history.

References

1. Varol GB. XIX. ve XX. yüzyıla intikal eden Amasya medreseleri [MSc]. Amasya: Amasya Üniversitesi; 2019.

2. Yıldırım N. SABUNCUOĞLU ŞEREFEDDİN. TDV İslam Ansiklopedisi. İstanbul2008. p. 358-9.

3. Gürlek M. Anadoluda Yazılmış İlk Türkçe Cerrahî Yazmalara Bir Örnek: Alâ'im-İ Cerrâhîn. Electronic Turkish Studies. 2011;6(3).

4. Yüksek E. Amasyalı Şerefeddin Sabuncuoğlu'nun Hayatı, Eserleri ve Tıp Alanına Getirdiği Yenilikler. Samsun 2020.

5. Konak R, Ateşgöz A. Resimli Cerrahiyye-i İlhaniyye nüshalarının Osmanlı resim sanatı açısından incelenmesi. Journal of Humanities and Tourism Research. 2021;11(2):379-95.

6. Acar HV. SabuncuoğluŞerefeddin's Surgical Treatise Cerrahiyetü'l-Haniyye and Its Significance in the History of Turkish Medicine. SabuncuogluSerefeddin Health Sciences. 2019;1(1):1-7.

7. Bayat AH. CERRÂHİYYE-i İLHÂNİYYE. TDV İslam Ansiklopedisi1993. p. 420.

8. Süveren K, Uzel İ. Şerefeddin Sabuncuoğlu Mücerrebname. Ankara: Atatürk Kültür Merkezi Yayınları; 1999.

9. Doğan Ş. Terceme-i Akrabâdîn \ Sabuncuoğlu Şerefeddin (Giriş-Inceleme-Metin-Dizinler), Birinci Cilt: Sakarya Universitesi (Turkey); 2009.

10. Bademci G. First illustrations of female "Neurosurgeons" in the fifteenth century by Serefeddin Sabuncuoglu. Neurocirugía. 2006;17(2):162-5.

11. Sarban S, Aksoy S, Uzel I, Iskan UE, Atik S. Orthopaedic techniques of Sabuncuoğlu in the 15th century Ottoman period. Clinical Orthopaedics and Related Research®. 2005;439:253-9.

12. Kurt ÜE. HekimŞerafeddinSabuncuoğlu'nunCerrahiyetü'lHaniyye Adlı Eserinde Yer Alan CerrahiAletlerinTanımlanması, Çizimi, SınıflanmasıveKarşılaştırılması. İstanbul Üniversitesi, SağlıkBilimleriEnstitüsü, DoktoraTezi, İstanbul. 2012.

13. Ertunç ÇÖ, Mazı LD. SabuncuoğluŞerefeddin'in Paris BibliothequeNationale'deBulunanCerrahiyyetü'lHaniyye İsimliEserininMinyatürÖzellikleri. İSTEM. 2020(36):305-23.

14. Ganidagli S, Cengiz M, Aksoy S, Verit A. Approach to painful disorders by Şerefeddin Sabuncuoğlu in the fifteenth century Ottoman period. The Journal of the American Society of Anesthesiologists. 2004;100(1):165-9.

15. Kadıoğlu NS, Öğenler O, Uzel I. Şerefeddin Sabuncuoğlu's drawings of gyneco-obstetric instruments. Turkish Journal of Medical Sciences. 2011;41(1):1-5.

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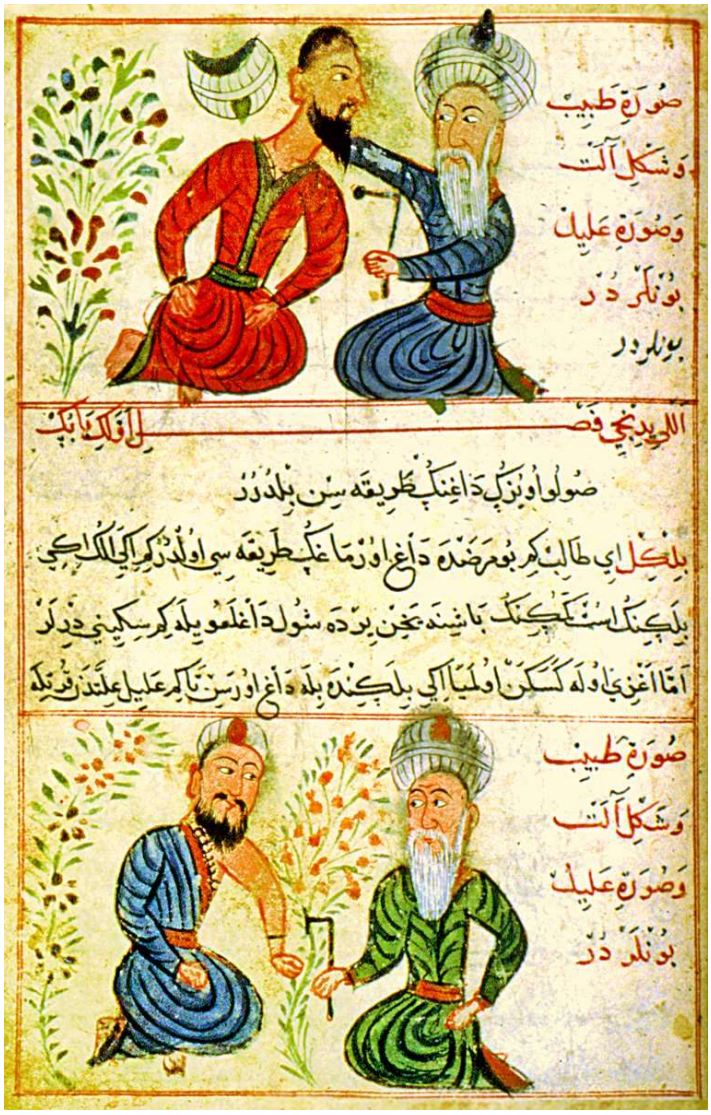

A miniature from Cerrâhiyye-i İlhâniyye (Millet Library, Medical Collection, no. 79/353, folio 47a)

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Physicians' Attributes as Described by the Ancestor Scholars

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Summary:

Modern scientific and medical literature is rich, describingthe qualities required for a good practicing doctor. Moreover, ancient literature, historians, and manuscripts of early Muslim doctors are also rich in describing the traits of physicians that they should embody to be sincere in performing their work. From the Hippocrates and Galen era to Al-Razi, Ibn Sina, Al-Rahawi, and others, much emphasis was put on these values, from the ancient Greek toMuslim physicians.

Introduction:

Abu Bakr Muhammad bin Yahya bin Zakariya Al-Razi (250 AH/864 CE - 311 AH/923 CE) said: "*Medicine is the preservation of the health of the healthy and restoring it to the sick as much as human capability allows*." (1-3)

The inspired physician Avicenna (Sheikh al-Rais Abu Ali, Hussein bin Abdullah Ibn Sina, who passed away in 428 AH), in his famous verse, defines medicine as " *the preservation of the health of someone who is ill, through a cause in the body that led to a symptom*."

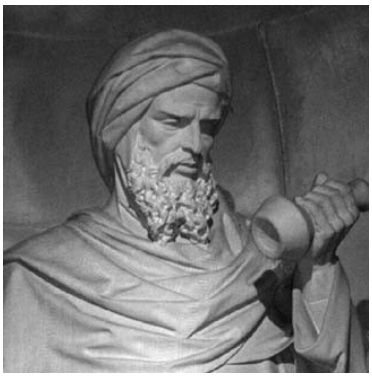
Al-Razi
(864 CE - 923 CE)

Al-Razi Book in Medicine

Ibn Sina
(980—1037)

AlcanonIn Medicine for Avicenna

However, Ibn Rushd (Muhammad bin Ahmad bin Muhammad Ibn Rushd Al-Andalusi), also known as Abu Walid (520-595 AH = 1126-1198 CE) had a different perspective. He said: "*The craft of medicine is a practical profession based on truthful principles, aimed at preserving the health of the human body and abolishing illness*." (4)



Ibn Alrushd
(1126-1198)

Hence, Medicine is a unique and pioneering profession, because it deals directly with the human body, soul, and emotions without any intermediary. Moreover, medicine is also the only profession with power and control over another person, where the patient voluntarily submits to the doctor's full authority without coercion. It is the profession with the most profound and direct impact on the life, well-being, or even the demise of a person, or their exposure to epidemics and diseases. For that doctors need to be distinguished by multiple and unique qualities, as patients are completely vulnerable, exposing all their personal sensations and physical barriers to the doctor, who uncovers their innermost self without reservation.

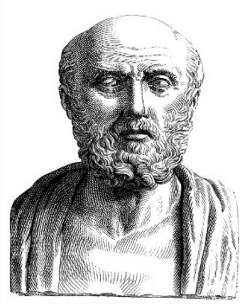
In this regard, Ishaq bin Ali Al-Rahawi in his book "The Ethics of the Physician" in the 4th century AH stated: *"The profession of medicine is the noblest of professions, and its science is the oldest of sciences. It must be ranked above all other professions and crafts..."* (5,6).

Ishaq bin Ali Al-Rahawi
(854-931)

The Ethics of the Physician

Mahmoud bin Saud bin Muslih Al-Farsi (710 AH) also emphasized the uniqueness of the medical profession, describing it as a divine gift of great honor: *"The science of medicine is the noblest of sciences after divine knowledge, for its subject is the human body...."* It is a difficult and almost impossible profession, reserved only for those who are blessed with it. Not everyone who desires it can attain it. According to both ancient and modern scholars, it is a gift from the blessings of God. It is a science among the divine sciences or one that is very

close to them. Hippocrates, known as the father of medicine (born on the island of Kos around 460 BCE), said, "*No human mind can fully grasp this science*." (7)



Hippocrates
(c. 460 BC – c. 370 BC)

The physician, as mentioned in ancient texts, must be wise in all meanings of wisdom, possessing multiple talents and diverse intellects, constantly distinguished, balanced in their approach, logical, knowledgeable about the sciences of humanity, in addition to being gifted with bright traits alongside their medical skills. Al-Rahawi mentioned in this regard: "*Every philosopher is a physician, and every virtuous physician is a philosopher. A philosopher cannot reform anything but the soul, while a virtuous physician can reform both the soul and the body*." (6)

The General Knowledge of the Physician:

Physicians must not limit themselves to just the medical sciences but are expected to broaden their knowledge and understanding in various theoretical and scientific fields and be fully familiar with the history of medicine, its origins, and the great scholars who contributed to its advancement. Additionally, they must possess specialized knowledge.

Therefore, a physician's knowledge should include the following:

1. **Theoretical Sciences:**

This knowledge comes from reviewing research, books, writings, and records of the results of studies implemented by past and present scholars in the fields of medicine. For example, they must be familiar with the legacy of ancient doctors like Ibn Sina, Al-Razi, Hippocrates, Galen, and others who shared their opinions. They must also strive to understand and uncover the complexity of modern scientific research. As Sa'id bin Al-Hassan (the physician Abu Alaa Sa'id bin Al-Hassan bin Sa'id, 464 AH) stated: *"The physician must be diligent in studying, reading, and reviewing the sciences of the ancients..."* (8). Thus, a physician cannot remain stagnant, content with what they have already acquired in basic sciences but must engage in continuous learning to keep up with new discoveries and medical theories based on the knowledge of the past and the efforts of modern scholars.

2. **Practical Sciences:**

Physicians acquire practical knowledge through attending conferences, and training courses during their service, as well as paying attention to patient follow-ups and continuously being present in hospital departments. They should also be familiar with medical laws and regulations. It is essential to acknowledge that the physician's expertise and experience in practicing medicine increase as they continue consulting and treating patients and accept the notion that they are constantly training and learning.

3. **Specialized Knowledge:**

Physicians acquire specialized knowledge by associating with experienced professors and veteran doctors. Through interactions with them, they benefit from their distilled experiences, which help them absorb more medical knowledge. They also gain from participating in their discussions, interventions, and methods for treating complex cases. All of this is facilitated through regular and daily meetings with their mentors and colleagues at all levels, whether in personal meetings, workshops, or specialized conferences. The Arab physician Ibn Ridwan (Abu Al-Hassan Ali bin Ridwan bin Ali bin Ja'far, who grew up in Egypt in the 5th century AH and died in 460 AH) said in the first chapter of his book The Approach to Happiness: *"Either the learner finds an excellent teacher who can explain the teachings of Hippocrates, thus accelerating his education as rapidly as Galen's, or he is deprived of such a teacher and needs to learn from Galen's books, which prolongs the time of learning if he applies the principles of logic in his education."* (9-10)

Ibn Ridwan (c. 988 - c. 1061)

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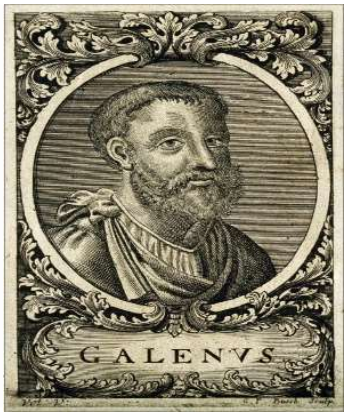
Physicians' attributes:

In addition to the previously mentioned characteristics of the medical profession, a physician must possess a variety of personal qualities. These include, for example, being of good character and integrity, not being spiteful or envious, not hasty or impatient, and not greedy. The qualities of a successful physician, as mentioned by Al-Rahawi, include *"being forgiving of faults, patient with people, steadfast and calm, knowledgeable in their work, gentle, humble, quick to do good deeds, content and grateful, delighted with sincere praise, abstaining from vice, and pure in both heart and actions." (5)*

Galen (a famous Greek physician and writer, born to Greek parents in the ancient city of Pergamum, now known as Bergama in Turkey, in 130 CE, and died in 200 CE) described the ideal physician, noting the difference between a physician and someone who merely practices medicine: *"A physician is the one who possesses all virtues—knowledge of teaching, natural sciences, divine matters, logic, medicine, good deeds, and excellent character."* (11)



Galen
(130 CE- 200 CE)

Sa'id bin Al-Hassan (8) described the traits of a physician, stating: *"The physician must have a balanced temperament, be pure in heart, committed to their religion, and follow the law. They should be intelligent, quick-witted, and insightful, known for their honesty, integrity, and care for the welfare of others. They should be moderate in their desires, not greedy for wealth or envious of others, well-mannered, well-educated, focused on their studies and always reading, compassionate with the weak and the poor, eager to treat them before the rich, practicing chastity, and discreet in keeping secrets. They should avoid excessive joking or error, not be swayed by the temptation of alcohol, and should not indulge in vice or immorality."* He also stated: *"A physician must be calm, clear-headed, quick to act with a strong mind, and trustworthy with the lives and wealth of others. They must not prescribe harmful or fatal medicine or anything that could harm an unborn child. They should treat everyone, regardless of their status, with the same dedication, as they would treat their loved ones."*

Sa'id bin Al-Hassan

A physician must also be mindful of God when dealing with patients, and the values of religion should guide their character and actions, regardless of their personal beliefs. Divine teachings, in general, encourage good treatment of others, including patients, and all people in general, as well as all creatures.

Ibn Ridwan believed that a virtuous physician should possess several qualities, which he outlined as follows, based on Hippocrates' opinion: (12)

First: The physician must have a perfect physique, be mentally sharp, have good eyesight, and possess rational thinking and good temperament.

Second: The physician should be well-dressed, have a pleasant scent, and maintain cleanliness in both body and clothing.

Third: The physician must keep the secrets of their patients and not divulge any details about their illnesses.

Fourth: The physician's desire to heal patients should surpass their desire for financial gain. They should prioritize treating the poor over the rich.

Fifth: The physician should be eager to learn and focus on benefiting others.

Sixth: The physician should have a pure heart, be modest, truthful in speech, and not have any immoral thoughts or desires related to wealth or women.

Seventh: The physician must be trustworthy, responsible for the well-being of others, and not prescribe harmful treatments or medications. They should approach their patients with a sincere heart, whether they are enemies or loved ones.

In this regard, the **American College of Physicians** issued a document in 2002 titled *The Medical Profession Charter*, which comprehensively outlines the foundational principles of a physician's interaction with patients. It establishes three main principles and ten essential responsibilities: (13, 14)

The Key Principles are:

1. **Priority to Patient's Welfare:** This principle emphasizes the physician's commitment to serving the patient's best interests without external influences.

2. **Patient Autonomy:** This refers to the physician's honesty with the patient and their commitment to encouraging patients to actively participate in decisions about their treatment.

3. **Social Justice:** This principle ensures equitable access to healthcare, which is considered a right for every individual. It calls on physicians to eliminate any form of discrimination based on race, gender, or any other basis that may prevent a patient from receiving medical care.

While the Primary Responsibilities of the Physician are:

This responsibility emphasizes that a physician must maintain a high standard of medical skill and continuously improve their qualifications throughout their career. Continuous learning is crucial to ensure competence and ability to meet evolving medical challenges. Hence physicians should ensure having:

1. **Appropriate Qualification**:

   It is the physician's responsibility to be at the required level and have a good reputation for medical skills, which requires continuous learning and teaching throughout his or her life.

2. **Commitment to Honesty with Patients:**
   A physician must be truthful and transparent with their patients, especially when errors occur. If a medical mistake happens, the physician must inform the patients honestly and ensure them to investigate, and mitigate any possible causes or risks that may lead to further harm.

