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Physicians, Magicians, Patients, and Prophets:
Echoes of the Soul and Medical Knowledge at the Margins of War

by

Ashwak Sam Hauter

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Joint Doctor of Philosophy

with University of California, San Francisco

in

Medical Anthropology

in the

Graduate Division

of the

University of California, Berkeley

Committee in Charge:

Professor Stefania Pandolfo, Chair

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Spring 2020

Abstract

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by

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Doctor of Philosophy in Medical Anthropology

University of California, Berkeley
University of California, San Francisco

Professor Stefania Pandolfo, Chair

This dissertation examines interlocutors' ideas of health and illness, as they have been inflected and intensified by the war in Yemen. My ethnography, based on 24 months of multi-sited field research, explores the demand for '*afiya* (physical, psychological, and spiritual wellness) and the human, as grounded in an Islamic cosmology. My fieldwork took place in university teaching hospitals, private hospitals, clinics, research centers, and mosques in three urban centers: Sana'a, Yemen; Jeddah, Saudi Arabia; and Amman, Jordan. As physicians, families, and imams are sought and become integrated into treatment plans, I argue that '*afiya*, rather than the patient, is the object of medical care, implicating a network of people in the alleviation of the illness. Unlike the vision of *sihha* (physical health), where illness must be destroyed utterly, under the rubric of '*afiya*, the illness becomes a trial and symptom open onto the experience of divine judgment (including of and on war, deprivation, and the migration and refugee crisis). This demand for '*afiya* among patients involved broader social advocacy for reform—of the body but also of the political, economic, and spiritual dimensions of the community. Physicians responded to this demand by their 1) engagement at the forefront of the 2011-2012 uprising in Sana'a, Yemen; 2) work with refugees and migrants in Amman and Jeddah; and 3) clinical trials of Prophetic Medicine in Jeddah, arguing that evidence in medicine should show long-term benefits rather than short-term efficacy. This response was framed in the three field sites as a reform (*islah*) of medicine and a (re)introduction of the Islamic medical tradition to global medicine and health. Rather than the Orientalist narrative of a golden age followed by the decline of Muslim science, I argue that ethnography discloses a different historical perspective on physicians' various positions with regard to the proper relationship of Islam to medicine, Islam to magic and astrology, and Prophetic Medicine to biomedicine. Each is part of a complex of engagements and arguments internal to the tradition regarding *islah* (reform and renewal). I locate these various arguments within the archive of Islamic scholarship concerning physics, cosmology, affinity, prognosis, the channels of God, and unknowledge (*al-ghayb*). Some of my interlocutors reconcile Islam and biomedicine; some call for a medicine grounded in Islamic thought and holistic form of a human with a soul; yet others distinguish medical efficacy from medical benefit. My dissertation rethinks the relationship between Islam and medicine through focusing on multiple scenes of "reform" where the binaries of tradition and development, local and global, fail to account for emergent realities.

Table of Contents

Acknowledgments iii

Preface vi

Introduction: Repetitions and Returns

Circumbobulation	1
Field and Soul	2
Sites of Reform (and Fieldwork)	4
Aporias of Ethnography	6
Institutional Ethics and/or Trust	8
Knots	10

Chapter 1: The Soul, The Knot, and Derangement

<i>Uqda</i>	12
Medicine in Contemporary Yemen	13
Medicine in the Eleventh–Fifteenth Century	16
<i>Ikhtilāf al-‘aql</i>	17
The Interpretation of Ibn Abī Šādiq	20
Worship and Inattention to the Body	26
Madness, Psyche, and Body	28
Conclusion: Toward a Medico-Psychology	30

Chapter 2: Benefit and Efficacy: Methods and Limits in Science and Islam

<i>Dalil</i> or <i>Ta’wil</i> ?	32
The Prophetic Medicine Clinic	36
Reform of Medicine, Reform of Sunnah	47
Toward a Plurality in Methods	50

Chapter 3: Echoes of (Re)Form: The Body of the Soul and the Soul’s Body

<i>Amana</i>	53
The Good Physician	57
Part I: Clinical Sense, Discipline, and the Law	60
Conscience (<i>Damir</i>) and Insight (<i>Firasa</i>)	64
The Unteachable: <i>Hads</i> and Imagination	65
Intellect (<i>‘Aql</i>) and Self/Soul (<i>Nafs</i>)	67
Knowing God, the Other, & Myself through the Other	69
Interlude: The Limits of the Body, the Limits of the Modern Soul	74
Part II: The Law: Is it Simply One’s Own?	78
The Ethical and the Legal	80
Traditional Ethics and the Ethics of Psychoanalysis	84
The Enigma of Desire: <i>Ibrah</i> (passage)	90

