Imagining Galeno-Islamic Medicine: an Ethics of Balancing in Healing

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Said the Prophet: "A visit to a sick man is only complete when one of you has put a hand upon his forehead and enquired how he is" (al-Suyūṭī as cited in Levey, 1967, 13).

Reading the ethical codes of a bygone era as indicators of complex processes of practical ethical formation requires a certain amount of imagination. Moses Ochuno, a scholar of colonial Nigeria, urges historians to adopt a methodology of sensing beyond the text, which he calls "a less formal ethnography." By this he means, "locating in one's senses the unseen constellation of energies and sensory forces that undergird African lives" (2015, 297). This strategy of reconstituting lifeworlds from textual residua speaks to a present need in the historiography of Islamic manuals of etiquette (*adab*) and morals (*akhlaq*) and signals the importance of imagination in this approach to Galeno-Islamic medical ethics. The methodology I will employ in performing this analysis begins by taking an "ethnographic stance" (Laidlaw 2014, 45) to historical documents, which James Laidlaw, who works at the intersection of anthropology and ethics, formulates as an epistemological openness to the ethical categories and evaluative principles of others without feeling it necessary to adopt them as one's own. In the course of this paper I

will briefly sketch a moral practice of care through interpersonal connection in medieval Islamic medicine and consider what such a model throws into relief in terms of current trends in humanizing medical practice.

The notion of development I have in mind for my purposes pertains to the increasing articulation of two distinct, yet interpenetrating, ethical horizons in the furnishing of medical care in the 9th to 11th Century Near East: 1) the ethical horizon of the physician providing care, and 2) the ethical horizon of the patient interested in restoring his wellbeing. In terms of ethics, I am building on scholarship that traces a genealogy of ethical practice initiated by Aristotle's *Nicomachean Ethics* and explored anew most recently in the scholarship of Talal Asad (1993) and Saba Mahmood (2005). The chain of transmission comprises the contingent growth of numerous strands of analytical description of modes of practical philosophy, or *phronesis*, cultivated in "relatively undetermined," yet "relatively unfree," (Lambek 2015, 3) acting subjects through forms of incremental disciplining with the purpose of creating in these subjects a certain type of person distinguished by an excellent character. In the world of Galeno-Islamic medicine, the development of ethical medical practice may be understood as a way of not only improving the diagnosis, explanation, and treatment of certain illnesses, but of shaping the character and wellbeing of the patient, to induce the greatest possible beneficial outcomes for her or him.

The vast aggregation and revision of medical knowledge and practice in the Medieval Islamic world first came about after the Abbasids rose to power in CE 750. Soon thereafter the Abbasids established their capital Baghdad, which became an epicenter of learning and cultural sophistication, during which time the caliphs began to incorporate the myriad philosophical writings produced by the Greeks. Patronage by Muslim elites financed the organization of several long-term translation projects that made the works of Plato, Aristotle, Galen, and Hippocrates, among others, available to the Arabic-speaking literati.

The *sheikh mutarjim* of the period was Ḥunayn ibn Isḥāḳ, who translated Greek philosophical and medical classics into Arabic at the behest of the Abbasid Caliph al-Maʾmūn at the beginning of the 9th Century. The ethical systems and the forms of reflection on the development of human virtues that crossed over into this Abbasid world from Antiquity largely derive from Aristotelian notions regarding the shaping of a sense of discernment in the human person as the outcome of the self's forming of the self with reference to a moral code applied in particular contexts based on practical judgment. Once distributed widely amongst the *ulama* of the early Abbasid period, Aristotelian ideas of reflexive human capacities that shape behavior in the pursuit of excellence fairly seamlessly intermixed with monotheistic notions of the alchemy of the soul through various forms of ascesis.

The disciplining of the self by the self in terms of its reflexive rationality (*'aql*) with reference to a moral code provided the backbone for Galeno-Islamic medical practice. Though some learned Islamic scholars resisted the trend of adapting Greek thought to Islamic political, social, and even theological goals, political and medical theorists largely utilized Greek forms of logical reasoning to formulate original philosophical treatises pertaining to a wide array of subjects from political science to metaphysics (McGinnis and Reisman 2007). Within this philosophically-undergirded tradition of medicine, a *hakim* (this term combines the notions of medical practitioner and wise man) achieved sufficient self-mastery of his passions to endow his subjectivity with certain bodily, epistemological, and spiritual powers that could be used to benefit his patients. Several medical practitioners, who doubled as philosophers, reworked and refined models of the *hakim* as the dispenser of salvific interpersonal contact via a transference of Allah's *baraka*, or blessing, through him to his patients.