3. **Adherence to Confidentiality:**
   The physician is responsible for maintaining the confidentiality of patient information. This includes not disclosing or discussing patient details without the patient's explicit consent, as protecting privacy is a cornerstone of medical ethics.

4. **Maintaining Professional and Humane Relationships with Patients:**
   The physician should build and maintain a respectful and professional relationship with patients. This relationship should not foster dependency on the physician nor be influenced by ulterior motives such as financial or sexual interests.

5. **Commitment to Improving the Quality of Care:**
   A physician is responsible for continuously striving to provide the best possible medical care. This means collaborating with relevant institutions and pursuing ongoing improvements in the delivery of care and treatment standards.

6. **Commitment to Improving Accessibility to Health Services:**
   Physicians must work toward facilitating access to health services for all patients, particularly in public health and preventive care, ensuring that healthcare is available and accessible without delay or hindrance.

7. **Commitment to Fair Distribution of Healthcare Resources:**
   It is the physician's responsibility to ensure that healthcare resources are distributed equitably. This includes the appropriate procurement of medical equipment and resources required for the healthcare provision.

8. **Commitment to Neutrality in Conflicts of Interest:**
   A physician should always prioritize the patient's well-being above other interests, especially when there are potential conflicts with the interests of pharmaceutical companies, medical device manufacturers, or other entities providing healthcare support.

9. **Commitment to Professional Responsibility:**
   Physicians must respect the opinions of their colleagues and seek input, when necessary, whether from local or international experts. This helps strengthen professional relationships and enhances their skills through collaboration and feedback.

10. **Commitment to Keeping Up with Scientific and Technological Advances:**
    Physicians must continuously update their knowledge and practices in line with scientific developments and the latest technologies. This ensures that they are equipped to meet the patients' needs effectively, utilizing the most advanced tools and methodologies available in healthcare.

Physician's Negligence and Mistakes:

The medical profession does not tolerate negligence or error, as these can lead to severe consequences, such as worsening the patient's condition or even causing death or permanent disability.

Moreover, it results in a significant loss of reputation for the physician and potential legal and moral consequences. Galen, in his differentiation between a true physician and a mere practitioner, stated: *"A true physician is the one who has perfected all the virtues and acquired extensive knowledge in medicine, philosophy, natural science, and ethics. If anyone lacks any of these characteristics, they are not truly a physician but merely a practitioner."* He also stressed that someone who claims to be a physician without adequate training is a fraud and unworthy of respect in the medical field.Some of these individuals, who claim expertise in medicine while lacking essential knowledge, may seek to assume leadership roles, which can be harmful to both patients and the profession. They are ignorant and dangerously uninformed, often unable to distinguish right from wrong, and their presence in the field can cause lasting damage to public trust.

Choosing and Testing a Physician:

In general, when seeking medical advice or consultation, the selection of a physician should be based on a comprehensive assessment of their qualifications, knowledge, and ethical standards. The primary means of testing a physician's competence is through inquiries into their professional history to confirm the depth of their medical knowledge and their adherence to the principles of the profession.As noted by Al-Shirazi, *"If a physician is modest, religious, and upright, then consider them for your care."* The physician's reputation, success in treating illnesses, and ethical standing play significant roles in their selection. Books, research publications, and scientific endeavors also help identify the best candidates for medical care, as these achievements reflect the physician's knowledge, dedication, and competence.Furthermore, Al-Shirazi pointed out that a physician's intellect is not only reflected in their knowledge but also in their ethical demeanor, self-restraint, and avoidance of indulgence in worldly desires. **"***A physician's true intellect begins not with the breadth of their knowledge, but with their ethical character and their ability to resist temptation."*

Sa'id bin Al-Hassan set forth additional criteria, stating that;*"A physician should not approach patients until they are called upon. This shows respect for their status and prevents the physician from becoming overly familiar or too eager to impose themselves on patients, which could diminish their authority."* He advised against excessive familiarity and stressed maintaining a balance in professional conduct.On the other hand, Al-Rahawi believed that testing a physician's knowledge is essential. He added that; "*it is equally important to observe a physician's actions, both in personal conduct and in their interaction with others, as this provides a clear indication of their competence and understanding*."

Thus, the selection of physicianshould be based not only on theoretical knowledge but also on their moral behavior, professional reputation, and consistent display of expertise in their field.

Benefits of the Medical Profession and Medical Sciences:

The field of medicine offers profound reflections on the greatness of God's creation. The intricate components of the human body—whether fluids, cells, organs, or systems—all work tirelessly since birth or even before without rest, except in the case of death. Some organs, like the heart, begin functioning from the moment of

conception, while others start after birth or even later in life. All of these are signs and miracles that testify to the greatness, power, and oneness of the Creator. Physicians, as the first observer and contemplator of this magnificent creation, are uniquely positioned to witness the marvels of God's work and to dedicate their efforts to the preservation of human health. This fosters a deep sense of belief and motivation to pursue further education and care for humanity.

It is truly astonishing that a practicing physician, who witnesses the miracles of God's creation firsthand, does not increase in faith. If a physician does not find their faith in God strengthened through these experiences, they are, without a doubt, ignorant and far from true understanding, thus deserving of great loss.Moreover, the physician and the science of medicine are blessed with divine favor—granting the physician the continued grace of mercy, forgiveness of sins, and the joy of maintaining physical health, mental peace, and spiritual contentment. All of this is a divine blessing that necessitates gratitude to God and a commitment to the profession for the benefit of humanity.

As Ibn Ridwan mentions in his book "Maqalat fi Sharaf al-Tibb" (Chapter 1), *"The benefits and virtues of this profession are immense; they pertain to the body, the soul, the attainment of Allah's grace, the acquisition of wealth, and the attainment of leadership and honor."*

In conclusion, we beseech Allah to protect us from the evil within ourselves and from those who are misguided. May He illuminate our hearts with the light of knowledge and guidance, and may He grant us clarity and insight to see the divine care surrounding us. We pray that we may be among the physicians who are steadfast in our faith, ever mindful of Allah in our treatment of patients.

References:

1. 1-https://ar.lib.efatwa.ir/45203/1/248
2. الحاوي في الطب، أبو بكر الرَّازي، الجزء الأول-
الطب العربي / تأليف ادوارد .ج .براون ؛ ترجمة احمد شوقي حسن
3. Ullman, Manfred – IslamicMedicine – Islamic Survey – Edinburgh University, 1978, p. XIII

   https://www.jstor.org/stable/44450546
4. https://iep.utm.edu/ibn-rushd-averroes
5. https://archive.org/download/aalam_almaarifa/233.pdf
6. https://www.islamstickers.uk/forum/attachments/medical-errors-pdf.16/
7. http://www.sjsu.edu/depts/Museum/hippoc.html
8. https://www.islamstory.com/ar/artical/3407740 (saad bin alhassan)
9. http://www.ishim.net/ankaadan6/alimasri.htm (Dr Abdul Nasir Kaadan)
10. ابن أبي أصيبعة : عيون الانباء ، 565
11. http://en.wikipedia.org/wiki/Galen
12. Leclerc, Lucien : Histoire de la médecine arabe, Burt, Franklin, New York, USA, 1978, tome 1, p.303
13. ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. Lancet. 2003; 136:243-6
14. Medical Professionalism Project. Medical Professionalism in the new millennium: a physicians' charter. Lancet. 2002; 359:520-2
15. Reuben Elder. Quality of Care. MedicinskaNaklada. CMJ Book Collection. Zagreb, 2005

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The "Passionate Love" Disease and its Treatment in the Heritage of Arab-Islamic Medicine

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History of the quintessence of passionate love disease:

Passionate love was considered for that excessive form of the highest form of love. At the time, love would be looked to for the highest affection humans were adorned. So passionate love was considered the example for the condition that occurs as a result of the extreme exaggeration in love, which reflected with the negative effect on the personality of the pretended lover with body disturbances, for behavioral disturbances which often push the wounded person to commit that was perpetrated other than reasonable.

Indeed, I have taken up this subject by the Arab writers, including poets on their particular manner of amorous feelings, and regarding the disease many among them that hoped not recovery.

Al Aassee put the palm of his hand[(1)] at his waist

He said the desire turning aside with this craft.

And also, the among literature what was the treatment advice of the conversation happening between passionate love sought for one's love feelings was left off:

Any lover of the multitude would have to learn by experience from God; if passionate love is the condition with the boy, what should he do?

Waste his desire, thereafter he covered his secret; and exercised restraint with all matters as was under control

And how would he waste, with the desire fighting the boy; and with every day his heart would cut off

Because he was not patient to suppress his secret; so even death would not benefit

Hear us, obey us; thereafter we died, then they attained; peace always for those hindered from reaching

While the ancient Muslim doctors, upon a manner contrary to the poets, had looked upon this disease as a another diseased condition from the neurological or psychiatric diseases like epilepsy, headaches and melancholy [(2)] caused illness with the signs, symptoms, and treatment ,Vavadoa in his commentary stated that this disease treatment was considered different to adjust the patient's condition and to the degree of culture, in addition to the nature of the circumstances surrounding it.

Perhaps the first who spoke about the disease of passionate love from doctors was the Greek physician, Hippocrates, by the nickname Father of Medicine. Whereas he said, describing what it was: "Passionate love was longed for generated in the heart and met the material sense. So, whenever it was strong, it increased its possessor in agitation and insistence, with severe anxiety and abundance of vigilance. And when melancholy was burning blood with the

condition, then from the tyranny of melancholy, with corruption of dull[3] thoughtand diminished mind. While pleased what was emitted completed, was led down to that madness. Then at that time perhaps the lover killed himself. And probably he died sad. Or probably he reached his lover. So, he died rejoicing or sorrowful. As you saw the lover, when he heard by mention who he liked, how his smear was escaped and changed his appearance. Then for whoever this condition declined gently from the Lord of the worlds, was not by management of addictions". [4]

Galen had described this disease by saying: 'The approval of passionate love was entertaining desire yielded for it to the self, as hidden in the brain, heart, and liver. While the lover refrained from food and drink for the functioning of the liver, and for the functioning of the imaginary of the brain. Then he mentioned the lover as thinking about them, so all of the dwellings were occupied therein. Consequently, when it did not work at the time of separation, it was not fancied". [5]

Causes of the passionate love disease:

Avicenna said about the causes mentioned of this disease: "This disease made evil suggestions similar for Melancholy [6], mankind had been brought the same influence of idea for approval some form as had its character doing evil to help him for that desire or not to help him[7].
Some have added to this disease the unmarried was naked and out of the work from the keeping of people. Ibn Hubal Al Baghdadi spoke about the occurrence of the disease mechanism, so that he says: "The passionate love presented from the persistence of the idea of the approval some form occurring in the imagination and persistence seen by desirable movements of the self to produce what was raised, and supported for movements of the desires. So, it presents from that thing from dullness and withering promise to Melancholy[8]". From the Hadith of Al Baghdadi, we can explain why the disease of passionate love followed the disease of melancholy in ancient Arabic Medical Publications.

Symptoms and signs:

Most of the sentence of the tribe of Mardini in its Medical Manuscript, named the 'Dispatched Flame' in the Medical Art signs and symptoms of the disease of passionate love says: 'The mark of deceived and dried eyes, except when crying, with thickened eyelids from the abundance of spending the night awake and the best perfume arising for that. Then his lover offered by putting the hand on his throbbing and he mentioned the highest and extended, if the throbbing he acknowledged was alternated [9]".

Indeed, most of the whole Muslim Arab doctors who talked about the passionate love disease had the disturbance of the throbbing from the important signs for diagnosis of the passionate love disease to recover, as down to the knowledge of the desired lover. The persistence for this is due to the story told from Avicenna, who compiled a treatise about passionate love written by Ibn Abdullah Al Faqih[10].

The summary of the story, it was an incurable disease that had befallen one of the youths from the sons of the Prince of Persia, and the doctors were frustrated at that time about the knowledge of this disease and with following its symptoms. For the youth was losing weight and strenght day after day, and had refrained from food. For he had lacked the appetite, even joked he stuck close to the bed. And since the doctors were frustrated about finding the panacea for this disease of the youth, the family resorted to Avicenna to beg him to visit the patient with the consideration in his case after that was completely difficult from his cure. Avicenna came immediately to reach the home of the patient, asked him about the symptoms of his illness and which people with the situation. Thereafter, he entered to the youth and examined him by observation. Then he sat beside his bed and put his finger on the pulse. Then he asked one of the attendants to count all of the neighborhoods of this city. And when the attendant arrived to mention as much as the neighborhoods, Avicenna had the good fortune for the pulse of the youth had hastened. With that he asked from the attendant to mention names of the families that were inhabitants the neighborhood. Then when that attendant mentioned about the source of these names, he had perceived much more by that pulse of the youth. And here Avicenna asked if this family was part of girls. As they answered yes, then the daughter appeared to the family of the youth. It was said to them that indeed the cause to remove the wonder, if your son was a lover of one daughter of these families. And this is the disease and its treatment with the giving in marriage of that girl.

This uncommon story is an explanation for why the multitude of Arab Muslim doctors who spoke about this passionate love disease had considered the presence of the disturbance of the pulse mentioned of

the lover was from the diagnostic signs of this disease. Avicenna said about the signs of this disease: "Its signs of the eyes of deceit as they fell with lack of tears, except when crying. Also, movement connected to eyelid laughing as looking to something delicious, or heard good news, or made fun. And he shall have many interruptions, while recovery is more the sigh. And his condition changes to joy and laughter or grief and crying when you hear the flirting, especially abandonment with distance. And all of his organs will be wilted except the eyes, so that it will be with its deceived big eyes of its awakened eyelids thickness. And his pulse had been a different pulse of the owner the system tested definitely as the significant pulse. Then his pulse changed with his condition when the special lover was mentioned and when meeting them suddenly. It can be concluded from that for the lover, if he did not recognize it, because the knowledge of the lover is one of the means of his treatment. The craft with that was to mention the names of the restoration many times with the hand on his pulse, and if different by that it means a great difference, while it became to resemble the devoted. Thereafter returning to rehearse that time known among them the name of the lover. Afterwards by mention in the same manner the dwelling, the neighbor, the occupation, the villages, and add all of them to the names of the lovers and saved the pulse, even if something collected mentioned changed one time from whose name of his lover that attribute." [(11)] By the profession that you knew. then if we tested this, we brought forth with it what stood for the benefit[(11)].
The signs and symptoms can be summarized, as the ancient Muslim doctors mentioned them: the wasting away - little appetite, deceiving eyes with thickened eyelids – the isolation of love with the recovery as a big sigh – the pulse disturbed and its peculiar hastening was the mention of the presence of the lover or anything related with them.

Treatment:

Indeed, the Arab Muslim doctors, who spoke about passionate love disease, agreed that the preferred and most useful treatment for this disease was the bringing together of the lover and the sweetheart as that according to permission the law.

The tribe of Mardini said about that: The treatment will have those who express regret as reached the desired way of law. Then they were disgraced with the ugliness of doing it, but kept occupied by some mental information by the credited administrative council. Thereafter some melancholy was emptied, as it often happened from water poured on their head. Also, watermelon, cucumbers, and herbs were fed; and the alarming sour was given to drink, as ordered to sleep under the dew. And they remembered to look to the moon, when it was full prevented this disease. Also, abundant washing in cold water was advised. But not to eat hot things from medicines, food, and desires [(12)].
From what preceded, it can be mentioned the components of treatment passionate love disease according the following:

First - try to bring together the lover and sweetheart to marry, if possible; in that Ibn Hubal Al Baghdadi said: "Nothing is more beneficial treatment of bringing together lover and sweetheart according to the desired way the law allowed, if it was right and cleared from blame. And if it was not, then he looked from afar. Then only, the procrastination [(13)] ".

And Avicenna explained this fact by saying: "Then you can only find as treatment management before them bringing together according to the religion allowed and done by law. And we have seen from its recurring safety, strength, as it restored their holding firmly. But they had been near to becoming dull and passed it, with the difficulty of harsh chronic diseases, by the long passion due to the weak power of intense passionate love. And when he perceived by reaching from his lover after the recurrence delayed with the shortest period spent by the wonder, then we concluded to obey nature's illusions of self [(14)] ".
Secondly – the lover was advised and chastised for actions, if he was wise. Avicenna also said: "Then advise and warn them, and be remiss having them ridiculed for and chastised with the illustration it presented for what only was whispered and set forth from the obsession, which its benefit did good, speaking effectively in such as that divided into sections [(15)] ".

Thirdly – the lover's occupation with some mental science and credited administrative council or occupied with some other worldly affairs that you spent thinking the about abundance of passionate love with his sweetheart. The Arab doctors had versatility in this area by innovative means that would accomplish this purpose. So, these are the things they mentioned:

1 – the patient works with some Mental Science by the credited community of the governing body, and

therefore if he was among those with its preparation. Then if he was from the religious people, he could console the ascetics, worshippers, and poor with news

2 – if the worker was an expert, whether worked, or kept busy with his work, or his work not harmed from bravery and gaps.

3 – length of travel from the established abode of the sweetheart, whereas that which generated the forgotten with the passage of time.

4 – some doctors mentioned – as Avicenna – it is from the people who forgot the delight and listen, and some of them get that of the increased from their anguish, as that can be recognized

5 – also these from which does good were administrative councils of pleasure, play, and joy, and walking with an abundance of looking at the moon. These are all the things considered from matter that change the lover's thinking about his lover.

Fourth - time of melancholy was emptied from the body and brought to an end against the negative factors in the flesh, as that with dehydration and cooling. Therefore, Al Razi advised by an abundance of washing with cold water, and to be cautious of hot things from food and drugs. In the same manner, he advised for sleep in cold places.