Chapter 4: Physicians, Magicians, and Prophets: Effectiveness of Medicine and Magic	
The Magicians	92
Love, War, and Affinity in the Hospital	93
The Prophet, the Magician, and the Incorporation	95
Physics of Affinity	100
Magic	103
<i>Alghayb</i>	104
The Neurologist: Astrology and Affinity	107
The Illusion	118
 Chapter 5: Illness as Passage: The Absent Patient	
The Illness as Passage	121
The Hospital	124
The Fall of the Father	127
<i>‘Ibrah</i> (Exemplar): The Enigma of the Illness	136
The Rise of the Martyr	
 Chapter 6: Between Fear and Fright: Psychic, Spiritual, and Physical Borders	
Which came first: the Fright or the Jaundice?	142
Yemen: Before and After the Wars	144
Migrants and Refugees in the Hospital	145
The Break of the Nafs/Self	147

Acknowledgments

One of the few memories I have of my maternal grandfather is his supplication “may God reform your soul” (*islahkum allah*). He invoked this whether we were sitting down or running around frantically. My maternal grandfather, Abdelrahman Alghazaly, was a family-taught jurist (*qadi*) in Badan, Yemen in the mountainous Ibb province. He is buried there alongside my grandmother behind their farmhouse overlooking the emerald terraces of wheat. His voice lives on in my mother’s stories, which she only began to share after I discovered his legacy accidentally as a teenager living in the Central Valley of California in the aftermath of my father’s death. Just as much of my dissertation evolved over the many years around a seminar table, so it did around my dining room with my family. A widow raising seven children on her own without her own source of income, my mother Wahbia Alghazaly carried both the burden and the honor of rooting us in our ancestral rituals, knowledge, and observance. Her wisdom, resilience, and creativity formed my soul and shaped my intellectual curiosities. More importantly, my mother’s herbal and Quranic practices derived from Prophetic Medicine and my eldest brother’s training in biomedicine inspired my pursuit and engagement with both traditions. I am grateful for Moneef’s courage to pursue his MD and to encourage and support my journey in higher education. Growing up I did not know many Yemeni women pursuing higher education. As his only daughter, my father praised my intellect and encouraged my academic pursuits even when community members disagreed with him. Although I lost my father at the age of 14, he instilled in me a drive for scholarship as he forwent seeking an education in order to work long hours in his Brooklyn bodega and provide for his entire family in Yemen. My dissertation is an embrace of all the voices that have come before me, that have coursed through me, and the unheard voices echoing through.

So much of this work was made possible by my interlocutors in Jordan, Saudia Arabia, and Yemen who graced me with their company and entrusted me with their stories, theories, and wisdom. I was adopted by exiled Yemeni medical students and physicians in Amman and by the physicians and oncologists at the University Hospital in Jeddah. The residents and interns in Yemen, Saudi Arabia, and Jordan became my companions and confidants. It would be an understatement to say I transformed during fieldwork. This was not due to the data I collected for my ethnography, but through the guidance given to me that shaped my thought, unlocking forgotten wisdom. This gift, in the form of guidance, is inestimable. I am grateful to my interlocutors at the hospitals, from which many have become my peers.

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Preface

On our layover in Germany, boarding a plane to Sana'a, Yemen, the flight attendant pointed to my mother's ticket and asked, "Alghazaly—like the scholar?" I repeated the question in Arabic, but my mom just shook her head with a bright smile. I was a teenager at the time. Growing up in the United States I had only met my maternal grandfather once, on an earlier trip to Yemen. I did not know much about him, let alone that he was a jurist (*qadi*). It was at that moment that I realized there was a whole history, a tradition that I had inherited (although never named) by way of my mother's stories, wisdom, and discipline. I began to read much of al-Ghazali's work on the soul, to recognize his name when mentioned in Friday sermons.

I write this preface amidst the coronavirus pandemic, reflecting on the story of discovering my mother's lineage, but also the cuts that came with my PhD and fieldwork. Following Stefania Pandolfo, here I consider "the cut" in light of psychoanalysis and Islamic philosophy and mysticism. The primordial cut of psychoanalysis (Lacan, Winnicott) is the necessary separation from the mother that enables entrance into the symbolic and relational world. The cut is the psychic experience of separation that forges recognition of the limits imposed upon the self as one journeys onward with others. The separation afforded by the cut creates a space between self and other that can produce either movement or stasis. Cuts can either give rise to new forms of relationalities or be incorporated into the self as despair. Throughout this pandemic, I have been thinking a lot about how the cut informs my personal life, my pedagogy, and my chosen profession of anthropology.

