Revelation and Science
Vol. 01, No. 01 (2011) 32-38

Research Article

Standards for medical practices as mirrored in Ḥisbah treatises

Abu Saim Md. Shahabuddin*
Department of Management,Faculty of Management and Human Resource Development,
University Technology Malaysia, 81310 Skudai, Johor, Malaysia

Abstract
Ḥisbah treatises were administrative manuals for official supervision of a wide range of activities in Muslim societies in the past. Medical practices were one of these activities. Relying mainly on *ḥisbah* treatises, this paper explores and discusses some medical standards which the profession of medicine in the past Muslim societies was to follow and uphold. The explored standards are discussed under five categories namely entry requirements (qualification of a physician, test of competence and oath taking), medical instrument, treatment procedure, accountability, and moral norms (maintenance of privacy and classified fees). A reflection on these standards reveals that the profession of medicine, an organized economic pursuit though, had transcended the mundane calculation of economics.

Keywords: *Ḥisbah, ḥisbah* treatise, *muḥtasib*, medical standards.

Abstrak
Perakuan *Ḥisbah* ialah manual bagi pemantauan rasmi terhadap pelbagai aktiviti orang Islam zaman silam. Amalan perubatan adalah satu daripadanya. Bersandarkan perakuan *ḥisbah*, kertas ini mengkaji dan membincangkan beberapa piawaian perubatan yang menjadi pegangan kepada pengamal-pengamal perubatan Islam pada zaman dahulu. Piawaian-piawaian yang dibincangkan terbahagi kepada lima kategori iaitu kelayakan masuk (kelayakan menjadi seorang doktor, ujian kompetensi dan ikrar), peralatan perubatan, prosedur rawatan, akauntabiliti, dan norma-norma moral (mengenakan yuran bagi kes-kes rahsia dan sulit). Kajian tentang piawaian-piawaian tersebut menunjukkan walaupun profesion perubatan mempunyai motif ekonomi, piawaian ini menjangkaui motif tersebut.

Kata kunci: *Ḥisbah*, perakuan *ḥisbah*, multasib, piawaian-piawaian perubatan.

INTRODUCTION

In the history of Islamic civilization, *ḥisbah* (or *iḥtisāb*) is a one-word expression of the Qur'anic injunction about commanding right and forbidding wrong. It is an Islamic social obligation (*farḍ al-kifāyah*). The discharge of such a sacred social obligation since the establishment of the Islamic governance at Medina had gradually assumed institutional form, which was for the first time termed as *al-Ḥisbah* during the early years of Abbasid Caliphate (Buckley 1992). The *muḥtasib* was the chief official of this institution (Cahen and Talbi 1971). He supervised diverse activities of vast domains including "both material and spiritual: religious rituals, public hygiene, morals, education, commerce, industry and crafts" (Essid 1995). In other words, his jurisdiction covered three broad functional areas: (i) organizing facilities for the performance of *ʿibādah* (worshipping or spiritual devotion) and supervising public moral conduct (ii) administering municipal services, and (iii)

**Corresponding author: ASM Shahabuddin, Senior Lecturer, Department of Management, Faculty of Management and HRD (FPPSM), UTM, 81310 Skudai, Johor, Malaysia*
E-mail: asmshihab@yahoo.com

regulating economic activities, i.e. trade, crafts and professions. The functional area mentioned at the last *included the profession of medicine* and practically outweighed the other two functional areas (Orman 1998).

For Muslim physicians, impetus for the development of medical practices had religious roots. For instance, Imām Muslim relates in his *Ṣaḥiḥ*, the Prophet ﷺ said:

> *"To every disease (dÉ') there is a remedy, and when the remedy (dawÉ') to the disease is found, he is cured by the permission of* Allāh*, the Glorious One."*
>
> *(Ṣaḥiḥ Muslim, ḥadith no2204)*

In another narration, related by Imām Bukhārī, the Prophet ﷺ said:

> "Allāh *did not send down any illness without sending down healing (shifÉ') for it."*
>
> *(Ṣaḥiḥ al-Bukhārī, ḥadith no.5354)*

Ibn Qayyim al-Jawziyya (d.1350 CE), a Muslim theologian as well as a practising physician, had seen in "for every illness a remedy" a sublime force –a force that encouraged physicians to seek and investigate that remedy. In seeking, investigating and applying remedies, inspired Muslims physicians such as al-Rāzī, al-Ṭabarī, Ibn Sīnā and Ibn Qayyim had played pioneering roles in systematizing and professionalizing the practice of medicine. Since the practice of this nobler profession of medicine in Muslim societies in the past was within the purview of the regulation and supervision of *al-Ḥisbah*, *ḥisbah* treatises (administrative handbooks for the *muḥtasib*) contain regulative guidelines concerning the practice.