Fifth – the tendency to eat some foods that had the cooling quality, such as the alarming sour, watermelon, cucumbers, herbs, and other foods that had helped for the evacuation of melancholy time, and with the utmost cooling degree achieved follows.

Sixth – finally some doctors had advised to treat this disease that swayed some advanced in years for the lover in the place where they endeavored in the passage of the lover's desire to the other gradually that was the lovers. Thereafter, their action was cut off before he could desire the second.

Passionate Love Disease and Modern Medicine:

At the end of this research, I have to point to the modern medical purpose of passionate love disease. Some may ask why not search modern medical publications, especially Psychiatry Books which was called ancient passionate love disease?

For the answer to that, we must know that passionate love disease can be expressed in a form of emotional stress that the patient was subject to. As this emotional distress according to degree may result for them different having psychological diseases. And that depends on the personal and social background of the patient, with the circumstances surrounding it, as preferred for the personal readiness. Some of those who are subjected to emotional distress may be afflicted with Anxiety Neurosis, including some afflicted with the condition of Reactive Depression. Just as some of the patients, who had been afflicted with at first as split personality, with cases of Schizophrenia manifestations, like the condition with Schizophrenia with the youth or what is called by Schizophrenia of Adolescence.

From this we conclude that what is known for passionate love disease is explained as a form of emotional distress that may lead to the occurrence of serious mental disorders, which can lead sometimes for the risk of the occurrence of suicide, especially those who have been afflicted with the reactive condition of inertia .

Notes and comments:

(1) Aasee is a doctor
(2) Meoncholy: passivity disease or depression
(3) Lack of understanding
(4) Eye news in layers doctors, pp.51-52
(5) News in the eyes layers doctors, p 131
(6) Melancholy is the tendency of sadness or depression
(7) The Canon of Medicine, c 2, pp. 71-72
(8) Anthology of Medicine, c 3, p 49
(9) Meteor manuscript letter in the medical industry, the tribe Mardini, Paper 45
(10) Eyes the news in layers doctors, pp. 458-459
(11) The Canon of Medicine, c 2, p 72
(12) Meteor manuscript letter in the medical industry, paper 54
(13) Anthology of Medicine, c 3, p 50
(14) The Canon of Medicine, c 2, p 72
(15) The Canon of Medicine, c 2, p72

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Muslim Women's Health and Reproductive Health Concerns Due to the 2023-24 War on Gaza

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Keywords:*Gaza war; Gaza women's health; reproductive health Gaza; Gaza girls; Gaza girls health*

Abstract

Women's reproductive health and well-being were and are being severely destroyed prior to and throughout the 2023-24 War on Gaza. With an overwhelming majority of the Gazan population being Muslim, this paper explores the specific issues and problems Muslim women in Gaza are facing during this on-going war. Access to essential resources including medical supplies, water, and electricity has been restricted by the Israeli government. As such, their ritual purification and structured hygienic practices have been greatly impeded. While the vast majority of the casualties and injuries are women and children, the violations towards the reproductive health and well-being of Gaza's women and girls have also increased. Beyond the physical well-being of Gazan women, their spiritual sanctity has also been endangered as a direct result of the war. Mothers are greatly revered in Islam, and it is reported that gendered violence during war is a deliberate attempt to humiliate women and girls. The entire reproductive cycle has been terribly disrupted, from pregnancy and child delivery to breastfeeding and neonatal care. To address the protected group of women, girls, and children, we must work together as an academic community to continue to document such atrocities and, first and foremost, advocate for an immediate and permanent ceasefire, to end the occupation and allow sufficient and unimpeded humanitarian aid and resources into Gaza today.

Introduction

The colonial violence and settler apartheid which has intensified into the on-going 2023-24 War on Gaza has been classified as a genocide.1,2,3 The occupation of Palestine since 1948 has caused destruction and devastation that disrupts every Palestinian and Gazan's health and human rights. 2,4,5 Since women's reproductive health and well-being are being severely destroyed, the war on Gaza is a feminist issue.5 With the overwhelming majority of the Gazan population being Muslim, this paper explores the specific issues and problems Muslim women in Gaza are facing, as well as their needs during this on-going war.

Muslim women have long been marginalised in medicine, beyond what is currently taking place in Gaza and Palestine. The first image to come to mind when a non-Muslim person thinks of a Muslim woman is a female being oppressed and restricted by the scarf on her head.6 Khan et al. commented that such a generalised and reductive perception of Muslim women has relegated

them to the peripheries of healthcare, by disproportionately discriminating against them as healthcare providers in healthcare settings.6 Khan et al. criticised this stereotype of Muslim women and stated that it results in depleting them of adequate and comprehensive healthcare as female patients and impeding them from delivering safe care as female Muslim physicians and healthcare providers.6

Such conditions are further intensified in the apartheid against Palestinian women and children. Access to essential resources including medical supplies, water, and electricity has been restricted by the Israeli government.4,5 With no supply of reproductive and menstrual care, the prevalence of infections increases every day.7 At the same time, the spiritual sanctity of Gazan women has been endangered as a direct result of this war beyond physical well-being.

Cleanliness is a hallmark of Islam, with physical cleanliness signifying religious purification.8 Reduced access to water and sanitation supplies prevents the passage of ablution, which is required for several religious practices and is central to a Muslim's state of being. This essay highlights how the physical and spiritual well-being of Muslim women in Gaza is being threatened, making this war a feminist issue that must be urgently addressed.

Muslim Women's General Hygienic Lifestyle and Needs

Ritual purification, or *tahara* in Arabic, dictates physical and spiritual cleansing practices for Muslims.8,9,10 Muslims can attain religious renewal by performing such acts of worship to Allah. For example, Islamic practice involves purifying oneself through ablution, or *wuduu* in Arabic, before the five daily prayers.9,10 Ablution involves using water to wash one's hands, arms, feet, and face. Ablution becomes invalid after defecation, urination, sleeping, flatulence, and more. Practising Muslims are habitually in a state of cleanliness.

Full ablution, or *ghusl*, which involves the washing the entire body from head to toe, is required after sexual relations. Muslim women must also perform full ablution after the completion of their menses and postpartum bleeding.10 Muslims may perform dry ablution, or *tayammum* (purification using dry soil) if clean water is unavailable or in insufficient supply.11 By performing ablutions and maintaining cleanliness, Muslims seek to get rid of physical impurities. They also serve as spiritual purifications, as Muslims strive to attain a state of inner devotion and closeness to Allah.

The structured hygienic practices outlined in Islam benefit both the individual and their community. Such practices can be linked to decreased disease transmission during the Covid-19 pandemic.9 The religious beliefs that dictate physical cleanliness have also instilled resilience and hope within believers as they combat difficulties such as living through a pandemic.

The Impact of War on Muslim Women's Health and Well-being

As Muslim women navigate purity through religious norms, it becomes essential to evaluate the impact of conflict and war on resources and religious identities.12 For instance, many Muslim women in India have found solace through routine religious practices, including performing daily ablution and prayers, when a rise in Islamophobia has threatened the livelihood of their Muslim communities. They have worked towards maintaining an inner connection with Allah through cleanliness and physical piety in a time when an outward one might endanger them. Similarly, religious practices have been impeded in Gaza's on-going war when a scarcity of clean water prevents women from performing ritual ablutions.13

Another example is the health and safety of female Syrian refugees who were threatened during the ongoing Syrian war conflict since March 2011.14 Syria is a Muslim-majority country with 92.8% Muslim.15 In this case, women were displaced from their homes and into new environments, resulting in isolation and anxiety.14 The study of Al-Natour, Morris, and Al-Ostaz observed that the emotional and physical well-being of these women worsened as access to medication and healthcare services became scarce—all of which became a testament of the will of refugee women working to keep the family unit together through culture and religion.14 Muslim women in Gaza face the same challenges as the result of the on-going war. As of March 2024, more than one million Gazan females have been displaced due to the current war.13,16,17

The Impact of the 2023-24 War on Gaza on Muslim Women's Health and Well-being

The violation of women's health and human rights by the Israeli occupation did not start on October 7, 2023; such violation was present before June 2007 when the siege

and closure policy was first enforced by Israel.1,16 The violations became more dire after October 7, 2023 when 67% of all casualties were observed to be women and children within the first month of the war.7 As of March 2024, the War on Gaza has taken the lives of more than 10,000 women,13 and more than 19,000 women have been injured. More than 3,000 women may have become widows and more than 10,000 children may have lost their fathers, thereby making more women the heads of their household. Thirty-seven mothers are killed in Gaza every day.16,17

There are many verses in the Qur'an that emphasise the importances of parents and specifically mothers in Islam. Most significantly, verse 46:15 states that 'And We have enjoined upon man, to his parents, good treatment. His mother carried him with hardship and gave birth to him with hardship, and his gestation and weaning [period] is thirty months'.18 This Qur'anic verse acknowledges the difficulties mothers experience during pregnancy, childbirth, nursing, and weaning a child. As such, Muslim children are commanded to respect and treat their mothers with care. The verse continues to explain that when a Muslim reaches adulthood, if they repent and remain grateful for all their blessings, then they too would ask to bear righteous Muslims as their children. Therefore, the reproductive life cycle and the roles women play in their families are known and revered by practising Muslims.

Awadallah's criticisms included the statement that gendered violence during war is a deliberate attempt to humiliate women and girls.16 Al- Halabi holds similar opinions stating that the current war prevents women from giving birth and nurturing their newborns in a safe, secure, and healthy environment because women's freedom to carry a child to full-term with proper nutrition has been impeded.1 Additionally, Al-Halabi criticised how pregnant women in Gaza are projected by the occupiers to be an enemy because they are carrying future Palestinian generations and their resistance figure to keep the family together.1 The author further explained that this reframing of Gazan women as the enemy by the occupiers distorts the traditional view of Gaza's society of child-bearing and nurturing Muslim mothers, exploiting women's identity and gender. Since the family unit is the foundation of Gaza and Palestinian society, the War disrupts Gazan women's national identity and dismantles the social structure that enables them to display their resilience in retaining and re-forming their family. Inhibiting women from giving birth to the next generation of Gazans deteriorates Gaza's traditions, culture, and existence.1

Gaza has been denied water, sanitation, and hygiene (WASH) services long before the current war began.13 However, the severity of the restrictions has increased dramatically with the war. For example, 70% of Gaza's civilian infrastructure (such as homes, hospitals, schools, and WASH facilities) has been destroyed or severely damaged.19 This leads to additional loss of daily essentials like hot water, food, electricity, and medical supplies.4,5,16 Without access to sanitary resources and clean water, women are at risk for health complications related to dehydration, urinary infections, menstrual hygiene, and pregnancy.13 With no supply of reproductive and menstrual care, the prevalence of infections increases every day.7 Not surprisingly, this has placed immense psychological stress on women and families in Gaza (Sabet et al. 2024).20

According to estimates from the UN Population Fund (UNFPA), since October 7, 155,000 women in Gaza are pregnant or breastfeeding, with 5,500 expected to deliver in every month.17 UNFPA further reported that Gazan women and girls did not have adequate access to reproductive health care services.16 As of February 29, 2024, many of the 17,000 women who gave birth during the war underwent caesarean sections without anaesthesia.16,20 A 300% increase of miscarriages was reported due to the war, and anyone undergoing the process of in vitro fertilisation was halted mid-treatment.20 Muslim women patients prefer and are more comfortable to be treated by female physicians and healthcare workers, specifically during obstetrics and gynaecology care, when possible.21 However, this war leaves women with no such option and forces them to give birth in public areas, such as birthing in the corridor of a hospital, with no privacy and care at all.1 It is apparent that all forms of reproductive health, from childbearing to child rearing, have been severely violated during this war on Gaza. Women and mothers bear the highly unfortunate burden of knowing that the United Nations called Gaza during this 2023-24 War the "most dangerous place to be a child".17

Conclusion

There are numerous medical interventions and practices that must be outlined to specifically address women and girls' health problems in Gaza. Therefore, we urge the greater feminist and humanitarian aid community to further explore and document such research and recommendations. Our goal in this essay is to shed light on the many issues and show the War on Gaza is a feminist issue, from an Islamic perspective for Muslim-majority Gaza. Areas needing academic attention include

but are not limited to the War on Gaza and prenatal and postnatal care of Muslims. It is essential to document the various ways Gazan Muslim women handle their menses and postnatal bleeding despite not having sufficient supplies of water or laundry, and document how Gaza women handle menopause which also leads into geriatric care. To address the protected group of women, girls, and children, we must work together as an academic community to continue to document such atrocities and, first and foremost, advocate for an immediate and permanent ceasefire, to end the occupation and to allow sufficient and unimpeded humanitarian aid and resources into Gaza today.

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References

1. Al-Halabi M. The Women of Gaza during the Current Genocide: Women, War and Resistance. *Policy Paper* 2024; 030. Lebanon: Institute for Palestine Studies. https://www.palestine-studies.org/en/node/1655116

2. GPCJournal. Call For Paper: Genocide is a Feminist Issue. *Gender, Place and Culture* 2023; Dec 21. https://genderplaceandculture.wordpress.com/2023/12/21/call-for-papers-genocide-is-a-feminist-issue.

3. Selcer R, Surya SL. Settler Colonialism and Health in Palestine: A Call to Action. *Health and Human Right Journal* 2023; Dec 20. https://www.hhrjournal.org/2023/12/palestine-health-and-settler-colonialism-a-call-to-action/.

4. Barr, H. Israel's Unlawful Blockade of Gaza Sparks Women's Rights Crisis: Lack of Treatment, Medicine Pose Risk to Women and Girls. *Human Rights Watch* 2023; Oct 24. https://www.hrw.org/news/2023/10/24/israels-unlawful-blockade-gaza-sparks-womens-rights-crisis.

5. Salla Dieng R. Why Palestine is a feminist and an anti-colonial issue. *ROAPE Journal* 2023; Nov 21. Available from: https://roape.net/2023/11/21/why-palestine-is-a-feminist-and-an-anti-colonial-issue/.

6. Khan S, Eldoma M, Malick A, Najeeb U, Furqan Z. Dismantling Gendered Islamophobia in Medicine. *Canadian Medical Association Journal* 2022; 194(21): E748-E750. https://doi.org/10.1503/cmaj.220445

7. WHO (World Health Organization). *Women and newborns bearing the brunt of the conflict in Gaza, UN agencies warn*. WHO, Nov 3, 2023. Available from: https://www.who.int/news/item/03-11-2023-women-and-newborns-bearing-the-brunt-of-the-conflict-in-gaza-un-agencies-warn.

8. Hamid LA, Toyong NMP, Rahman AA. Hygiene Practice and the Adaptation of the Modern Muslim. *Procedia - Social and Behavioral Sciences* 2016; 222: 800-806. https://doi.org/10.1016/j.sbspro.2016.05.170.

9. Mahayosnand PP, Gheno G, Sabra AM, Sabra DM. Muslim-majority countries have fewer COVID-19 cases and deaths: a cross-country analysis of 165 countries during the 3 global peak dates in 2020-2021. *HPHR* 2021;48. https://doi.org/10.54111/0001/vv2.

10. Osim SE, Eteng NG. Women and Ritual Purity in Islam. *Indonesian Journal of Social and Educational Studies* 2021; 2(1): 117-127. Available from: download.garuda.kemdikbud.go.id.

11. Adam NJ. *Kitab Al-Salaah (The Book of Prayer)*. 1991. https://islambasics.com/book/kitab-al-salaah-the-book-of-prayer/

12. Vasudev R, Inbanathan A. Performance of Piety: Lived Experiences of Muslim Women. *Institute for Social and Economic Change* 2021; ISEC Working Paper No 522. Available from https://www.isec.ac.in/wp-content/uploads/2023/07/WP-522-Romica-Vasudev-and-Anand-Inbanathan-Final.pdf.

13. UN Women. *Gender alert: Scarcity and fear: A gender analysis of the impact of the war in Gaza on vital services essential to women's and girls' health, safety, and dignity – Water, sanitation, and hygiene (WASH)*. UN Women, Apr 2024. Available from: https://www.unwomen.org/en/digital-library/publications/2024/04/gender-alert-gender-analysis-of-the-impact-of-the-war-in-gaza-on-vital-services-essential-to-womens-and-girls-health-safety-and-dignity.

14. Al-Natour A, Morris EJ, Al-Ostaz SM. Through Her Eyes: The Impact of War on Syrian Refugee Families. *Journal of Transcultural Nursing* 2022; 33(1): 26-32.https://doi.org/10.1177/10436596211026367.

15. Muslim Majority Countries. *World Population Review* 2024; Aug 7. Available from: https://worldpopulationreview.com/country-rankings/muslim-majority-countries.

16. Awadallah A. The forgotten women and girls in Gaza: A sexual and reproductive health catastrophe. *Bond* 2024; Feb 29. https://www.bond.org.uk/news/2024/02/the-forgotten-women-and-girls-in-gaza-a-sexual-and-reproductive-health-catastrophe/.

17. UN Women. *Facts and figures: Women and girls during the war in Gaza*. UN Women 2024a; Apr 16. Available from: https://www.unwomen.org/en/news-stories/feature-story/2023/10/facts-and-figures-women-and-girls-during-the-war-in-gaza.

18. Al-Muntada, Al-Islami. *The Noble Qur'an - Translation of the Meaning of the Qur'an*. Translated by Saheeh International. Riyadh: AbulQasim Publishing House, 1997.