First, there is my story of embarking on the journey to obtain a PhD in medical anthropology. I am the only daughter in a family of eleven. My parents grew up on village farms in Yemen, had no formal education, and embodied the praxis of egalitarianism and hospitality of the tribes and the mysticism of Sufi scholars. My mother, a descendent of the renowned Islamic scholar Abu Hamid al-Ghazali, had long felt ambivalent toward my studies. She feared that my doctoral studies in a discipline historically hostile to non-Western forms of knowledge would cut me off from her tradition. A year into my program, I almost gave up until my advisor reminded me that what mattered most was not how well I knew Kant or Hegel, but that I could think from and through another tradition. Then, when I was planning my field research, a series of events—the Arab Spring uprisings in 2011, the war breaking out in Yemen in 2015, a US "Muslim Ban" on Yemenis in 2016—confronted me as other cuts, ruptures in the coherence of the world I hoped to immerse myself in. I could not continue fieldwork in Yemen. In and through each cut, anthropology became my refuge, offering a way to think about the space between the realization of loss and transition toward invention, what in Arabic might be translated best as *barzakh* (isthmus, barrier, threshold). Anthropology would help me reflect across my identities, traditions, and worlds. As I moved in and out of the spaces in-between, I recalled my mother's words: *la tansi nafsik* (do not forget yourself, know what is conditioning your soul). When she reminded me to never forget my soul/self, she was reminding me not to forget my desire, to not forget justice in the transition between cuts.

The fourteenth-century historian Ibn Khaldun wrote that one response to interruptions (or cuts, if you will) is to turn to pedagogy, to allow for a form of thinking and writing demanded by another world. He argued that when people are cut off from direct transmission of a tradition and its formation of the soul, discipline is required to establish the limits that can preserve desire: to form the soul without breaking it. The soul must be formed, but it must also breathe, for desire is necessary for any rebuilding to take place. Thinking with Ibn Khaldun, who was writing at the

time of the bubonic plague, I am reminded that tribulation (*fitna*) and ordeal (*ibtala*) are cyclical. Every community, in every time, is afflicted with a trial of its own, and usually the decline of an empire stems from its abandoning the cultivation of the sciences and the production of crafts. Recursive images: the city is the reflection of the souls that build it up, just as souls reflect the knowledge that builds the city. Ibn Khaldun warns that those who refuse a pedagogy of the soul will be taught by time. The question of the soul—in medicine, ethics, revolution—would be my vehicle. In the space in-between, I continue to study the ways the soul makes its way into Muslim medical practices and into patients' demands for wellbeing (‘*afiya*’).

Instead of succumbing to the stasis of my soul brought about by the isolation imposed by the cuts of geopolitical upheaval in my fieldwork, I turned to pedagogy. I spent many mornings on the ground floor of my host family's home in Saudi Arabia sipping Yemeni coffee, eating dates, and reading Claude Lévi-Strauss' *Tristes Tropiques*—alone. Lévi-Strauss, too, wrote from conditions of isolation during fieldwork, in his case in Brazil, reflecting on how he came to anthropology. He portrayed anthropologists as those who withdraw into themselves in order to study phenomena, in near monastic fashion. The ethnographer rests in place to bear witness, to hear the silences, to remember the forgotten, and to unearth the absences in the passing moment as the world continues to move.

As the world rests in place from the COVID-19 pandemic, as listening is interrupted by the slowing of the world's motion, what lessons are we to learn from dwelling-in-place? Reading Ibn Khaldun and Lévi-Strauss together suggests that from the space between cuts, we can (if we attend to our souls) leap into new relationalities. How can we condition our souls not to forget our recursive relationships to the larger world?

Anthropology is in its own way an in-between space, invested not merely in deciphering the laws of societal norms but also in examining the ways that time builds or buries habits. Ethnography shows us how knowledge is transferential: it is neither in me nor in you. We look on in this time of the novel coronavirus not to diagnose but to bear witness to its contingency and connectedness (from which the word *contagion* is derived). The space of isolation erases histories of suffering but also recreates them. When we forget, we ultimately repeat, again and again, until we remember the drive that necessitated the cut. We must dwell in the space in-between to reconsider our drives for capital, security, control, and surplus enjoyment (*jouissance*).