The purpose of this paper is to study these guidelines in order to explore and discuss some of the standards that were put in place for a wise practice of medicine. Thus, the significance of the paper lies in its potential to enhance our understanding of how physicians in Muslim societies were expected to practice their craft and how their endeavors had led to the formation of pioneering standards of excellent medical practice.

MATERIALS AND METHOD

Source of Materials

The *ḥisbah* treatises as a species of classical literature on Islamic governance are the main source of materials for our current interest. Most of the materials are collected from al-Shayzarī's (d.1193 CE) *ḥisbah* treatise *Kitāb Nihāyat al-Rutbah fī Ṭalab al-Ḥisbah*. Al-Shayzarī was well versed in medical matters and his treatise contains "lengthy and detailed chapters on apothecaries, phlebotomists and cuppers, physicians, eye doctors, bone setters and surgeons" (Buckley, 1999). This fact makes his treatise the key source of materials. Apart from this text, Ibn al-Ukhuwwah's (d.1329) treatise *Maʿālim al-Qurbah fī Aḥkām al-Ḥisbah* and Ibn al-Ḥajj's (d.1336 CE) chapter on *Ādāb al-Ṭabīb* in his *al-Madkhal* have been used to extract materials on medical standards.

Suitability of the Source

As indicated above, *ḥisbah* treatises were administrative manuals which facilitated the *muḥtasib* in his supervision of various trades. The suitability of *ḥisbah* treatises to offer materials on standards can be appreciated by considering the logical link between the regulation and the standards. For regulation to take place, it is a necessary condition to have a set of standards – no matter qualitative or quantitative, crude or refined, loosely defined or precise – which, as a basis of comparison, provides reference point for any performance in view to be judged. Also, the regulation-standards link can be found in contemporary literature on economic standards or economic regulation. For instance, commonly accepted David Greenstein categorization classifies technical rules or standards into four categories in terms of their authorship. "*Mandatory standards or regulations of government regulatory authorities*" (Blind 2004) are one of these categories. Here, government regulations are synonymous with a type of standards. On the other hand, Palgrave's article on regulation and deregulation, which is in tone disapproving of government regulation, mentions "*standard setting*" as one of the methods to enforce the regulation (Breyer and Paul W. MacAvoy 1991).

Method of Organizing the Discussion

This should be noted that throughout *ḥisbah* treatises, the *muḥtasib* is seen to order the practitioners of trades, crafts and professions to do

this or not to do that. This fact made Essid (1995) perceive *ḥisbah* treatises as ones "which invariably consider the problem solely from the standpoint of the theological ideal of hunting down *munkar* wherever it is found" (Essid, 1995). This being the case, our reading of the source needed a special mental exercise which enabled us to take out the *muḥtasib* from the scenario and look closely at the physicians and their acts at which regulative instructions were directed. The explored materials for standards concerning certain aspects of the medical profession are presented and discussed under five categories namely entry requirements, medical instrument, treatment procedure, accountability and moral norms. Admittedly, we resort to frequent and long quotations to build the following discussion because on the one hand these quotations in their entirety are found suitable for our present purpose and on the other hand their paraphrase could have meddling ramifications.

RESULTS AND DISCUSSION

Entry Requirements

A physician could not practice medicine until and unless he had obtained proper authorization. To prevent unauthorized practice, a system of standards was in place to qualify and license physicians (Ajlouni and Khalidi, 1997). The following description of the qualifications of a physician, test of his competence and administration of oath can supply an idea about who could enter into the profession of medicine and how.