19. UN Women. *"We need real action"—Palestinian women speak of hope and resilience amid the horrors of war in Gaza*. Palestine: UN Women, 2024c. Available from: https://palestine.unwomen.org/en/stories/feature-story/2024/04/we-need-real-action-palestinian-women-speak-of-hope-and-resilience-amid-the-horrors-of-war-in-gaza-0.

20. Sabet C, Nguyen D, Nada SA, Abuzerr S, Taha AM. Women and girls in Gaza are increasingly dire physical and mental health challenges. *BMJ* 2024; 384: q625. https://doi.org/10.1136/bmj.q625.

21. Mahayosnand PP, Gomez S, Ahmed S, Sabra ZM. Muslim Women Have a Gender Preference for Female Physicians. *JBIMA* 2024; 16(6). https://www.jbima.com/article/muslim-women-have-a-gender-preference-for-female-physicians/

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Face Masks and the Niqab: Learning from the Parallel

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The Niqab in Islam:

Many Muslim women around the world choose to wear the Niqab (face veil) for the pleasure of God. While opinions on its necessity differ within the Muslim community, Islamic teachings provide strong legal and scholarly support for its practice. For Muslim women, wearing the niqab is a means to seek the pleasure of God rather than responding to societal pressures.

Unfortunately, western media often misrepresents the niqab, implying that it is worn out of coercion rather than personal choice. However, many women, equate it with an expression of freedom – a freedom that liberates them from the world's focus on women's bodies and sexuality.

Niqab and Islamophobia

In recent years, the niqab has been unfairly linked with extremism often in conjunction with Islamophobia. Despite their strong desire to wear the niqab, many Muslim women find themselves in doubt due to the hostility and scepticism they face in Western societies. [1]
Public debates in the UK, particularly in the media, have ridiculed the niqab, with political figures even using derogatory terms like "letterbox" to belittle Muslim women who wear it. Such comments have caused immense distress within the British Muslim community. Similarly, in 2010, France passed a law prohibiting the wearing of full-face coverings in public spaces, further contributing to the stigmatization of the niqab. This has impacted Muslim women in job interviews and at times rendered them unsafe in Public. [2]

Face masks and the Niqab: a comparison

The global COVID-19 pandemic brought about a universal requirement for face masks, enforced by health authorities worldwide. As a result, wearing face masks became mandatory in hospitals, workplaces, shopping malls, and public spaces. Various forms of PPE(personal protective equipment)were introduced in various health care settings. From surgeons and physicians to nurses and ICU staff, all adhered to wearing the appropriate face mask coverings based on the requirements of their roles. Remarkably, no one questioned the need for identification, communication, or personal choice when it came to wearing face masks. Life continued as normal, even with people covering their faces.

In contrast, Muslim women who choose to wear the niqab face constant scrutiny and judgment. They are often asked questions such as, "How can anyone identify you?" or "Are you forced to wear this by your husband?" In Western societies, where secularism often clashes with religious practices, the niqab is frequently seen as a barrier to communication, a symbol of extremism and a sign of oppression.

Some people within the Muslim community also question a woman's choice to wear the niqab, saying it is not required in Islam.

The struggle of wearing the niqab in the NHS

In the UK, Muslim women have been advised to remove their face veil when taking exams such as the Professional and Linguistic Assessments Board (PLAB) exam, a challenge I personally faced. Many NHS trusts' uniform policies previously overlooked religious attire, such as the niqab and hijab, and failed to acknowledge the religious significance of personal clothing choices.

However, thanks to the efforts of advocates within organisations like BIMA (British Islamic Medical Association), dress code policies have been updated to accommodate religious attire, such as allowing hijabs in healthcare settings and providing options for full-length sleeves in wards to accommodate Muslim women working in the NHS. [3] [4]

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Although wearing veils (Christian or niqab) is now permitted on religious grounds in the uniforms and workwear guidance for NHS employers, practically there are still significant barriers to accepting the niqab in certain professional settings, especially within the NHS. [5]

Understanding and respecting the Niqab

The COVID-19 pandemic showed how attitudes toward face coverings could change. With face masks being mandatory worldwide during the global Covid 19 pandemic, many Muslim women found themselves less judged and less discriminated against. The global response to face masks showed that communication and identification was not a problem and business could function smoothly despite face coverings.[6]

So, if the world can operate efficiently with face masks, why should there be scepticism about Muslim women wearing the niqab? Muslim women, like all individuals, are capable of excelling in all industries, from business to aviation to surgery, while wearing the niqab. The face veil is not a barrier to professional success or personal achievement, and it should not be perceived as such.

References:

1. https://www.amnesty.org/en/latest/news/2020/05/face-masks-and-niqabs/
2. https://www.channel4.com/news/birmingham-niqab-ban-a-safety-precaution-or-islamophobia
3. https://britishima.org/advice/hbbe-policy-changes-update
4. https://www.england.nhs.uk/coronavirus/documents/uniforms-and-workwear-guidance-for-nhs-employers/#:~:text=Uniforms%20must%20be%20clean%20at,travel%20to%20and%20from%20work
5. https://www.independent.co.uk/news/uk/politics/few-if-any-muslim-hospital-workers-wear-full-veil-8826042.html
6. https://www.researchgate.net/publication/237289463_Effects_of_different_types_of_face_coverings_on_speech_acoustics_and_intelligibility

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Profile: Gaza Doctors and Healthcare Workers as Role Models in Islam

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Keywords: ***Gaza healthcare workers**, Gaza doctors, Gaza physicians, Muslim **doctor, Muslim** physician, war Gaza*

Practicing medicine is considered a noble profession in Islam (1, 2). The ideal Muslimphysician must be trustworthy, compassionate, and have the genuine desire to alleviate their patient's physical, mental, and emotional pain. They must acknowledge and value their roles as knowledgeable advisors and pure-intentioned do-gooders who are entrusted with their patient's care.

Muslim physicians must be humble and understand that they are not healers, for only Allah heals. (1, 2) With patience and steadfastness, they have the profound opportunity to positively influence their patient's lives. Optimally, a Muslim doctor should adhere to the following hadith:

A Muslim is a Muslim's brother: he does not wrong him or abandon him. If anyone cares for his brother's need, Allah will care for his need; if anyone removes a Muslim's anxiety, Allah will remove from him, on account of it, one of the anxieties of the Day of Resurrection; and if anyone conceals a Muslim's fault, Allah will conceal his fault on the Day of Resurrection. (Sunan Abi Dawud 4893, 43:121) (1, 3)

Throughout this brutal war on Gaza (4), there have been deliberate attacks on the healthcare system. (5, 6, 7, 8, 9) Yet Gazan physicians have shown they possess admirable characteristics, (10, 11) unshakable faith, (12) and an ability to be insanely resourceful. (7, 13) They work unpaid 24-hour shifts, (7, 11) are detained, (14) shot at, (15) and killed. (6, 7, 12) They choose duty over the natural human desire to escape safely with family. (7, 12) Often, they only reunite with their families when they arriveinjured or dead at the hospital. (16, 17, 18)

Their mental and religious strength is indescribable by humanitarian mission workers volunteering to assist them. (7, 11, 12, 19) This war's healthcare workers should be studied by all Muslims not just those in the healthcare profession.

Additionally, Gaza's community atlarge should be acknowledged for their efforts to create such aspirational leaders. It is seen as an Islamic duty upon the entire community (fard kifayah) to train and have a sufficient number of healthcare workers to serve them. (2)

All 3 of my children were medical students at the Islamic University of Gaza, (20)2 of whom were wartime volunteers. I can attest to the fact that the entire community of extended family, friends, and neighbours, as well as the medical school and hospital system (from the north's Indonesian Hospital to the south's European Hospital) actively supported thenew generation of physicians-in-training.

Living in Gaza as a non-Arab and American was challenging. However, it was ablessing to liveamong some of the best Muslims in this world. Having travelled to 49 States and 18 countries, I am not inexperienced.

ISSN 2634 8071

Evacuating this war means my family and I lost and suffered much. However, we have not lost our memories, nor have we lost our experiences. As painful as it is, I feel compelled to tell the tales of and historicise Gazans. (21) It is my hope thatGazan healthcare workers can be studied and, God willing, emulated.

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Reference

1. Mahayosnand, MPH PP. Taking Care of the Sick - A Rewarding Islamic Obligation for Muslims. In: Grasso ME, editor. The Ethics of Care in Times of Social and Moral Upheaval: Utopia or Reality? Cambridge Scholars Publishing; p. 132–62. Available from: https://www.cambridgescholars.com/product/978-1-0364-0233-4

2. Chamsi-Pasha H, Albar M. Doctor-patient relationship. Islamic perspective. Saudi Medical Journal. 2016 Feb 1;37(2):121–6. https://doi.org/10.15537/smj.2016.2.13602

3. Sunan Abi Dawud 4893 - General Behavior (Kitab Al-Adab) Sunnah.com - Sayings and Teachings of Prophet Muhammad (صلى الله عليه و سلم) [Internet]. Sunnah.com. 2024. Available from: https://sunnah.com/abudawud:4893

4. Ijaz N, Habib AR. Public Health Crisis in Gaza—The Responsibility of US-Based Academic Medical Journals. JAMA. 2024 May 30 doi:10.1001/jama.2024.10766

5. Administrator. Attacks on health care in Gaza Strip unacceptable, says WHO [Internet]. World Health Organization - Regional Office for the Eastern Mediterranean. Available from: https://www.emro.who.int/media/news/attacks-on-health-care-in-gaza-strip-unacceptable-says-who.html

6. Palestine. Hospitals in the Gaza Strip at a breaking point, warns WHO [Internet]. World Health Organization - Regional Office for the Eastern Mediterranean. Available from: https://www.emro.who.int/opt/news/hospitals-in-the-gaza-strip-at-a-breaking-point-warns-who.html

7. Doctor Just Back from Gaza: Cutting UNRWA Funds Is "Unconscionable" as Hospitals Barely Functional [Internet]. Democracy Now! Available from: https://www.democracynow.org/2024/1/29/dr_thaer_ahmad_gaza_part2

8. WHO condemns targeting of ambulance convoy in Gaza | | UN News [Internet]. news.un.org. 2023. Available from: https://news.un.org/en/audio/2023/11/1143207

9. Ghada Al-Jadba, Zeidan W, Spiegel PB, Shaer T, Najjar S, Akihiro Seita. UNRWA at the frontlines: managing health care in Gaza during catastrophe. The Lancet. 2024 Feb 1; https://doi.org/10.1016/S0140-6736(24)00230-7

10. Samara S. OFFICIAL Gaza Healthcare Workers Nobel Peace Prize Nomination 2024 [Internet]. Change.org. 2023 [cited 2024 Aug 6]. Available from: https://www.change.org/p/official-gaza-healthcare-workers-nobel-peace-prize-nomination-2024

11. Now D. Chicago ER Doctor Just Back from Gaza Says Patients, Medical Staff Face Catastrophic Conditions [Internet]. Democracy Now! 2024 [cited 2024 Aug 6]. Available from: https://www.democracynow.org/2024/1/29/gaza_hospitals

12. "Beacon of Light": Fellow Doctors Recall Dr. Hamman Alloh, Gaza Doctor Killed by Israeli Airstrike [Internet]. Democracy Now! 2023; Nov 13 [cited 2024 Aug 6] Available from: https://www.democracynow.org/2023/11/13/medical_workers_killed_colleagues_mourn_hamma m

ISSN 2634 8071

13. Suha Hamshari, Sondos Hamadneh, Mukaram Ghneem, Khalaf R, Daqqa S, Rola Abu Alwafa, et al. Barriers faced by primary healthcare providers in addressing emergencies in the Northern region of Palestine before and during the Gaza war. BMC Primary Care. 2024 Jul 17;25(1). https://doi.org/10.1186/s12875-024-02512-3

14. Ramahi A, Alfiky A, Cornwell A. Gazan paramedic recounts alleged mistreatment in Israeli detention [Internet]. Reuters. 2024 [cited 2024 Aug 6]. Available from: https://www.reuters.com/world/middle-east/gazan-paramedic-recounts-alleged-mistreatment-israeli-detention-2024-07-11/

15. Al Jazeera English. Israeli snipers have been shooting civilians outside Nasser Hospital in #Gaza's southern city of Khan Younis, where 21 have been reportedly…https://www.instagram.com/p/C3IKxGXsCKa/ 2024; Feb 9. [cited 2024 Aug 6] Available from https://www.instagram.com/aljazeeraenglish/

16. Middle East Monitor. Gaza paramedic consoles his kids after Israeli air strike destroyed their home. 2023; Dec 16. [cited 2024 Aug 6] Available from https://www.middleeastmonitor.com/20231226-gaza-paramedic-consoles-his-kids-after-israeli-air-strike-destroyed-their-home/

17. Middle East Monitor. Gaza doctor in shock as her daughter is rushed in on a stretcher. 2023; Nov 1. [cited 2024 Aug 6] https://www.middleeastmonitor.com/20231101-gaza-doctor-in-shock-as-her-daughter-is-rushed-in-on-a-stretcher/

18. Al Jazeera. Palestinian doctor breaks down when he sees family at hospital. 2023; Oct 17. [cited 2024 Aug 6] https://www.aljazeera.com/program/newsfeed/2023/10/17/palestinian-doctor-breaks-down-when-he-sees-family-at-hospital-2

19. Bhimani A. Australian Doctor REVEALS Experience INSIDE Gaza [Internet]. YouTube: OnePath Network; 2024 May 23 [cited 2024 Aug 6]. Available from: https://youtu.be/pynvwAli_yo?si=2HDqiyw-53XTmEiA

20. Mahayosnand PP, Sabra ZA, Sabra DM. COVID-19 and Gaza: The Ideal Time to Establish a Medical Reserve Corps of Public Health Preventive Medicine Specialists. Health Security. 2021 Apr 8;19(2):235–9. https://doi.org/10.1089/hs.2020.0192

21. Refaat in Gaza @itranslate123 If I must die, let it be a tale. #FreePalestine #Gaza https://x.com/itranslate123/status/1719701312990830934 2023; Nov 1. [cited 2024 Aug 6] [Tweet]. Available from: https://x.com/itranslate123

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Sight Beyond Borders: The Inspiring Saga of FIMA Save Vision

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Abstract

The FIMA Save Vision (FSV) program, initiated in response to the Darfur crisis in 2004, has evolved into a global effort to combat preventable blindness. Led by renowned ophthalmologists, the program has established eye care facilities and conducted training workshops across Africa and Asia. Notable achievements include the creation of eye hospitals in Sudan, Sri Lanka, Pakistan, Afghanistan, and Somaliland, as well as the implementation of training programs for local medical personnel. The program has significantly improved access to eye care, reduced cataract surgery waiting times, and trained numerous eye specialists, thereby enhancing healthcare infrastructure in underserved regions. FIMA Save Vision's efforts have been recognized with prestigious awards and have inspired additional initiatives under the FIMA umbrella, demonstrating the transformative power of international collaboration in addressing public health challenges.

Background

The Darfur crisis of 2004 marked a pivotal moment for global medical outreach, catalyzing the launch of the FIMA Save Vision (FSV) program. During this crisis, Dr. Aly Mishal, then president of the Federation of Islamic Medical Associations (FIMA), held a crucial meeting with the Sudanese government. When asked how FIMA could assist with medical relief, the President of Sudan emphasized the dire need for ophthalmologists, saying: *'Ophthalmologists! Ophthalmologists!! and Ophthalmologists'*. At that time, the crisis-affected region of Darfur was divided into three areas:

Darfur North (Al-fashir): Population of 2 million, only one eye surgeon.
Darfur South (Nyala): Population of 2 million, only one eye surgeon.
Darfur West (Genina): Population of 2 million, no eye surgeon.

Recognizing the severity of the situation, Dr. Mishal conferred with Dr. Hafeez Ur Rahman, then General Secretary of FIMA, and together they launched an initiative to alleviate the suffering caused by visual impairment in these conflict-ridden regions.

Leadership from Inception to Present

Dr. Hafeez Ur Rahman: Founding Director FSV (2006-2012)
Dr. Intizar Hussain: Director FSV (2013-2016)
Dr. MisbahUl Aziz: Director FSV (2016-present)

First Steps in Darfur

In January 2005, the first free eye care camp was set up in Alfashir, North Darfur. Led by Dr. Hafeez Ur Rahman and Dr. Imran Azam Butt, the team successfully performed 250 cataract surgeries.After a couple of weeks another eye camp of 250 eye surgeries was conducted in Alfashir,North Darfur.

Expanding Reach: Genena and Beyond

Encouraged by the results of the first two camps, a thirdcamp was organized two months later, supported by the Government of Sudan in collaboration with PIMA, SIMA, Alkhidmat, and FIMA in Genena, West Darfur, a region with no prior history of eye surgery and not a single inch of metallic road connections. The local airport had carcasses of crashed planes. Thepower supply was only through generators.

Here, the team conducted 500cataract surgeries. Seeing the backlog of cataract, another camp of 1005 cataract surgeries was done in the same area after few months. At the end of this second camp 1000 patients were still awaiting treatment to which Sudanese government responded by requesting the visiting team to stay longer.This led to the establishment of first FIMA Eye hospital in Genena.

Formation of FIMA Save Vision

In 2006, parallel eye camps wereconducted in Gadarif and Kasala, Sudan, which marked a significant milestone in the field of eye care in Africa. During this camp, a team of doctors from five different countries Pakistan, South Africa, Jordan, Egypt, and Bangladesh came together to perform a total of 1,000 cataract surgeries.