An antidote to the stasis of cuts and pandemics arises from the study of the soul. Studying the soul speaks to what gives life to movement, what patterns repeat, what allows ethics and trust to arise within a given space. As we step into an uncertain future of cuts—government cuts threaten the social sciences, collapsing economies threaten job security, family isolation threatens community—how will we respond with a pedagogy of the soul? The twelfth-century scholar al-Ghazali argues that souls expand when anchored. The soul's knowledge of itself is elusive; it slowly acquires this knowledge through the outer and inner senses. To avoid a deadening oscillation between stasis and movement, one must make space for the soul's needs and inner senses (appetite, anger, and intellect) while cultivating them into courage, temperance, and wisdom. Wielding one's inner senses opens the imagination to creative memory, rather than letting it run wild. When we all are at home sheltered in place, inert from lack of movement and lack of experience, perhaps discipline itself can move us, rather than constrict us.

In the final class of my course this semester, Anthropology of the Soul, I invited my students to consider the soul not simply as something interior and inaccessible which one molds and shields, but as a force that is structured by and structures the worlds around us. Our souls are

reflected in our habits and our relationships. I instructed students to document their new daily routines and to think about how the soul inhibited their work. Did they feel hopeful, apathetic, or resigned? I asked them to speak with a new person every week (remotely) and to reflect on this interaction in relation to the knowledge produced in-between cuts. I wanted my students to understand the need of the soul to move, to breathe, and to find a new space of limits within which to desire. But during the COVID-19 crisis, we might consider the space necessary for the expansion of others' desires as well. These lessons on the movement of the soul are even more critical as the pandemic will only further isolate those who seek the space to expand their souls by migrating; those whose movement is forced by wars and impoverishment—thinking now of the Central American migrations and the wars in Yemen, Iraq, and Syria. Making space for others to desire amid the cuts that divide.

The lesson here is that cuts don't simply divide. Cuts also expand our perimeters. My own spatial and intellectual return to Yemen and the Islamic tradition came as a result of my being cut off from my traditions, but also from my desire to engage my interlocutors' relation to the generativity of Islam as a form of resistance (including the ambivalence felt by some). The Islamic tradition, its civilization, and the history of Yemen that I have come to know is drastically different from how it is commonly portrayed. In the media, in literature, and in certain academic circles Islam is portrayed as draconian, patriarchal and oppressive, and associated with tribalism, irrationality, and an intolerance of science. As Edward Said has shown, there have been well over three centuries of a discourse that othered Islam and Muslim societies. This representation fuels interventionist politics that aim to unshackle Muslims from the imagined dead weight of their traditions and practices and instead to export to them enlightening knowledge and expertise, rendering the suffering of Muslims expendable and their indigenous knowledge ineffective. My work examines the psychic and subjective effects of this global and historical othering. It also points to the failure to recognize the contributions made by Muslim philosophy, medicine, and science to modern Western thought and sciences.

Much of Yemen's history has been reduced to statistics. In the time of COVID-19, it is no different. At the end of April 2020, cases of the novel coronavirus were reported in various regions in the country, with many occurring in Aden. The five-year conflict with ten allied countries has seen no end. As COVID-19 began to spread, and the UN pulled out 100 employees, Doctors Without Borders noted that the country's 400 ventilators could not possibly cover the forthcoming ICU hospital needs. The blockade by Saudi Arabia to the North and by Oman to the West has contributed to severe food shortage, leaving 18 million to famine. Physicians in rural districts are scrambling to attend to children dying. The country is facing a cholera outbreak, typhoid fever, and dengue fever. Photos began to circulate of men in hazmat suits spraying markets with what seems to be disinfectant while crowds gather to make their purchases for the breaking of their Ramadan fast. In the south, Aden has been overtaken by floods and Taiz continues to be under siege by rebels. Due to food shortages and famine, Yemenis from Hadramawt and Hodeida were forced to migrate to Sana'a. These dispossessed Yemenis have set out camp in the streets, begging for food, aid, and shelter. They are now considered refugees in their own country. This image of a state in despair, ruins, and plight circulates over and over again.

I set out to write an ethnography of Yemen's spirit and history of reform, *islah*, in the multiple senses of this word, both in Arabic and English, political and spiritual, collective and intimate. What I received, in following the voices of the dispossessed Yemenis I met over the years, in Yemen, Jordan, and Saudi Arabia, was closer to the reality on the ground. The desire

for recognition, witnessing, and justice, and their historical returns can be glanced in watermark through scenes within the practice of medicine. This dissertation is a marriage of the traditions I inherited, those I was disciplined in, and the anthropological imagination cultivated between them: my intellectual interests in medical anthropology, in the history of science and medicine, in the Islamic tradition's writings on the soul, and in psychoanalytical theories of the psyche. Amidst multiple closures, possibilities opened up to pursue a scholarly inquiry that aims at a collection of the voices, dreams, and wisdom of Yemen. Upon returning from fieldwork, I have come to embrace the silences, voids, loss, and invention in writing. As I was reminded, writing is love, and love is giving someone what one does not have to someone who does not want it.