Qualifications of a Physician

> *The physician is the one who knows about the body's anatomy, the physical constitution of the organs and the diseases which afflict them, their causes, symptoms and characteristics and the medicines which benefit them. He knows the substitutes for medicines which are not available, the manner of extracting them and the way they act, so that he can give the correct kind and dosage of medicine for the disease. It is unlawful for anyone who does not have this knowledge to treat sick people, nor is such a person allowed to embark upon any treatment in which there is a risk, or to meddle in any of the things we have mentioned which he does not fully understand*
>
> *(Shayzarī d.1193 CE).*

Test of Competence

Ḥisbah treatises eulogize Greek kings for the tradition of having in each city a chief of physicians who was famous for his learning and wisdom. One of his functions was to examine physicians' competence to decide if they were fit to practice medicine. Upon examination, "he ordered any whose knowledge he found deficient to study and to read science and forbade them from practicing" (Shayzarī d.1193 CE). That Muslim cities had adopted similar medical administration can be understood from the fact that *ḥisbah* treatises ask the *muḥtasib* to examine physicians. The *muḥtasib* could not conduct such an examination without expert assistance, provided he himself was not an expert physician. Thus, the chief of physicians, who would have presumably functioned as a *ʿarīf* in his relation to the institution of *al-Ḥisbah*, had examined the physicians' competence on behalf of the *muḥtasib*. It is understood that various types of competence test had been employed to examine their abilities; a few examples of them are as follows. General physicians would be examined "on what Ḥunayn b. Isḥāq wrote in his well-known book *The Trial of the Physician*" (Shayzarī, d.1193 CE). Similarly, eye-doctors would be tested "on a book by Ḥunayn b. Isḥāq, namely, *The Ten Treatises of the Eye*" (Shayzarī, d.1193 CE). For phlebotomists, knowledge of various veins and their location in a human body would be tested (Shayzarī d.1193 CE). Cupper's expertise would be examined through practical test. He would be required

> *to make an incision in a leaf stuck to a backed brick. If the cut goes through the leaf then the cupper has a heavy hand and is not proficient. The sign of a cupper's skill is a light touch and his not hurting the patient*
>
> *(Shayzarī d.1193 CE).*

Oath Taking

It is understandable that the physicians who had attended their test to the satisfaction of the chief of physicians would now take oath prior to the commencement of their medical career. Although *ḥisbah* treatises customarily mention that the *muḥtasib* must make them take the oath (Shayzarī d.1193 CE), the oath might have administered by the chief of physicians in practice. Whatever the

case might be, the oath itself was the issue. They physician would take the Hippocratic Oath and swear

> *not to administer harmful medicine to anyone, not to prepare poison for them, not to describe amulets to anyone from the general public, not to mention to women the medicine for abortions and not to mention to men the medicine preventing the begetting of children*
>
> *(Shayzarī d.1193 CE).*

Depending on the kind of medical practitioners who were to take oath, there could be additional or customized statements in the pronouncements of oath. The oath of phlebotomists, for instance, showed distinction.

> *"There are two veins behind the ears, which are bled to stop the begetting of children. The muḥtasib must make them swear that they will not bleed either of these veins because it stops procreation and this is unlawful"*
>
> *(Shayzarī d.1193 CE).*

Medical Instruments

This point is closely related to the previous one in the sense that a physician could not have started his practice without acquiring minimum amount of medical instruments. In other words, he was to be adequately equipped with various types of medical apparatus.

> *The physician should have a complete set of medical instruments to hand. These are pincers for extracting molar teeth, cauterisering iron for the spleen, tweezers for removing blood clots, syringes used to treat colic and for the penis, a clamp for holding haemorrhoids prior to removal, an instrument for removing excess flesh from the nostrils, a probe for fistulas, an instrument for lifting up the eyelid, a piece of lead for weighing, a key for the womb, an instrument for detecting pregnancy, a poultice for the intestines, a vessel for removing air from the chest, and other things which he needs to practice medicine, apart from the instruments of the eye-doctor and the surgeon*
>
> *(Shayzarī d.1193 CE).*

Treatment Procedure

The patient care and treatment procedure was thorough and systematic. The following quotation captures this procedure succinctly.