This collaborative effort was instrumental in formalizing the FIMA Save Vision programan initiative aimed at addressing the widespread issue of cataract-induced blindness in the region. Dr. Hafeez Ur Rahman (Ex- Gen Secretary FIMA) of the Pakistan Islamic Medical Association (PIMA) was the founding director of the FIMA Save Vision program

FIMA Save Vision: Objectives

The primary objectives of the FIMA Save Vision programare to:

1. Reducing the backlog of cataract by doing eye surgeries through regular eye camps.
2. Establishing indigenous facilities with appropriate equipment
3. Capacity building by training of local human resource for continuous service delivery

Decreasing backlog of cataract surgery:

Following successful implementation of the initial eye camps in Alfashir, Genena, Gadarifand Kasla, the FIMA Save Vision program garnered significant support and sponsorships from the Sudanese government. This support enabled the expansion of the program, leading to dozens of additional eye camps across Sudan.

Expanding Global Reach

The FIMA Save Vision team extended its reach beyond Sudan, establishing multiple cataract surgery camps in various countries across Africa and Asia:

- **Africa**: Sudan, Somalia, Nigeria, Niger, Somaliland, Senegal, Mali, Burkina Faso, Gambia, Cameroon, Morocco, South Africa, Chad, Zimbabwe.
- **Asia**: Gaza (Palestine), Bangladesh, Maldives, Sri Lanka, Indonesia, Pakistan, Afghanistan, Syria.

Until now FIMA Save vision has conducted more than 950 eye camps in 22 countries. Around twenty-one hundred thousand (2.1 million) patients were examined in the OPD of these camps and more than three hundred and fifty thousand patients under-went free of cost cataract surgery with intraocular lens implantation.

Outpatient	2.1 million
Surgeries	>350,000
Countries	22
Eye Camps	>950
Students eye Screening	70,000 students in >200 schools

Brief Statistics of free eye camps

Glimpses of few camps:

Burkina Fasso

Nigeria

Gambia

Cameroon

Chad

IMA's Actively involved in Prevention of Blindness in Africa and other Places

- Prevention of Blindness Trust (POB) Pakistan Islamic Medical Association (PIMA)
- SIMA (Sudanese Islamic Medical Association)
- Doctors Worldwide Turkey
- Islamic Medical Association of Zimbabwe
- Islamic Medical Association of Kingdom of Saudi Arabia
- Islamic Medical Association of South Africa
- Islamic Medical Association of Somalia
- Horn of Africa Save Vision (Somaliland & Somalia)
- Islamic Medical Association of Nigeria
- Islamic Medical Association of Malaysia
- Islamic Medical Association of Indonesia
- Serendib Foundation of Sri Lanka

Partner organizationsother than IMA's:

- WAMY (World Assembly of Muslim Youth)
- IICO – KSA
- WHO-EMRO
- MOH Sudan
- Arab Medical Union
- Manhal Charitable Organization
- Alwaleed Bin Talal Foundation

Establishing indigenous facilities with appropriate equipment

FIMA Eye Hospital Genina – Sudan

The first eye hospital by FIMA Save Vision was established in Genina, Sudan. The government renovated

an old school building into a hospital and provided paramedical staff. The eye care equipment was sent from Pakistan, donated by PIMA. As there was no local consultant available in the region, Dr. Usman Saeed, a consultant ophthalmologist from Pakistan, stayed for two months to provide eye care and train a local doctor. According to the latest report from this hospital, more than 10,000 cataract surgeries have been performed there.

Dr. Hafeezur Rahman, Dr Intzar Hussain, Dr. Azhar Qazi with the local doctors at the inauguration of first FIMA Eye Hospital in Genena-Sudan

FIMA Eye Care Centre Puttalam - Sri Lanka

The FIMA Eye Care Centre in Puttalam, Sri Lanka, was established in 2008 to address the region's need for specialized eye care services. Staffed by experienced ophthalmologists and healthcare professionals, the centre is dedicated to providing high-quality, compassionate care. Known for its community outreach programs, the FIMA Eye Care Centre plays a vital role in enhancing eye health and vision for the local population. Thousands of cataract and other ocular surgeries have been performed to date.

FIMA Eye Care Centre Putlam- Sri Lanka

FIMA-POB Eye Centre in PMC – Peshawar, Pakistan

FIMA and POB designated the ophthalmology department of Kuwait Teaching Hospital, a relief hospital affiliated with Peshawar Medical College, as its regional center by sponsoring cataract surgeries for poor patients. Thousands of cataract surgeries have been performed at this center.

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POB Hospitals in other cities of Pakistan

Inspired by the success of the FIMA Save Vision program, where the majority of ophthalmologists providing voluntary services were from Pakistan, a similar trust was established in Pakistan called the POB Trust (Prevention of Blindness Trust). POB Trust, a project of PIMA (a member IMA of FIMA), is chaired by Dr. Misbahul Aziz (Director FSV). Apart from participating in relief activities and conducting free eye camps nationally and internationally in collaboration with FIMA Save Vision, this trust has established four state-of-the-art eye hospitals in Karachi and one in Lahore. These hospitals provide free eye care services.

POB Eye Hospital in Karachi offers services in all ophthalmology subspecialties, including Vitreo-Retina, Glaucoma, Oculoplastic, etc. It is also recognized by the College of Physicians and Surgeons Pakistan (CPSP) for a four-year fellowship training in Ophthalmology.

One of the POB Eye Hospitals in Karachi

Vitreo-Retina and Oculoplastic Eye Surgical Unit in Kabul – Afghanistan

Afghanistan lacked a single vitreo-retinal surgical setup, forcing patients needing retinal surgeries to travel to Pakistan or India, incurring significant expenses. Due to its proximity to the Afghan border, the FIMA/POB Eye Centre at Peshawar Medical College frequently received many of these patients, offering surgeries at subsidized rates or free of cost. However, travel expenses still burdened the patients, and many could not afford them.

To address this issue, Afghanistan's first-ever vitreo-retinal surgical unit was established in 2022 at Al-Noor Eye Hospital in Kabul. POB Trust and Alkhidmat Foundation Pakistan sponsored this project by providing the unit with the latest surgical microscope, phaco machine, vitrectomy, and laser machines.

Vitreo-Retina and Oculoplastic Eye Surgical Unit. Kabul Afghanistan

Advanced Ophthalmic Surgical Training Centre Hargeisa – Somaliland

Somalia and Somaliland similarly lacked a vitreo-retinal surgical setup, forcing patients to travel to neighboring countries like Ethiopia, Kenya, or as far as India, which involved significant expenses. To address this issue, an advanced ophthalmic surgical training center was established in 2023. A surgical microscope compatible with retinal surgery was purchased from Pakistan, and a phaco-vitrectomy machine was acquired from Switzerland through a Turkish vendor. Both machines were installed at Manhal Specialty Hospital in Hargeisa. To date, two Phaco Training and Oculoplastic surgical camps have been organized, where local eye specialists were trained in microsurgical techniques by visiting consultants from Pakistan.

<u>Capacity building of local human resource for continuous service delivery:</u>

Postgraduate Diploma and Masters in Ophthalmology Program at Hargeisa, Somaliland

In 2006, Somalia had only 3-4 eye surgeons for its 13 million people, severely limiting access to eye care. The first cataract surgical camp conducted by FIMA Save Vision in Mogadishu benefited around 500 patients, but it became clear that temporary camps were insufficient for long-term impact.

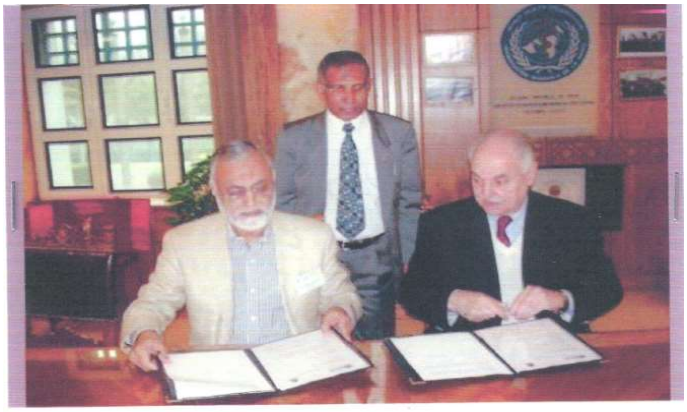
To address this, FIMA Save Vision, in collaboration with WHO-EMRO, MOH Somaliland, and Manhal Charitable Organization, launched an academic postgraduate program at Manhal Specialty Hospital, University of Hargeisa, in partnership with Peshawar Medical College and Riphah International University Islamabad. The first batch of six students was admitted in 2013. Dr. Aslam Bhatti, a consultant ophthalmologist from Pakistan, was appointed as a full-time professor. Regular visits by external faculty from Pakistan ensured high-quality training. The program was upgraded to master's level in 2016.

To date, 24 eye surgeons have graduated with a Diploma, and 5 surgeons have graduated from the Master's Program. They are providing ophthalmic services in various parts of Somalia and Somaliland. Inspired by their trainers' teachings, they also conduct free eye camps throughout the country and other regions of Africa under the Horn of Africa Save Vision initiative. This has led to a significant improvement in ophthalmological services across Somalia, Somaliland, and the Horn of Africa

Phaco, Vitreo-Retinal, and Oculoplastic Training Program, Hargeisa – Somaliland

Keeping the significant impact of the Diploma and Masters in Ophthalmology program on the eye care services of Somalia and Somaliland in mind, Alkhidmat

Foundation sponsored the equipment for establishing the Advanced Ophthalmic Surgical Training Centre at Manhal Specialty Hospital, Hargeisa. Three Oculoplastic and Phaco surgical training camps were organized in 2023, two in Somaliland and one in Somalia.



Professor Dr. Hafeez Ur Rahman
Director FIMA Save Vision Program

Hussein Gezairy, M.D., F.R.C.S
Regional Director, WHO/EMRO

Dr. Hafeezur Rahman and Dr Intzar Hussain with the students and resident Faculty

Dr. MisbahulAziz(Current Director FSV)at the graduation ceremony of second batch

Dr. Hafeezur Rahman, Dr MUsman and Dr Aslam Bhatti (Resident Faculty) with the graduates of DO-4th batch

Dr. Misbahul Aziz addressing the launching ceremony of Master's Program

Dr. Ahmed Noor and Dr. Mahmoud Shiine graduates of MS Batch-1 receiving their Degrees from President of Somaliland

Dr. Idrees and Dr. Usman with the trainee doctors Somaliland

Dr. Idrees and Dr. Usman with the trainee doctors in Somalia

Workshops for Doctors and Paramedics

Since its inception, FIMA Save Vision, in collaboration with member IMAs, has conducted multiple workshops in Africa, Pakistan, Afghanistan, and Gaza. A short summary of a selected few is mentioned below:

- **Workshop on Oculoplastic at Khartoum and Genina**: The first workshop was conducted in December 2006. Prof. Dr. Imran AkramSahaf and Dr. Intizar Hussain trained local eye specialists in diagnosing and managing a variety of difficult oculoplastic cases.
- **Workshop for Doctors at Lagos and Katsina - Nigeria, June 2008**
- **Workshop for Paramedics in Lagos and Katsina**
- **Corneal Transplant Workshop in Sudan**: A workshop and free corneal transplant eye camp was conducted in Sudan. Ten donor corneas were provided from Sri Lanka through the help of Mr. Rafiq, the administrator of Kuwait Hospital Puttalam, in collaboration with the Serendib Foundation. Prof. Dr. Abdul Haye and Dr. Intizar Hussain trained local doctors in two types of transplant procedures: penetrating keratoplasty and DALK (deep anterior lamellar keratoplasty).
- **Workshop for Eye Surgeons in Oculoplastic and Vitreo-Retinal Surgeries - Gaza**: A training workshop for local eye surgeons in Gaza was conducted in February 2013. They were trained in vitreo-retina and oculoplastic surgeries by Dr. Imran Ghayyor (vitreo-retinal consultant), Dr. Imran Akram
- **Phaco Training Workshop for Foreign Eye Specialists in Pakistan**: A hands-on training workshop was conducted in Lahore, Pakistan, where eye specialists from Egypt, Jordan, Sudan and Palestine were trained in phacoemulsification surgery for cataract removal.
- **Multiple Training Workshops for Local Eye Specialists and Paramedics in Pakistan**: 23 workshops have been conducted for doctors and paramedics to date, with 356 participants.

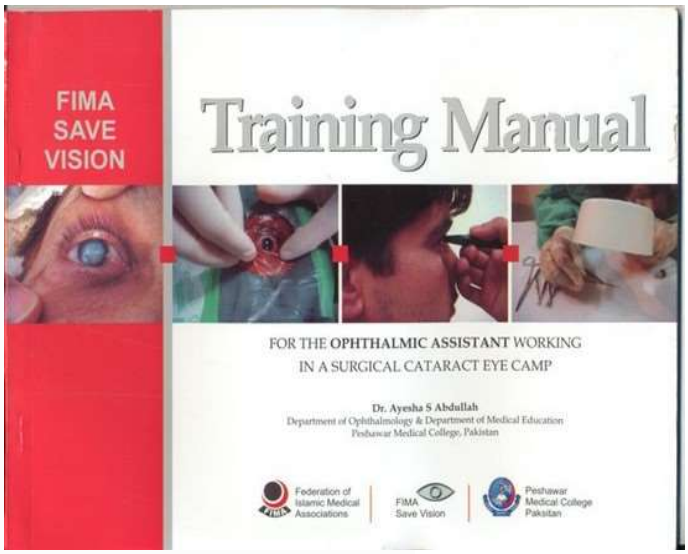
Glimpses of Few workshops/Training sessions:

Workshop for doctors at Lagos and Katsina- Nigeria June 2008

Workshop for doctors at Lagos and Katsina- Nigeria June 2008

Workshop for Paramedics Lagos and Katsina:

Workshop for Paramedics Lagos and Katsina:



Training Manual for Paramedics

Training workshop for Paramedics, Malakal-Sudan October 2008

Phaco-training Afghanistan

Vitreo-Retinal,Oculoplastic and phaco Training program, Kabul- Afghanistan

A series of three eye camps were organized in 2022 and 2023 to train local eye specialists in retinal and oculoplastic surgeries. These camps also offered free cataract, vitreo-retinal, oculoplastic and corneal transplant surgeries

Corneal transplant	12
Cataract surgeries	1170
Oculoplastic surgeries	88
Vitreo-Retina Surgery	56
Total OPD Screening	>10000

Statistics of three training workshop and surgical camps in Kabul Afghanistan

One eye specialist from Afghanistan was then enrolled in a training program at Peshawar medical college and he was trained in Vitreo-retinal and Corneal transplant surgery for one year. Now after training, he is providing eye-care services in Afghanistan.

Awards and Recognition

Recognizing the significant impact of the FIMA Save Vision program in eye healthcare, it has received several prestigious awards:

1. **The Richard and Hinda Rosenthal Award - 2009**: Presented at the annual convention of the American College of Physicians, this award honors exceptional innovation and effectiveness in healthcare.

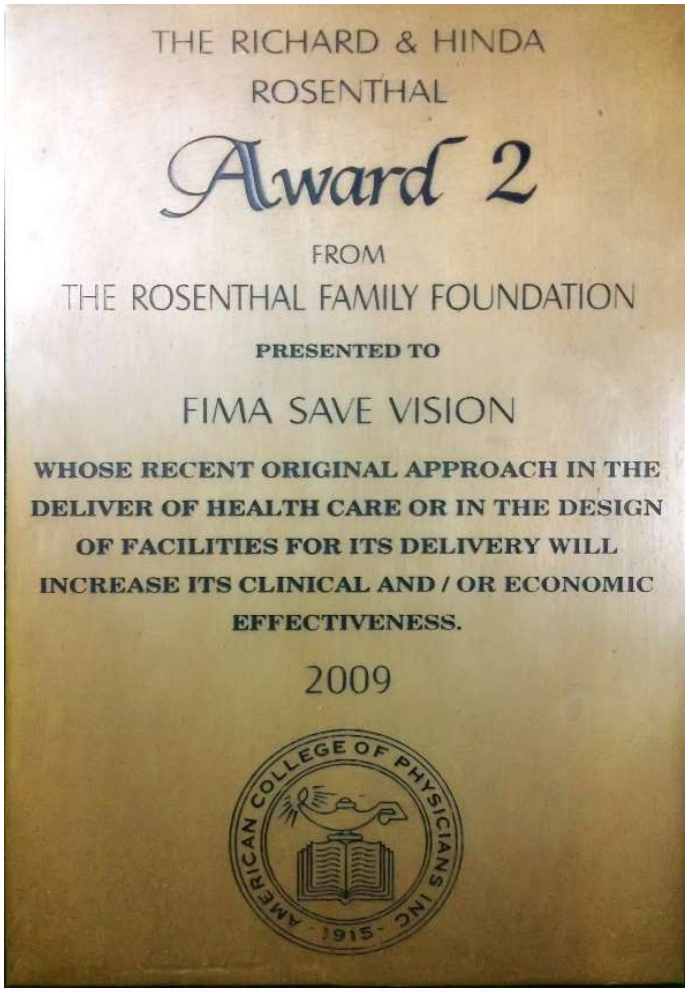
2. **FIMA Lifetime Achievement Award**: Dr. Hafeez Ur Rahman and Dr. Adnan Jaljuli were awarded the FIMA Lifetime Achievement Award in recognition of their services to FIMA and FIMA Save Vision.