After the translation of Greek medical texts into Arabic, numerous polymaths in Baghdad and later Persia further developed the empirical and theoretical medical knowledge they received. A lineage of the Galeno-Islamic *hakims* includes Ḥunayn ibn Isḥāḳ, al-Rāzī, and Miskawayh, all working in Rey from the 9th to the 11th Centuries. At the beginning of this period al-Ruhāwī composed his Adab at-Tabib in the 9th Century

in Cairo. It is al-Ruhāwī's expression of medical ethics to which I will now turn to elaborate on the mechanics of Galeno-Islamic medicine in more detail.

Within the medical world described by al-Ruhāwī, the *hakim* rebalances the humoral disequilibrium of his patients. In the reckoning of the humoral system, bodies constantly change and alter, for they are blended of opposing factors. With a fearful symmetry, the four humors of the human body (Levy 1967, Longrigg 1993)—blood, phlegm, yellow bile, and black bile—mirror the four elements of the cosmos—air, water, fire, and earth (Levy 1967, Jackson 1986). The humors also coordinate with the four seasons. Tout court: the rightly functioning microcosm of the human being reflects the properly balanced macrocosm of the universe. "If the microcosm is rightly ordered, the macrocosm serves it" (Harvey 1975, 2). The season of birth, the direction one's house faces and its ventilation, and the quality of air that surrounds one all have potential to induce excess or deficiency in the patient (Levy 1967, Longrigg 1993). Excess in the form of an overabundance of a humor causes disease, as does a deficiency. The virtuous physician is a philosopher who diagnoses imbalance in his patients and then restores their health through curative means such as potions, tonics, change in dietary regime, exercise, evacuation, listening to the patient's narratives, or the use of the *hakim*'s healing touch. In this system, every human has an underlying complexion or temperament that disposes her or him to certain forms of illness. Galeno-Islamic

medicine classifies human predispositions into nine types, one of which is an exemplar of balance.

In order for the *hakim* to develop 'justice' (*'adāla*) as the 'just mean' (*wasaṭ*) between two forms of 'injustice' (*jawr*)—excess and deficiency—he must undertake sustained engagement with reading, contemplating, and applying moral behaviors while reviewing the actions of the self in light of *adab* (Emami 2002). So that he could perfect his own complexion and refine his soul, which therefore meant he could render care to his patients, a *hakim* maintained a relationship with a codified body of moral knowledge and surveyed his own bodily actions. His actions had the power to change the course of the patient's healing by introducing to the treatment environment beneficent or maleficent smells, sights, sounds, airs, alimentation, etc. (Levy 1967). Ibn Khaldūn describes *malaka* or habit as "that inner quality developed as a result of outer practice which makes practice a perfect ability of the soul of the actor" (Mahmood 2005, 137). As the sociologist of Islamic medicine Samar Farage comments, "*akhlaq* or ethos aimed at the cultivation of a transformed nature as excellence through habituated practices" (2008, 28) a transformed nature that could effect healing in the *hakim*'s patients by the force of his ethicality. Moreover the physician shared experience through touch to create a bond of compassion with the patient, using his body as the ultimate medical instrument to diagnose irregularities of pulse. "The shared experience of both the patient

and doctor of flowing humors, as expressed in the pulse, permitted the physician to empathize with the patient" (Farage 2008, 26). Human touch linked patient and physician in a moral practice of socially constituted healing.

An additional way the physician shared experience and compassion with patients was through listening to her or his illness narratives. Al-Ruhāwī advises practitioners of medicine with regard to their patients to "pay attention to any statement heard from them" (1967, 55). He further recommends "total disclosure" (1967, 67) by patients to physicians, so that nothing is concealed from the *hakim*. It is this practice of extensively listening to patient narratives that most pointedly indexes the greatest deficiency of medicine as doctors typically practice it in the contemporary US. The historian of medicine John Harley Warner claims that since the very beginnings of biomedicine's rise, and at the same institution that spurred its rapid growth—Johns Hopkins—the historiography of medicine has figured the practice of its discipline as a means to humanize medicine (2013). This was viewed as a necessary intervention to prevent an overreliance on scientific reductionism in crafting treatment regimes. The notion was that medical students well educated in the history of medicine would assume an identity of gentlemen doctors by virtue of that knowledge. From its very beginnings, the idea of the history of medicine animated itself with a diagnostics of lack.