> *When a physician visited a sick person, he asked him the cause of his illness and what pain he was feeling. Then he prescribed some medicaments and such like. After this, the physician made a note of what the patient had told him and what he had prescribed for him during the consultation, and submitted this to the patient's relatives, along with the testimony of the patient and those who were with him. On the following day, the physician returned, checked the progress of the illness and wrote another prescription according to the circumstances. He made another record of this and once again submitted it to the patient's relatives. He did likewise on the third day, the fourth day and so on until the patient either recovered or died*
>
> *(Shayzarī d.1193 CE).*[1]

For contemporary physicians, it is easy to see in this description several standards elements of patient care and treatment like patient consultation and search for medical history of the patient, diagnosis of disease, documentation of medications and progress and its authentication, medical record-keeping and routine follow-up (Ajlouni and Khalidi 1997). Of these elements, an elaboration of the diagnosis of disease can shed further light upon the thoroughness and delicacy of treatment procedure. In the above quotation, one means of diagnosis is clear: 'asking.' The doctor would ask the patient as well his relatives or attendants (Ibn al-Ḥajj d.1336 CE) to know about patient's current sickness and his relevant medical history. While asking the patient, doctor would act slow, repeat his questions and give the patient sufficient time to describe his problems (Ibn al-Ḥajj d.1336 CE). Information obtained thus could be sufficient – depending on the nature of sickness – for initial and immediate prescription. Nonetheless, the doctor would not solely rely on the description of the patient or his attendants for subsequent prescription if necessary; he would 'let the disease speak,' which means he would "inspect the urine-flask."[2] The significance of the urine test resides in the fact that while the oral description is susceptible to mistakes, the urine seldom falls short of supplying accurate indications of disease (Ibn al-Ḥajj d.1336 CE). For the urine 'to speak reliably,' there were, according to Ibn al-Ḥajj, many conditions to be met. He mentions two of the conditions, which concerned time of collection and amount of urine. The patient would

[1] Al-Shayzarī describes this treatment procedure as a part of Greek medical tradition. Almost same description appears in Ibn al-Ukhuwwa (p.178) as the norm of medical care in Muslim lands.

[2] Ibn al-Ukhuwwa (p.178) makes it explicit that during follow-up visit the doctor must examine urine. Thus, his almost verbatim account of al-Shayzarī makes a significant addition to, or provides a clarification of, the treatment procedure.

collect urine when he would get up in the morning; if he could not sleep whole night, he would collect when he urinated first in the night. As for the amount, unlike present day's collection of a few drops, the urine-flask would have to hold full amount, which the patient released at the time of collection.

Accountability

The treatment procedure under a particular physician would end up with either recovery or death, provided the patient had not stopped taking medication or the doctor had not referred the patient to someone else. The first outcome was desirable and it naturally pleased both parties. Without doubt, death, which is eventually inescapable, was not the expected outcome of treatment. Therefore, when death occurred, the physician's performance concerning the deceased patient went under strict scrutiny to judge if he had discharged his duty properly. *Ḥisbah* treatises speak about it at length.

> *If the patient recovers from his illness, the physician receives his fee and his considerate rewards. If he dies, the close relatives will go to the chief physician and submit the copies of the prescriptions which the patient's doctor had written for him. If he decides that the wisdom and art of medicine was practiced correctly without any negligence or deficiency of the physician, then he declares, 'Death occurred at the termination of his allotted span.' If he decides oppositely, he declares to them, 'Demand your blood money from the physician for your kin for he killed him by his lack of the art and his inadequacy'*
>
> *(Ibn al-Ukhuwwa d.1329).*

From the perspective of contemporary medicine, "the review of the records by the Chief of Physicians after death occurred represents the post-mortem examination of the outcome of therapy by a peer" (Ajlouni and Khalidi 1997). Clearly, result of such a peer review could be problematic for the physician concerned. When the death was declared to be resulted from the doctor's negligence and deficiency, a part of his wealth was at stake for the payment of blood money. Had this immediate financial payment been the only upshot of the death, perhaps he could manage somehow; nonetheless, it is not difficult to imagine how the negative result of standard peer review jeopardized his future professional career.