3. **APAO Award**: The Asia-Pacific Academy of Ophthalmology presented this award to Dr. Intizar Hussain in recognition of his services in preventing blindness in the Asia-Pacific region through FIMA Save Vision and POB Trust.

4. **OSP Gold Medal**: The Ophthalmological Society of Pakistan presented this gold medal to Dr. Intizar Hussain in recognition of his services in preventing blindness through FIMA Save Vision and POB Trust.

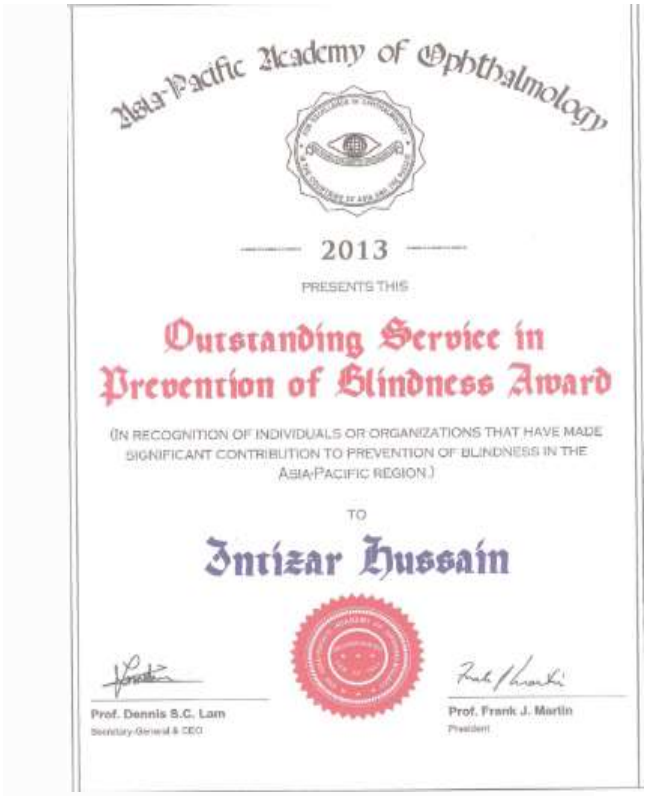
5. **Nimatullah Khan Lifetime Achievement Award**: Dr. Intizar Hussain received this award in 2019, and Dr. Misbahul Aziz received it in 2023.

Dr. Parvaiz Malik (President FIMA) with Dr. Jeffrey Harris (President American College of Physicians) to receive The Richard and Hinda Rosenthal Award at the convocation of American College of Physicians 2009



The Richard & Hinda Rosenthal Award

FIMA Lifetime Achievement Award. Dr Hafeezur Rahman



Asia-Pacific academy of Ophthalmology award

Dr. Misbahul Aziz Receiving 'Nimatullah Khan Life time achievement award'

Dr. Intzar Hussain Receiving 'Nimatullah Khan Life time achievement award'

Impact to Date

Example of Regional Impact: Somalia & Somaliland

Indicator	2013	2021
Population	13 Million	16 Million
Region Access	2	10
Qualified Doctors	3	32
Cataract Surgery Rate	230/Million/Year	1200/millon/year
Cataract Surgery Waiting time	>2 Years	<2months

Impact of training Program in Somalia/Somaliland

Like Somalia/Somaliland, FSV program had a significant impact in eye care services in various parts of Africa and Asia specially by decreasing the backlog of preventable

blindness by doing more than 350,000 cataract surgeries. Establishing sustainable eye care centres and training eye specialists and paramedics

Conclusion

FIMA Save Vision's history is a testament to the power of collaboration and dedication in addressing global health crises. From its origins in Darfur to expanding across Africa and Asia, the program continues to restore sight and hope to thousands, embodying the true spirit of humanitarian aid.

The FIMA Save Vision program represents a remarkable collaborative effort among the member Islamic Medical Associations (IMAs) of the Federation of Islamic Medical Associations (FIMA). By coming together under a unified umbrella, these organizations have successfully pooled their resources, expertise, and dedication to work towards a common goal: the eradication of preventable blindness through comprehensive eye care initiatives.

This collective endeavour has led to outstanding results, demonstrating the power of international cooperation in addressing significant public health challenges.

Success story of FSV was instrumental to start otherprograms like FIMA Save Smile, Fima Save Dignity, Fima Save Heart and so on under the umbrella of FIMA.

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Research

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A Qualitative Exploration of Lived Experiences of Religious OCD within Muslim Communities

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Keywords: *Religious OCD, Obsessive-Compulsive Disorder, Religiosity, Waswasa, Compulsions, Black and White Thinking, Support, Coping, Muslim, Islam, Mental Health*

Abstract

Obsessive-Compulsive Disorder (OCD) is an anxiety disorder that is characterised by two distinct symptoms; obsessions, compulsions or both (American Psychiatric Association [APA], 2013; Besiroglu, Karaca&Keski, 2012). Often overlooked, Religious Scrupulosity or Religious OCD (ROCD) is a subtype of OCD which manifests as pathological guilt, doubt and distress arising from intrusive, unwanted thoughts, images, or urges about violating their religious, moral, or ethical beliefs (Huppert &Siev, 2010; Miller & Hedges, 2008).

This research sought to fill the gap in understanding the personal, lived experiences of Muslims with ROCD and increase accessibility of mental health services for such individuals. Using thematic analysis, this study found 5 main themes of ROCD sufferers: Finding purity when engaging in compulsions, Black and white perspective of Islam, Physically and emotionally challenging experiences, Lack of support and Ways of coping. The present study concluded by providing insightful implications and avenues of further research for healthcare providers, mental health professionals and members of the religious clergy.

Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) is an anxiety disorder that is characterised by two distinct symptoms; obsessions, compulsions or both (American Psychiatric Association [APA], 2013; Besiroglu, Karaca & Keski, 2012). Obsessions are repetitive, intrusive, distressing thoughts and ideas that the individual is unable to control (American Psychiatric Association, 2000). According to research, around 94% of the world's population encounters intrusive thoughts (Radomsky et al., 2010). Common obsessions can be presented as harm to oneself or others and fears of contamination (Foa & Kozak et al., 1995). Compulsions may be mental or physical

behaviours performed in accordance with specific rules that are implemented to reduce an individual's distress surrounding their obsessions (APA, 2000). Common compulsions include excessive cleaning and checking (Foa et al., 1995). What sets OCD apart from other anxiety disorders is that the obsessive thoughts, which are excessive and irrational, are then followed by compulsive actions to reduce the level of distress (Valentine, 2021), thereby significantly interfering with the person's daily functioning (American Psychiatric Association, 2005).

Conceptual models of obsessive difficulties propose that distress linked to doubt and obsessional preoccupation will lead to attempts, by the individual, to reduce this distress by attempting to control these thoughts, dismiss them, seek out their meaning, or take action to prevent feared consequences. For instance, the individual may repeat a particular act until perfect, ask others for reassurance about their doubts or avoid stimuli that trigger the thought occurrences. Thought suppression, compulsive rituals, avoidance behaviours, and other strategies though may seem helpful by reducing obsessional distress in the short-term, are actually counterproductive in the long-term. For example, these strategies can develop into strong patterns that impact functioning; they also prevent the individual from learning to cope with, or overcome these difficulties which leads to further distress (Abramowitz, & Jacoby, 2014). Also, due to the absolute certainty of some of these thoughts and the inability to prove them, these acts or reassurance from others and seeking absolute certainty will maintain levels of distress and obsessional thinking (Radomsky, Gilchrist and Dussault, 2006).

Religious OCD

Often overlooked, Religious Scrupulosity or Religious OCD (ROCD) is a subtype of OCD which manifests as pathological guilt, doubt and distress arising from intrusive, unwanted thoughts, images, or urges about violating their religious, moral, or ethical beliefs (Huppert &Siev, 2010; Miller & Hedges, 2008). Experts estimate between 10-33% of people with OCD may experience ROCD (McIngvale et al., 2017), with a notable prevalence of regional differences. For instance, research has demonstrated a higher level of ROCD within eastern areas of Turkey, compared to western areas (Karadag et al., 2006). Differences can also be observed across countries. Findings by Yorulmaz, Gencoz and Woody (2009) support that Turkish Muslims demonstrate increased levels of ROCD symptoms and concerns in their thoughts compared to Canadian Christians. However, Steketee, Quay and White (1991) found that a more religious individual, regardless of religious denomination, is more likely to experience religious obsessions.

ROCD obsessions typically include obsessive religious doubts, unwanted and intrusive blasphemous thoughts and images which stem from the fear of committing a sin and/or fear of punishment (Mohamed, Elsweedy, Elsayed, Rajab, and Elzahar, 2014; Nelson et al, 2006; Abramowitz & Jacoby, 2014). ROCD compulsions in response to obsessive thoughts may include ritualistic cleaning procedures, hypermorality, constant reassurance-seeking from religious leaders about religion matters, avoiding places of worship and excessive praying (Himle, Chatters, Taylor and Nguyen, 2011; Abramowitz et al, 2002). The individual may present their symptoms as excessive and unreasonable (Himle et al., 2011), such as focusing upon particular details of the religion while turning a blind eye to other aspects (Mohamed et al., 2014). Engagement in such behaviours exceed religious laws and are often concerned with minor dilemmas which do not contribute to the central practices and core beliefs of their associated faith (Nazar, Haq and Idrees, 2011).

Solaim and Loewenthal (2011) found that such symptoms were increasingly distressing, time-consuming and physically exhausting for the individuals experiencing them. For instance, individuals may become distressed when obsessive thoughts about cleanliness come to effect (Abouhendy& Jawad 2013). Having such irrational fear also leads to compulsions which compromises the repetition of Wudu or Islamic ritual cleaning (Zakaria, Halim, Ramli, Bakar, Fauzi, Sahran & Mamat, 2020). This is supported by a study which consisted of females of Saudi Arabian origin who had OCD. Findings showed that although religious symptoms dominated both the obsessions and compulsions, ultimately doubt was the most common feature among them (Mahgoub& Abdul-Hafez, 1991).

ROCD has been identified in many religions, including Christianity, Islam and Judaism. 2% of patients with ROCD have been reported in the UK (Greenberg & Huppert, 2010). The ROCD rate is much higher in other countries, such as Turkey who reported an average of 27% patients with ROCD and the Middle East with 52% (Greenberg & Huppert, 2010). It appears that religious issues in the context of OCD are more salient and present in clinical populations of Muslim, Jewish, and Middle Eastern cultures in comparison to populations in the West, India and the Far East.

Research by Abramowitz & Jacoby (2014) has found that different religious groups present ROCD differently, in which highly religious Protestant Christians were more susceptible to scrupulosity than their Jewish counterparts who scored lower in fear of Divine Punishment. This may be due to differing beliefs on punishments in the afterlife. Orthodox Jews may be more susceptible to scrupulous thoughts associated with committing sins, such as violating dietary guidance, than a Christian, who has no dietary requirements. Likewise, a Jew is less likely to concern themselves with confessing to a Rabbi as this is a practice exclusive to Christianity. Muslim individuals place a strong emphasis on the importance of controlling their intrusive thoughts (Yorulmaz et al., 2009) and are more likely to engage in ritualistic compulsions, which can be attributed to many Muslims believing that they achieve salvation by abiding by strict rules and guided rituals (Inozu et al., 2012). Individuals with scrupulosity from all religious backgrounds may experience anxiety connected with their religious beliefs, which can turn their normal religious practices and rituals into compulsive behaviour (Deacon & Nelson, 2008). This emphasises that scrupulosity can be influenced by religious creed and practices, therefore insinuating that diagnosis and treatment of ROCD requires a theologically-informed approach.

Mahintorabi et al. (2015) have contributed to some understanding of ROCD within the Muslim population through the investigation of Muslim Iranian women in Tehran with OCD washing subtype (OCD-W). It was found that the women who were attributed more religious characteristics engaged in more religious rituals and scored higher on a measure of scrupulosity compared to non-practicing Muslim women. However, this study focused predominantly on help-seeking and treatment for ROCD, and less on the experiences of Muslims with such difficulties. There is a clear gap within the literature that limits our understanding of ROCD within the Muslim community, namely, the specific day-to-day experiences related to cognitions and behaviours using rich and in-depth research designs.

ROCD, the Cognitive Behavioural Model & Religiosity

Psychological theories have recognised the association between religion and obsessive symptoms (Sica, Novara &Danavio, 2002; Yorulmaz, Gencoz &, Woody, 2009). For instance, cognitive-behavioural models of obsessions suggest that there are three processes that are salient in individuals with high levels of religiosity; threat appraisals of intrusions, heightened mental control, and misinterpretation of failed thought control.

Though high levels of religiosity are positively associated with beliefs that unwanted thoughts are significant, which are associated with scrupulosity, most religious people do not suffer from ROCD. This indicates that these associations are not always pathological. Clinical observations indicate that people with ROCD tend to have difficulty with the distinctions between sinful and non-sinful cognitions (Abramowitz, & Jacoby, 2014). Usually, people with ROCD will seek out evidence or proof that these thoughts are not true, for example, that they will not receive a punishment, though these matters cannot be proven.

A principal concern for clinicians may be differentiating scrupulosity from healthy religious practice, especially because scrupulous obsessions and compulsions often have some basis in conventional religious beliefs. Unintentionally, the person's religious community may also support or reinforce the scrupulous behaviour, perceiving it merely as an enthusiastic devout religious adherence. The individual with scrupulosity, however, typically has excessive and rigid (obsessional) concerns regarding a few particular facets of religious practice, which paradoxically tend to interfere with other valued aspects of religious observance. For example, one patient with an extreme fear of having blasphemous thoughts strictly avoided her church so as to not have such thoughts there. Conversely, healthy religious observance is generally typified by more moderate and flexible approaches to religious belief and practice, viewing perfect adherence as the ideal rather than as necessary to avoid severe punishment. Additionally, healthy religious practice and rituals are usually associated with positive emotions, whereas scrupulosity-driven rituals are typically linked with marked fear and anxiety (Greenberg &Shefler, 2002).

Furthermore, Abramowitz (2008) argued that over-emphasising the importance of controlling 'impure' thoughts might contribute to heightened OCD symptoms. Therefore, it was thought that individuals who are highly religious are more likely to have maladaptive beliefs in relation to controlling unwanted intrusive thoughts and an increased sense to refrain from 'sinful' or 'impure' cognitions. For example, if individuals misinterpret these unwanted thoughts as being highly significant and possibly sinful, they are more likely to experience doubt, guilt, fear of God, distress, and a need to control these thoughts (Abramowitz, & Jacoby, 2014).

Research has found that religiosity can influence the way in which ROCD is experienced (Tukel et al., 2005). For instance, ROCD symptoms have been found to occur earlier in the course of progression than other OCD symptoms (Greenbers&Witztum, 1994; Hasler et al.,2000). However, due to the cognitive association of morality, belief systems and religious observance, there is difficulty in distinguishing religious practice from scrupulous symptoms which delay diagnosis and the identification of ROCD as a potential problem, especially in highly devout and religious persons (Deacon et al., 2013; Mahintorabi, Jones, Harris &Zahiroddin, 2015; Yorulmax, Karanci &Tekok-Kilic, 2002). For example, research by Jones, Harris &Esfahani (2019) discusses that advice given by clergy can have an impact on professional help-seeking which can explain why more-practising Muslim women sought delayed help after consulting a religious leader. It was found that the majority of Imams (Muslim community leaders) in the study were unaware of scrupulosity being indicative of a mental health problem and were also unfamiliar with psychological treatment for OCD, such as Exposure and Response Prevention (ERP). Additionally, practising Muslim women reported a significantly longer time seeking professional help and presented more severe symptoms at the time of seeking help than non-practicing Muslim women (Besiroglu and Agargu, 2006). The nature of ROCD is that individuals struggling with scrupulosity confide in religious leaders and seek religious guidance instead of clinical treatment, which may further exacerbate the situation. This has led to Imams providing support that is inconsistent and in contradiction to recognised models of treatment, which can contribute to the aggravation of ROCD symptoms (Besiroglu and Agargu, 2006).

Furthermore, there is a general lack of diagnostic criteria for ROCD in psychology and psychiatric textbooks. The DSM-IV makes brief mention of scrupulosity in the context of Obsessive-Compulsive Personality Disorder (OCDP). However, this is problematic with consideration to the prevalence and clinical distress associated with scrupulosity. It remains unclear whether ROCD is a subcategory of OCD or OCPD and whether it may be a different disorder altogether within the OCD spectrum. According to the International OCD Foundation (2014), it can take anywhere between 14-17 years from the time an individual begins experiencing symptoms of OCD to access the right type of treatment and learn to manage their mental health, and this is without accounting for the barriers outlined above.

The current mental health system does not accommodate effectively for individuals suffering from ROCD. While 70% of patients with OCD benefit from Cognitive Behavioural Therapy (CBT) (International OCD Foundation, 2014), there is sparse research to show the efficacy of CBT in patients with ROCD, and there is also very limited research for those patients with an Islamic religious denomination.

Exposure with Response Prevention (ERP) is one of the most beneficial treatments for OCD (Koran, Hanna, Hollander, Nestadt, & Simpson, 2007; NICE, 2006). ERP involves repeated exposure to specific thoughts and actions while refraining from performing compulsive rituals, as a way to reduce the number and severity of OCD symptoms (Foa et al., 2007; McKay, 2006; Rowa, Antony, &Swinson, 2007). Scrupulosity has a very strong cognitive component, and is closely related to religious and moral belief systems, and to religious observances (Deacon et al., 2013; Mahintorabi, Jones, Harris, & Zahiroddin, 2015).