Awareness of the primary deficiency of medical care in the age of biomedicine, despite its revolutionary technologies and miraculous treatments, may come from an imaginative reading about healing practiced in other worlds of medical care whose values and commitments we can logically inhabit without necessarily wanting to practice them again wholesale. Since at least the publication of Arthur Kleinman's the *Illness Narratives* (1988) it has not escaped the notice of reformers in the medical community that a sense of connection between physicians and patients, a productive blending of ethical horizons, often fails to transpire. What is most heartening with regard to this problem is that interventions are emerging in response to challenges of recovering the balance of ethical care among stakeholders in the various projects of healing that medical establishments organize and undertake.

In this vein, an article from the Harvard Gazette entitled "The Healing Power of Story" narrates the work of Suzanne Koven, physician and writer-in-residence at Massachusetts General Hospital, who facilitates discussions for physicians around various genres of literature. "The storytelling," she says, "is really where the medicine is" (Cooney 2015, 1). Journalist Elizabeth Cooney relates that Koven "convenes small groups of physicians to read and discuss literature. That's where the magic happens" (Cooney 2015, 2). The magic of reintroducing the virtue of empathy as a normative aim into the medical curriculum through practical modeling interfuses human horizons of

meaningful action and reflective freedom. "This is medicine," Koven opines, "because we're hearing from patients that they want to feel that their stories are being heard. They want to be listened to. And literature, I think, is a very fine kind of listening and very good training for listening" (Cooney 2015, 3).

Will this intervention at MGH lead to greater healing among the patients there? Does exposure to literature lead these physicians to more sensitive ethical actions amidst the dizzying pace of medical care in a large urban hospital in 21st Century America? These questions I cannot answer, but I can say the return of the power of storytelling and the reintroduction of a mode of reciprocity into the sociality of medicine gives physicians and patients the means to get in touch with each other so that they may aspire to achieve the ends of healing together. This particular history of healing reclaims the possibility of physician and patient coming together through speaking and hearing. Therefore illness will not necessarily mean, as anthropologist Michael Jackson says, the patient is "rendered passive before impersonal forces he or she cannot comprehend and with which he or she cannot negotiate" (2007, 116) A listening doctor may render the patient a human actor once more, not just the acted upon but rather an ethical subject in the care of a beneficent *hakim* wise to the truth games of self-expression.

Works Cited

Asad, Talal. 1993. *Genealogies of Religion: Discipline and Reasons of Power in Christianity and Islam.* Baltimore, MD: Johns Hopkins University Press.

Cooney, Elizabeth. "The Healing Power of Story" http://hms.harvrd.edu. Accessed 5/22/15.

Emami, Abu'l-Qassem. 2002. "Abū ʿAlī Miskawayh" tr. Suheyl Umar In *The Encyclopaedia of Islam [electronic resource]* eds. P. J. Bearman, Marc Garborieau. Leiden: Brill.

Farage, Samar. 2008. "The Ethics of the Physician in the Galeno-Islamic Tradition" In *Muslim Medical Ethics: from Theory to Practice* in ed. Jonathan Brockopp, Thomas Eich, 21-37. Columbia, SC: University of South Carolina Press.

Harvey, E. Ruth. 1975. *The Inward Wits: Psychological Theory in the Middle Ages and the Renaissance*. Warburg institute surveys. London: Warburg Institute, University of London.

Jackson, Michael. 2007. *Excursions.* Durham, NC: Duke University Press.

Kleinman, Arthur. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition.* New York: Basic Books.

Levey, Martin. 1967. "Medical Ethics of Medieval Islam with Special Reference to al-Ruhāwī's 'Practical Ethics of the Physician'" in *Transactions of the American Philosophical Society* 57.3: 1-100.

Longrigg, James. 1998. *Greek Medicine: From the Heroic to the Hellenistic Age: A Source Book*. New York: Routledge.

———. 1993. *Greek Rational Medicine: Philosophy and Medicine from Alcmaeon to the Alexandrians*. London: Routledge.

Lambek, Michael. 2014. *The Ethical Condition: Essays on Action, Person, and Value.* Chicago: University of Chicago Press.

Mahmood, Saba. 2005. *The Politics of Piety: The Islamic Revival and the Feminist Subject.* Princeton, NJ: Princeton University Press.

McGinnis, Jon, and David C. Reisman. 2007. "Introduction" In *Classical Arabic Philosophy: an Anthology of Sources* ed. Jon McGinnis, David C. Reisman. Indianapolis: Hackett Pub. Company.

Ochonu, Moses. 2015. "Elusive History: Fractured Archives, Politicized Orality, and Sensing the Postcolonial Past" in *History in Africa.* New Brunswick, NJ: African Studies Association.

Warner, John Harley. 2013. "The Humanizing Power of Medical History: Responses to Biomedicine in the 20th-Century United States." *Procedia: Social and Behavioral Sciences 77: 322-329.*