Moral Norms

We do not attempt to present a full-length discussion of ethical behavior of the physicians. Rather, we focus on two issues just to demonstrate them as examples of moral concerns in the practice of medicine. One of them relates to patient's confidentiality – clearly a moral issue that emerges as a natural concomitant of medical treatment. The second issue is physician's fee, which is not integral to the act of treatment itself, but medicinal practice as an economic pursuit cannot dispense with it; this issue, as will be explained below, appeared to have moral bent.

Maintenance of Privacy

Physicians are people to whom people disclose their secrets. It was essential that the physicians did not divulge their secrets. Hence, they were expected to be aware of and respectful to patient's reaction to the presence of anyone when they inquired and examined the patient.They would not allow a person to attend whom the patient suspected and did not want to know about his disease (Ibn al-Ḥajj d.1336 CE). Maintenance of confidentiality or privacy had another significant dimension in the past when the physicians used to go to patient's house to treat the ailment. Thus, the house, a private and personal space of the patient, was temporarily exposed to them – outsiders indeed. When this was the case,

> *"they must avert their eyes from the women's quarters when they visit their patients, and they must not disclose the secrets nor lift up veils"*
>
> *(Shayzarī d.1193 CE).*

Classified Fees

If the patient recovers from his illness, the physician receives his fee and his considerate rewards. This leaves us with the impression that the physician would not claim his fee when the patient did not recover. Taking time to render medical services and making the realization of fee conditional on pleasant outcome – recovery from illness – was in all likelihood morally grounded in the physician's fellow feelings. What Ibn al-Ḥajj

narrates about the categorization of patients in terms of their financial ability corroborates this inference. This categorization is worth quoting at some length.

> *It is imperative that the doctor does not consider his patients alike and he classifies them in groups. He will take [his fee] from one group, will not take from another group and will give another group what his prescription costs them. The first group consists of people who have worldly affluence. In the second group are scholarly, godly and ascetic people; instead of taking from them anything, the doctor will seek blessings by providing them medical care and serving their needs. If they offer him anything, he can accept only if he is needy; otherwise, he will return it. The third group comprises of poor people who cannot afford to bear medical expenses; therefore, the doctor will bear what his prescription will cost them provided the doctor is wealthy*
>
> *(Ibn al-Ḥajj d.1336 CE).*

This quotation can well remind us one of the pricing policies of government owned enterprises: 'What the traffic can bear.' If this policy is taken to be a moral dictum in pricing private services, it can be safely said that this policy had defined the standard of minimum threshold for the formation of physicians' attitude and response to their fee. Viewing from this perspective, the profession of medicine –an organized economic pursuit –had transcended the mundane calculation of economics.

CONCLUSION

The above discussion demonstrated that the medical practice in Islamic civilization had created a unique history of high standards and excellence. It had not been easy for anyone to get into medical profession and to practice it. Physicians had to meet rigorous entry requirements, maintain strict procedure of treatment, accept the responsibility for any unpleasant consequences of treatment resulted from a physician's proven negligence, and uphold religio-moral norms in their behavior as physicians. By the first quarter of 14th century, Ibn al-Ukhuwwa observed the members of Muslim community vying for the study of jurisprudence leaving or neglecting the profession of medicine. The reason for such negligence, as he pointed out, was that "by medicine there is no access to judgeships and governorships whereby [by jurisprudence] it is possible to claim superiority over rivals and to acquire authority over enemies" (Ibn al-Ukhuwwa d.1329). It is however possible to think of rigorous requirements and high degree of accountability concerning the practice of medicine as a further reason for many Muslims' reluctance to practice it who had 'jurisprudence' as an alternative avenue – plausibly safer and palpably better – to secure higher social status. The relevant point here is that despite the negligence and reluctance by many Muslim members of the then Islamic society who could potentially achieve medical qualifications and practice medicine, the rigors of medical standards had not been compromised at all to attract (more) Muslim entrants into the profession.

A final note can be added indicating possible further research utilizing *ḥisbah*-based medical standards. The current study is limited to the tasks of exploration and classified reporting of medical practice related standards. Comparing and contrasting these classical medical standards with contemporary medical standards is certainly a good idea which might be the subject-matter of a new study.

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Article History

Received:03/11/2010

Accepted:18/05/2011