The Islamic Concept of 'Waswasa'

Religious OCD hides behind many barriers, including cultural and religious stigma, cultural suppression and the fact that these religious obsessions are associated with a positive, high level of religiosity and encouraged by religious leaders (Moron, Biolik-Moron & Matuszewki, 2022). While this claim may be valid, Islam is a religion of moderation and discourages extremity in all things.

"Do good deeds properly, sincerely and moderately, and always adopt a middle, moderate, regular course whereby you will reach your target."
Prophet Muhammad (ﷺ)

From scripture and Prophetic narrations to works by theologians, Muslim physicians, and traditional Islamic academics, researchers have investigated the prevalence and importance of intrusive recurring thoughts, as well as their influence or absence thereof on Islamic religious rites (Farfur, 2002, Badri, 2013; Bint Abdur Rahman, 2013).

Based on the Qur'an, Prophetic traditions, and Islamic academic publications, the concept of *Waswasa*, often known as 'overwhelming whisperings', is mentioned five times in the Qur'an.

فَوَسْوَسَ إِلَيْهِ ٱلشَّيْطَٰنُ قَالَ يَٰٓـَٔادَمُ هَلْ أَدُلُّكَ عَلَىٰ شَجَرَةِ ٱلْخُلْدِ وَمُلْكٍ لَّا يَبْلَىٰ

"But Satan whispered to Adam, saying, 'Adam, shall I show you the tree of immortality and power that never decays?'."
[Qur'an 20:120]

The theme of Satan misleading people originates from the story of creation in the three Abrahamic faiths: Islam, Christianity, and Judaism. The Serpent (Satan) **told** Eve to eat fruit from the forbidden tree in the book of Genesis (Genesis 3:1-3, New King James Version), whereas Satan **whispered** to both to approach the forbidden tree in the Quran (20:120). The word *Waswasa* is used exclusively in the Qur'an.

فَوَسْوَسَ لَهُمَاٱلشَّيْطَٰنُ لِيُبْدِىَ لَهُمَا

"Then Satan whispered to them that he might manifest unto them."
[Qur'an 7:20]

Whilst the interpretation in Islamic studies varies by *tafsir* (Islamic explanations) and scholars, it is associated as a type of OCD. The emphasis on cleanliness, purity, and religious practices is the standard in Islam. However, when these behaviours go beyond the requirements of religious practice, they are classified as *Waswasa*. This is a mental health disorder which is not recognised as being a religious presentation of OCD within western classifications, and this can be particularly limiting for many Muslims seeking support from traditional mental health services within the UK. It is commonly observed in the Muslim community however, it is not recognised by the Diagnostic and Statistical Manual of Mental Disorders (DSM) due to the lack of research in the topic area, its overlap amongst other diagnoses as well as American Psychiatric Association's lack of recognition of spiritually-linked mental health conditions (Latif, 2014). Researchers have emphasised the need of conducting research with Muslim populations in order to better understand this disorder, as prior studies on religion and OCD have mostly focused on the Judeo-Christian heritage (Rassool, 2019; Ahmad, 2022).

"Allah will forgive my ummah (followers) for whatever crosses their minds so long as they do not speak of it or act upon it." **Prophet Muhammad (ﷺ)**

Study Aims and Rationale

There are studies that have arrived at a conclusion as to what the best methods are to treat religious OCD (Huppert &Siev, 2010; Mahintorabi, Jones & Harris, 2017; Omranifard, Akuchakian, Almasi &Maraci, 2011; Rosli, Sharip& Thomas, 2019). These consider the role of Muslim leaders in helping to combat ROCD which have been investigated (Jones, Harris & Esfahani, 2019), the cognitive perspective and framework to observe religious OCD (Abramwitz& Jacoby, 2014; Besiroglu, Karaca & Keskin, 2014; Nelson, Abramwitz, Whiteside & Deacon, 2006), and the development of new measures to test for religious OCD have been established (Abramowitz, Huppert, Cohen, Tolin& Cahill, 2002; Ong, Betancourt &Fisak, 2021). There is no known research that takes an Islamic perspective into consideration that applies a closer look into everyday life, i.e. 'putting yourself in their shoes' and understanding how ROCD is perceived and experienced by Muslims, in particular the specific thoughts and rituals, related feelings, and general mental health and wellbeing. Arguably, there is a need for qualitative research to investigate the experiences of Muslims with ROCD. The purpose of this study is to improve our understanding of ROCD through a clinical and Islamic perspective using a qualitative design.

The purpose of this research is to improve our understanding by investigating the personal and lived experiences of a person who has ROCD. It is therefore hoped that this research will contribute by providing an insight into religious OCD and what it truly consists of with the aim that this research will support increasing the accessibility of mental health services for individuals with ROCD, from ethnically diverse communities. The research findings will hopefully provide new insights into avenues of support and inclusive service access. This study has the potential to inform treatment, specifically in regards to the processes experienced within the Muslim community.

Methodology

Research Design

The focus of this study was to investigate the lived experiences of ROCD within Muslim communities by utilising the thematic analysis approach (Braun & Clarke, 2006). Thematic analysis is an inductive qualitative method which is used to identify, analyse and report patterned themes within a dataset. The reason for selecting thematic analysis is because it explores an issue to a level of depth and flexibility that is not often obtained in quantitative methods (Attride-Stirling, 2001). Being an inductive approach, thematic analysis takes context into consideration, allowing for themes within the data to emerge organically and inform the dynamics

of a particular research area (Braun & Clarke, 2006). This enriches the study, and results in analysis that is suited to informing policy development.

The research process began by consulting the existing literature around ROCD experienced by Muslims, for which research was sparse, but present. This literature helped us narrow our target sample to those who have experienced symptoms of OCD related to religion and morality.

Data Collection, Storage & Analysis

This study used heterogeneous purposive sampling, which ensured that the sample was suitable for the research topic. Potential participants were first asked to answer a few screening questions which were based on our selection criteria. This selection criteria included common symptoms of ROCD, including obsessions and compulsions. Successful participants were selected by completing a consent form, and then were sent a template of diary entries for a period of 14 days or invited to a structured virtual interview. A total of 5 participants took part.

The diary process involved documenting parts of their experiences as they happened throughout the day and answering specific questions about their difficulties (for example, ROCD behaviours and/or thoughts). Participants that were contacted to take part in a structured virtual interview were audio-recorded with consent and further details around information and data protection was shared and agreed to in the consent form. After collecting the data from 5 participants, each audio file was transcribed manually and each participant was given a pseudonym to protect their identity. Following this, each transcript was read and re-read in order to identify codes, which were drawn out in a mind-map format.

The final level of analysis involved reviewing and combining these initial codes into overarching themes and the research question informed this process. Finally, the themes were presented in this Findings and Discussion section of this paper, drawing excerpts from the rich data transcripts.

Ethical Considerations

Ethical research procedures were adhered to in accordance with the British Psychological Society's (BPS) Ethical guidelines.

Prior to the experiment, participants were provided an information sheet in the consent form, including the reasons for the research being undertaken and outlining the participants' roles in the study and their right to withdraw themselves and their data from the study at any time. An email address was included to provide the participants with an opportunity to request further details regarding the research.

We acknowledge the potential of the participants experiencing psychological distress during the study when recounting their obsessions and compulsions, especially for those who may not be receiving treatment for their ROCD. This risk will be made very clear to participants on the information sheet prior to the experiment, alongside their right to halt the study at any point in which they felt distressed. The information sheet also signposted OCD support services for participants if they felt affected at any point throughout the study and participants were again made aware of these services when conducting the interview.

Participants consented to the audio recording of interviews, which were subsequently anonymised and transcribed.

Once the diary entries and interviews were completed, a participant debrief sheet was provided to all participants, which also included signposted support services for OCD and ROCD. Inspirited Minds was fully GDPR compliant during the research and continues to remain compliant.

Findings & Discussion

This study sought to understand the first hand experiences of Religious OCD (ROCD) as a Muslim and utilised Thematic analysis to capture the richness of lived experiences of mental health. As a result, this study found many key features of the experiences of ROCD that were common in all participants. These were organised into the following themes:

1. Finding purity when engaging in compulsions
2. Black and white perspective of Islam
3. Physically and emotionally challenging experiences
4. Lack of support
5. Ways of coping

Each theme was then divided into sub-themes based on the most prominent findings.

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Figure 1: Themes and sub-themes presented in the present study.

Finding Purity when Engaging in Compulsions

This theme surrounded participants having ROCD-related obsessive thoughts and compulsions. The theme found that participants felt intrusive thoughts were mentally challenging and intense in nature, which led them to engage in religious-related compulsions to cope. There were ideas around these compulsions being physically demanding however, they had become habitual in nature over time and engaging in these behaviours led to feeling pure and more at peace with oneself.

This theme is therefore divided into the following sub-themes:

- Obsessive thoughts are about purity
- Feeling pure again when engaging in compulsions

There was a common theme around participants' experiences of instructive thoughts and beliefs relating to being 'impure' which led to a range of feelings such as anxiety, panic, fear, guilt and confusion. Participants engaged in compulsions or rituals in order to cope with these thoughts and feelings. For example, multiple participants expressed experiences of repeating their ablution (Wudu) multiple times due to thoughts of not doing the practice properly or as a way to become pure from beliefs that they believed were impure.

"I became scared of everything being so impure. I had to do washing in a specific way, and it couldn't be done, and then I'd be having a panic attack.... I'd pray and if my head touched the bed sheet then I'd go and wash it in the shower straight afterwards, so just like, so a lot of and if not, if I could not do it there and then I'd have to avoid touching my head on anything, or avoid touching my hand there." Participant 4

"When I was 19-20 it got very bad, I was doing continuous ablutions and staying on the Musallah [prayer mat]…"
Participant 3

Furthermore, compulsions were also individualised to the person. Whilst for some this looked like physically washing, for others impurity was experienced in the mind or in their lifestyle.

"I had to clean my mind, so I became very obsessed with listening to Qur'an and only Qur'an, and I don't watch much TV and if I do it's very 'PG' things. I can't remember the last time I picked up my Mushaf [Qur'an] not because I'm not physically clean but because I can't purify my brain. So I use my phone to recite the Qur'an instead."
Participant 5

"I didn't care about Riyya [ostentation] but as soon as I saw it was a form of Shirk, I was like OMG!... I have to limit what I am exposed to online, you know instagram reels and videos or even like people's comments - that can sometimes trigger it."
Participant 1

Rituals and compulsions are widely experienced by individuals with OCD. Individuals with washing rituals related to their religious beliefs also commonly experience significant impairments related to their ROCD (Himle et al, 2011). These rituals commonly involve washing or rinsing to make up for sinful thoughts or actions. Studies show that more often these rituals involve excessive washing and cleaning, whereby individuals experience relief after this (Himle et al, 2011). Furthermore, research from different cultures and religious populations propose that beliefs and practices of a particular religion could impact the expression of an individual's OCD symptoms (Rachman, 1997). For example, studies carried out in Australia found that individuals with OCD will wash because they feel contaminated by dirt and germs, and by carrying out these washing rituals they will prevent diseases (Jones & Menzies, 1998). However, studies from Iran, Egypt and Saudi Arabia reported that OCD washing rituals are more likely to be driven by beliefs about purity, and that these beliefs are related with cultural practices of religions such as Islam e.g., Greenberg and Shefler (2002), which support the current study's findings.

"I felt like my prayer will never be good enough, hence lacking validity and acceptance and I will never do it properly and it will always be imperfect and lacklustre. I felt hopeless, as I can't seem to do one of the basic acts of worship in Islam well."
Participant 2

"My thoughts were about being impure and I was disgusted with myself, then I would go do ghusl [major ablution]. I wanted to be pure again…"
Participant 3

"I'd pray and if my head touched the bed sheet then I'd go and wash it in the shower straight afterwards, so just like, so a lot of and if not. If I could not do it there and then I'd have to avoid touching my head on anything, or avoid touching my hand there."
Participant 4

Although participants were aware their compulsions were irrational, the urges were so strong that they had to carry these out despite having this awareness, and at times these behaviours were carried out habitually without the participant making great effort. Moreover, it was only until after participants carried out these behaviours that they felt a sense of relief and reduced levels of anxiety. Therefore, despite rituals or compulsions being demanding, they were a means to feel pure again, bringing a sense of comfort and peace.

"I would do it [ablution] over and over again until I was sure I was pure, until I felt peace."
Participant 3

'I don't know if I kind of fit into that box, of you know performing [rituals] them per se, erm, but they bring a sense of like comfort. I guess it is relief or just like erm, I'd rather do the act or go out of my way not to watch something rather than deal with like the visions and the thoughts and ideas that I get afterwards".
Participant 5

The functions of OCD have been widely studied, with the dominant function of compulsions being to alleviate distress or anxiety caused by the obsessions (Starcevic et al, 2011). However, compulsions have also been found to serve multiple functions. Pietrefesa and Coles (2008) reported a sense of incompleteness and harm avoidance were an underlying motivation for performing washing/cleaning, checking, and mental compulsions.

These findings align with our study, whereby participants reported a sense of relief and completeness during and after performing compulsions such as repeating Wudu over and over again. Similarly, in Wairauch et. al.'s (2024) study, participants shared their experiences of

negative feelings prior to beginning their rituals, and a significant sense of relief upon completing them. Participants reported positive feelings such as calmness and satisfaction.

Black and White Perspective of Islam

In our current study, all participants collectively shared that their perception of Islam played a key role in their lived experience of ROCD. Indeed, previous studies have found religion to be an important element of life for Muslims, and fulfilling religious practices in an inadequate manner have been observed to bring about fear-led responses, resulting in distress and anxiety (Solaim & Loewenthal, 2011). However, participants in the current study specified having a black and white perspective of Islam as a main factor in their presentation of ROCD. Black and white thinking (also known as all-or-nothing thinking or dichotomous thinking), is a cognitive distortion that is characterised by a rigid, all-or-nothing way of information processing, such that an individual's thought patterns consist of absolute terms (Knapp & Beck, 2008). Black and white thinking can feature in the symptomatology of OCD (Williams &Shafran, 2018). It may be that individuals with OCD engage in black and white thinking as it grants them a perception of control (Rowland, Jainer& Panchal; 2017).

In Religious OCD, this may present itself in an all-or-nothing perception of God. This cognitive distortion was clearly identified when interviewing the Muslim participants for this study. The presupposition that Allah (SWT) is a God who hates someone because of their 'bad deeds' and loves someone because of their 'good deeds' is observed as a black and white perspective of religion.

"Then I thought to myself - 'Oh no, I'm going to Hell'. Like, I was just constantly thinking to myself about Hell fire."
Participant 1

"You've had a tough life just because Allah wants you to have a tough life. Things aren't going to get better for you."
Participant 5

"At some point, I thought it was wrath from Allah."
Participant 3

An individual believing that they are going to go to Hell can be considered as having a black and white perspective of religion. This is because, for example, in Islam, a fundamental belief is that Allah (SWT) possesses qualities, i.e. being the Most Merciful and the Most Forgiving. Black and white thinking typically only views Allah (SWT) in one extreme, i.e. as a generally angry or wrathful God which notably is not in accordance with Islamic beliefs.

"I felt almost, like, betrayed by God… I felt like, that He doesn't really care, neglectful, felt abandonment. Yeah, like, a very, like, wrathful, vengeful God. That's the way I was perceiving it." Participant 1
"Allah doesn't like you… Allah hates you"
Participant 5

Studies have shown increased symptoms and religious obsessions related to OCD among practising Muslims and within Muslims countries compared to practising Christians and western countries (Himle, Chatters, Taylor & Nguyen, 2011). This study suggested that the way in which Muslims practice their faith may facilitate the expression of OCD. However, the current study illustrates that it is an individual's perception and understanding of religion that determines their experience of ROCD.

However, religion can also be a means of understanding ROCD, whereby individuals can learn more about moderate ways of thinking to cope and come to terms with their understanding of God, religion and their ROCD symptoms, hence providing permanent relief of obsessional symptoms (Solaim&Loewenthal, 2011). This also raises a point of concern for how religion is taught to individuals, particularly how Islam is taught to Muslims, i.e. having a black and white perspective of Islam and of Allah (swt).

"Growing up, I wanted to be perfect in the eyes of Allah…'
Participant 1

"But before 2020, in my university days when I was learning more about Islam, I noticed I had started developing anxious thoughts and became paranoid."
Participant 2

"I feel like everything is black and white with them [Imams and Sheikhs]."
Participant 3

One participant did express that this perspective of Islam led them to feel like their mind is their enemy:
"My mind has become my worst enemy."
Participant 1

Physically and emotionally challenging experiences

ROCD is a very emotionally draining disorder, in that it convinces the individual that their efforts in their religious identity are not sufficient, leading them to feel insecure and unfulfilled in their acts of worship. For example, as discussed in the theme above, praying excessively is the most common presentation of ROCD, and also consists of repeating the prayer multiple times due to anxiety and doubts surrounding the thought of whether the prayer has been performed correctly and in accordance with Islamic guidelines (Rosmarin, Pirutinsky & Siev, 2010).

Similar to existing studies, our study found that religious obsessions and ritualistic compulsions were also associated with personal insecurity, black and white thinking and/or personal trauma:

"I felt like my prayer will never be good enough, hence lacking validity and acceptance and I will never do it properly and it will always be imperfect and lacklustre. I felt hopeless, as I can't seem to do one of the basic acts of worship in Islam, well."
Participant 2

"I feel like my duas are not being heard. I feel like He is ignoring me. In some ways, I've given up making dua."
Participant 1

"I get these thoughts at the back of my head saying that 'You're not going to get the status of a mother in Islam because of what happened to you and because of the things that you imagine and the things that you do', and this has affected my relationship with my husband and child."
Participant 5

"I became stressed and hopeless, like I was doomed. It gets extreme to the point that I wish I didn't exist because I don't want to experience dying… I felt like I was becoming delusional. I felt paranoid and frazzled."
Participant 2

"I had this excessive fear of halal and haram."
Participant 4

Compulsions were also physically draining for participants. Some participants expressed washing for long periods of time and as a result injuring themselves. These findings support research showing that religious obsessions and compulsions can severely impact an individual's social, professional and academic life (Solaim & Loewenthal, 2011). This is further supported by our findings whereby participants expressed their difficulties impacted multiple aspects of their lives, and one participant even said they became bedridden from these difficulties.

"My most recent experience of this and probably my most prominent one is wiping different parts of my house with water, as I thought blood may have touched it. However, I was unsure and frazzled most of the time. So eventually, I became frustrated and panicked, as I thought that it was endless, due to the possibility that it may have transferred everywhere. I lost the reason to why I was even doing it. I wasn't even sure if the item had blood on it, so when it went on the floor, no visible blood was there. But I still went on a wiping spree, eventually doing it to different parts of my house including my prayer mat and prayer clothes."
Participant 2

"I get thirsty all the time but I rarely drink water. The main reason is because I don't want to use the bathroom because I can become impure… In the past, I could go a whole day without eating but now I am much better, I eat."
Participant 3

"I physically injured my foot from standing, uh, one foot in the sink and one foot outside it at a weird angle for 45 minutes plus. Hand-washing used to take 50 minutes, I used to dehydrate myself so that I don't have to use the toilet, so I'd only have to go once a day maximum."
Participant 4

One participant summarised it well when they explained that the entire experience of ROCD was traumatic for them:

"It was quite traumatic for me. When you are flooded with waswas, it's a terrible experience. I feel like I still have that stored in my memory or my body. I would get panic attacks, nightmares and chicken pox as well even though I was vaccinated. It was quite traumatic."
Participant 1

Lack of Support

It is clear that there are numerous ways in which ROCD presents itself. Not all presentations have been covered within this paper. However, the themes of doubts, the devil, insecurity and fear are prominent. This resulted in

participants reporting experiences of ROCD to be isolating:

"It's just so isolating, the whole experience. I can't connect with the Muslim community."
Participant 1

"I feel like I can't connect with people on a deeper level."
Participant 3

"Not many people understand religious OCD… This is something I am going through alone"
Participant 1

Experiencing isolation in OCD has been reported before, particularly as a result of feeling emotions of unworthiness and insufficiency (Petrocchi et al., 2021) and the present study also corroborated with previous findings. Within this study, participants consensually reported a lack of support from family and wider community when disclosing their experiences, including the following subthemes:

- Lack of understanding of ROCD leading to non-disclosure

"I didn't tell my parents at all because I didn't want to stress them. I didn't think they'd understand it very well."
Participant 4

"I remember trying to go to scholars but not really disclosing stuff… I guess at that time no one really knew about ROCD so I didn't feel comfortable to disclose stuff, so I just hid it the whole time." Participant 1

- Lack of understanding of ROCD leading to judgemental responses

"My father told me, 'You have gone forever. You have gone for good. You are the devil." over and over again… My relationship with my mum also deteriorated."
Participant 3

"If I did not know how to do something, they should have guided me instead of saying 'Oh, you are going to the hellfire', I know that already."
Participant 3

- Non-helpful advice from Religious Scholars

"I did tell my dad once when I was young, and he was nice enough to take me to this Islamic conference in Canada thinking that the Shuyukh might help me. But they didn't. It [advice from scholars] gave me temporary relief but it didn't make the Waswasa go away. Someone told me to say 'Shut-up Shaitaan' and I did that but it didn't work."
Participant 1

"I was told to ignore it, ignore it, ignore it. But that did not help me. It was not that easy, how do I ignore it? I did not receive the help I needed."
Participant 3

"The Imam kind of took advantage of my vulnerability now that I think about it. He told me some things that made me feel worse. He let me down."
Participant 3

Ways of Coping

Our participants shared their personal ways of coping and what helped them the most, which have been shared in this section.

- Separating trauma response from judgement of Allah (SWT)

"I've spoken to a person of knowledge that I have close contact with once, and they said 'You won't be held responsible for these thoughts because they are not coming from you, you are not intending them, they are a trauma response." This made me feel relieved."
Participant 5

"I tried separating my thoughts from myself, so acknowledging that I am thinking this right now and then realising that these thoughts are outside of me. This helped me."
Participant 1

- Engaging in self-care and self-compassion

"The journey to loving Allah came after I got out of bed, after I started making improvements." Participant 4

""I go out for a walk every Friday, which helps me stay positive."
Participant 5

"I engaged in Ruqyah which also helped."
Participant 3

Petrocchi et al. (2021)'s study revealed that a compassion-focused approach can significantly mitigate

feelings of isolation, unworthiness, insufficiency and lack of support, whether that is in the form of parental warmth, compassion-focused therapy or compassionate support from the community.

- Seeking integrative mental health support

"I've been seeing a therapist once a month for the past 6 years, which has been really helpful." Participant 5

One participant did share that they accessed therapy support for their ROCD experiences from a religious scholar who integrated ERP (exposure response prevention) therapy with Islamic teachings, which proved to be very helpful in their recovery journey:

"No Sheikh would give you the advice to spread impurities but he made me do it in a way that complied with Islamic teachings and ERP. That was one of my biggest worries in accessing support from the NHS. I was scared that they would try to treat the condition rather than look at the bigger picture, and religion is a big part."
Participant 4

This highlights the need of integrating religion with psychological treatment for ROCD which can make mental health support much more accessible, whilst simultaneously addressing the core ideas and beliefs of ROCD.

Implications

The present study offers insightful implications for healthcare providers, mental health professionals and members of the religious clergy. For example:

- The contents of this research can be used to inform the diagnosis and intervention for individuals with ROCD who need a more culturally-tailored and individual-centric approach. As demonstrated by the findings of this research, effective interventions for scrupulosity may need to address the meaning of unique symptoms for each individual.
- Previous research has revealed that the first and main source of guidance for scrupulous people will often be religious authorities, such as Christian clergy, Jewish rabbis, Muslim Imams and faith-based healers, rather than health professionals (Al-Solaim&Loewenthal, 2011; Greenberg &Shefler, 2008; Huppert &Siev, 2010; Wills &DePaulo, 1991). Thus, familiarising figures of religious authority in the community with the experiences of ROCD can guide them to better support and signpost for individuals struggling with these symptoms, which is something that this research provides.
- At the outset of this research, it was identified that a principal concern for clinicians may be differentiating scrupulosity from healthy religious practice, This research offers insight into the unhealthy religious practices that are engaged in by individuals with ROCD.
- Finally, this research can be used as a platform to further research into the sphere of ROCD and Muslim mental health, and the efficacy of faith-sensitive person-centric interventions as a treatment option for ROCD.

Limitations & Further Research

There are some presenting limitations which are worth noting. As this research consists of thematic analysis, the researchers could have potentially influenced the way themes unfolded through their subjective nature and different interpretations of a particular theme. Since the analysis aims to align with research presented, the themes will be a shadow of the conceptual framework adopted.

Additionally, it is prudent to note the extent to how representative this study is of all individuals who experience ROCD, as everybody's experience of ROCD may be unique to them. This study should therefore be used as a guideline bearing this in mind.

Finally, this research did not take into consideration how ROCD would present in those individuals who are seeking treatment. It is more likely that those actively seeking treatment would be more aware of their symptomatology and emotions related to their experience of ROCD. Therefore, further research in this area should seek to understand how an individual's experience of ROCD would be different when seeking treatment or intervention. Additional research endeavours should also seek to understand the link between trauma and OCD/ROCD as they may be correlated.

References

Abdul-Rahman, M. (2004). Islam: Questions and Answers – Jurisprudence and Islamic Rulings: Transactions, Part 5. London, United Kingdom: MSA Publication Limited.

Abouhendy,W., & Jawad, S. (2013). Transcultural perspectives of sensory phenomena in Arab Muslim patients suffering from obsessive–compulsive disorder. Irish Journal of Psychological Medicine, 30(3), 205-207.

Ahmad, M. (2022). Clarification Of The Relationship Between Self-Reproach And Obsession: A Psychological Study From The Prophetic Tradition's View. Journal of Positive School Psychology, 6(9), 3258–3270.

Badri, M. (2013). Translation and annotation of Abu Zayd al-Balkhi's Sustenance of the Soul. Richmond, VA: International Institute of Islamic Thought.

Bint Abdur-Rahman, K. (2013). Aḥkām al-Marīḍ al-Nafsīfī al-Fiqh al-Islāmī. Riyaḍ: Dar al-Somaie. https://www.journalppw.com/index.php/jpsp/article/view/12841, accessed 22/07/2024

Himle, J.A., Chatters, L.M., Taylor, R.J., & Nguyen, A. (2011). The Relationship Between Obsessive-Compulsive Disorder and Religious Faith: Clinical Characteristics and Implications for Treatment. Psychology of Religion and Spirituality, 3(4), 241-258.

Knapp, P., & Beck, A. T. (2008). Cognitive therapy: foundations, conceptual models, applications and research. RevistaBrasileira de Psiquiatria, 30(suppl 2), s54–s64. https://doi.org/10.1590/s1516-44462008000600002, accessed 22/07/2024

Latif, A. (2014) Obsessive-Compulsive Disorder: Its What And How From An Islamic Perspective. ResearchGate.https://www.researchgate.net/publication/273042383_Obsessive-Compulsive_Disorder_Its_What_And_How_From_An_Islamic_Perspective, accessed 22/07/2024

Mohamed, N.R, Elsweedy, M.S., Elsayed, S.M., Rajab, A.Z., &Elzahar, S.T. (2015). Obsessive–Compulsive Disorder, an Islamic View. Menoufia Medical Journal, 28, 289-294.

Muhammad, A. Y. (2017). Al-Qur'an as a Remedy for Human Physical and Spiritual Illnesses, and Social Vices: Past, Present and Future. Journal of Islamic Studies and Culture, 5(2).https://doi.org/10.15640/jisc.v5n2a3, accessed 22/07/2024

Nazar, Z., Haq, M. M. U., and Idrees, M. (2011). Frequency of religious themes in obsessive compulsive disorder. Journal of Postgraduate Medical Institute, 25(1), 35-39.

Petrocchi, N., Cosentino, T., Pellegrini, V., Femia, G., D'Innocenzo, A., & Mancini, F. (2021). Compassion-focused group therapy for treatment-resistant OCD: Initial evaluation using a multiple baseline design. Frontiers in Psychology, 11. https://doi.org/10.3389/fpsyg.2020.594277, accessed 22/07/2024

Radomsky, A. S., Shafran, R., Coughtrey, A. E., &Rachman, S. (2010). Cognitive-Behavior Therapy for Compulsive Checking in OCD. Cognitive and Behavioral Practice, 17(2), 119–131.https://doi.org/10.1016/j.cbpra.2009.10.002, accessed 22/07/2024

Rahman, M. Z. A., Zulkiply, S. R. I., & Mustapha, A. M. (2021). The Term Waswas and Obsessive-Compulsive Disorder (OCD) In Islamic Perspectives. Al Hikmah International Journal of Islamic Studies and Human Sciences, 4(3), 452–469.https://doi.org/10.46722/hkmh.4.3.21s, accessed 22/07/2024

Rosmarin, D.H., Pirutinsky, S., &Siev., J. (2010). Recognition of Scrupulosity and Non-Religious OCD by Orthodox and Non-Orthodox Jews. *Journal of Social and Clinical Psychology*, 29(8), 930-944.

Rassool, G.H. (2019). Obsessional Compulsive Disorder (Waswâs al-Qahri (Overwhelming Whisperings): Case Report and Spiritual Interventions. International Journal of Mental Health & Psychiatry, 2019.https://www.scitechnol.com/peer-review/obsessional-compulsive-disorder-wasws-alqahri-overwhelming-whisperings-case-report-and-spiritual-interventions-Z0Te.php?article_id=9554#4, accessed 22/07/2024

Rowland, T. A., Kumar Jainer, A., & Panchal, R. (2017). Living with obsessional personality. BJPsych Bulletin, 41(6), 366–367. https://doi.org/10.1192/pb.41.6.366a, accessed 22/07/2024

Solaim, L.A., &Loewenthal, K.M. (2011) Religion and obsessive-compulsive disorder (OCD) among young Muslim women in Saudi Arabia. Mental Health Religion & Culture, 14(2), 169-182.

Williams, T. I., &Shafran, R. (2015). Obsessive–compulsive disorder in young people. BJPsych

Advances, 21(3), 196–205. https://doi.org/10.1192/apt.bp.113.011759, accessed 22/07/2024

Zakaria, N., Halim, A.S.A., Ramli, R.R., Bakar, R.S., Fauzi, A.N., Sahran, N.F., &Mamat, M.N. (2020). Observe Your Child Ablution; They Could Have Obsessive-Compulsive Disorders. Malaysian Journal of Paediatrics and Child Health, 25(2), 30-32.

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BIMA Support Clinic needs your support (and you may need them one day!)

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As a Muslim doctor, I had heard about the British Islamic Medical Association (BIMA) and the good work they were doing in the community. They play a crucial role in supporting Muslim healthcare professionals, advocating for a more inclusive healthcare system, promoting Islamic ethical practices in medicine, and engaging in charitable health initiatives.

What I was not aware of, is that one day I might be the very individual that is seeking their help. This is where the BIMA Support Clinic came into its own and really shone through when I needed them most.

The BIMA Support Clinic, a key initiative of BIMA, advocates against discrimination, particularly Islamophobia, within the healthcare system.

It offers confidential advice and advocacy for healthcare professionals and patients who face discrimination due to their Muslim identity. The BIMA Support Service is especially important for healthcare workers who may be experiencing threats, maligned investigations, or mistreatment because of their faith or support for causes like Palestine. By providing support, the clinic helps individuals navigate these challenges and work towards eliminating Islamophobia from healthcare settings

So how did this apply to me directly? It was one random Tuesday in April 2024. I received an email from the GMC asking if they could confirm I was Dr Abdullah Albeyatti and that this was the correct email address to engage with myself about a complaint. If you work in healthcare, you know an email from the GMC is never a welcome correspondence!

As well as replying to confirm my details, I telephoned the GMC immediately to understand what this was all about. I was told exactly this:

I am writing to let you know that we have received some information from Campaign Against Anti-semitism.

An Assistant Registrar (a senior decision maker at the GMC) has considered the information and received advice from a medically qualified colleague, and has decided that the concerns raised do not meet our threshold for investigation, therefore we have not opened a case. A copy of the complaint is enclosed. I have written to the complainant to let them know that we will not be investigating this matter.

My initial reactions were a mixed one. One of relief that the matter was closed (or so I had believed!), pride that I had been doing my moral and ethical duty not only as a doctor but as a muslim highlighting the plight of Palestinians and that I had caused enough disturbance to be picked up on someone's radar and on deeper reflection, sadness that as a muslim doctor I have been targeted to be silenced and that coming after my profession, my livelihood was how they planned to achieve this.

Unfortunately, the GMC, although closing the matter themselves, felt it was worthwhile asking NHS England for their opinion on the matter. At the time of writing, the NHS England's planned closure is already underway and I for one am pleased given my experience with them. They were so close minded to the idea that I was in fact the victim of all of this. That I was being targeted, silenced and vilified for my political views and that as a doctor, who happens to be muslim I should think twice about what I post online, regardless if it was true. That highlighting war crimes was best avoided as I might offend someone.

This is when I called upon BIMA to come to my aid. I was so impressed at how proactive they were in offering

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me support. They checked in with me constantly to see how I had been affected, asked me what they could do to help me and shared with me their experience of dealing with these fictitious accusations. I realised I was not the only doctor going through this turmoil and having them in my corner gave me great confidence. The icing on the cake was the NHS England Teams Meeting call we had where I sat back and saw Dr Salman Waqar (former BIMA President) dismantle their impotent attack and lay bare the farce of even having this discussion about a manufactured complaint by an Israeli lobby group.

I benefited from BIMA who works on a broad level by gathering anonymised data on incidents of discrimination and pushing for systemic change in healthcare institutions. The BIMA Support Clinic serves as a vital tool in tackling both health inequities and systemic bias which affects us as health professionals directly.

The staff understands the unique challenges faced by marginalized individuals and works tirelessly to ensure that each person feels valued and supported. Whether it's providing direct care, offering mental health support, or standing up against Islamophobia, BIMA ensures that no one is left behind in their pursuit of health and dignity.

Support for the BIMA Support Clinic is essential to sustaining and expanding its impact. Donations, volunteer efforts, and partnerships with local organizations are crucial in ensuring the continuation of these services.

The BIMA Support Clinic is a vital resource that provides comprehensive medical support while also advocating for justice and inclusivity in the healthcare system. Its focus on eliminating discrimination and ensuring equal access to care makes it an essential service for marginalized communities. By supporting BIMA, we can help ensure that these services continue to reach those in need, improving lives and creating a more equitable healthcare system for all.