Ashwak Sam Hauter
May 2020

Introduction: Repetitions and Returns

Circumbobulation

There I was, at 1 a.m., hiding behind one of the 20-foot-long golden doors of the sacred mosque in Mecca, Saudi Arabia, during the first night of the Ramadan night prayers—trying to find the best acoustics to allow me to hear and be heard by my analyst. While my right hand was shoving my iPhone onto my ear lobe, my left hand served as an umbrella over my upper lip. The woman guarding the door open to one of the few ladies' sections looked my way and ignored me, as I started mumbling to my analyst in Oakland, California, that this predicament was typical of many of my fieldwork dilemmas. I had spent the entire day at the hospital where I was doing fieldwork, staying late because it had taken me seven months to gain access and now I had to maximize my time. I had finally received Internal Review Board (IRB) approval from both the hospital's ethical committee and Berkeley's IRB, after having to address security policies regarding the digital storage of my fieldwork notes while traveling, in new questions following the US 2016 "Muslim Ban". These institutional forces were an additional pressure after I had relocated my fieldwork outside of Yemen due to the 2015 war.

In a daze, I began to recount to my analyst the beauty of the *tawaf* rite (circumambulating the Ka'ba), which in English I mispronounced as "circumbobulating." I went on a tangent, feeling ashamed of taking time away from the night prayer because of my need of the one hour a week with my analyst to stay afloat in the field. I had been feeling disorganized and at constant loss while conducting fieldwork inside the hospital, listening to patients' desires for physical, psychic, and spiritual well-being (*'afiya*) and listening to physicians' attempts to address wellbeing beyond that of the anatomical body through recourse to the soul and the law. I felt the need to explain how politically- and socially-infused circling the house of God had been for me during this month of Ramadan. I explained how I understood why people here enter their own spaces; in the movements of their own rhythm and supplications and force, they step on you and shove you to each side, maintaining their course. People often scold you during *tawaf* for these moments of self-wandering, coming together and coming apart, summoning you back to the rhythm of the group.

As I continued to speak of the rite, my analyst interrupted, "The word is circumambulate. You created a new word, circumbobulate; how clever."

I paused, then said, "There's something about the self that is reclaimed within this space."

My analyst said, "Well, doesn't it sound like discombobulate?"

"That's just it," I replied: "I feel myself coming together, as if *bobulated*. To be discombobulated is to be estranged from oneself and become absorbed and captured by the trappings of social life. When I circumambulate the Ka'ba instead, I feel myself coming together. Even though circumambulation is meant to be a communal experience of worshipping God, I always take it as a moment of witnessing—witnessing of my relationship with God. There I am also projecting that onto others, making room for their own way of relating to God." I told my analyst that we cannot always trust the world, that we must be grounded in God. The Arabic word *tawaf* means to wander, to roam, to circle, but also to become acquainted with something and to come to know. It means to ambulate and as I put it, in an instance of unconscious poetics, "bobulate." My research on the question of the soul within the hospital suddenly seemed relevant in this personal moment of communal worship, for the soul involves unconscious processes. As exemplified in the *tawaf*, the soul requires space for its expression and desire; it gravitates

towards poles of communion and introspection, and its “expansion” and “constriction”, to use the Quranic figure, depend on the laws set to form it without breaking it.

I understood at that moment, as I was standing between pillars in the sacred mosque, how the soul emerges as a force that can constrict or broaden one’s horizon, one’s potentiality; and that its constant surveillance and the suppression of its needs result in a form of death. In turn, I realized that what I had been calling “the soul within the hospital” is the limit of the institution’s hold on the person, as for it entails more than the recovery of that person’s physical well-being (*sihha*). In tending to merely the physical body, the institution evades the soul and ignores the socio-political economic field that contributes to its movement and inertia. The soul bears witness to unjust laws that land refugees in the emergency room; it testifies to the limit of science in uncertain prognosis, to the limit of the body to cultivate goodness in a physician, and to the love and hate that arise between physicians and patients. In that moment of religious worship, I came to realize the unconscious drive of my intellectual inquiry.

Field and Soul

I found myself in Jeddah, Saudi Arabia after I could not return to conduct dissertation fieldwork on reform (*islah*) within the hospital and ethico-medical traditions in Sana’a, Yemen in 2015. With this rupture I lost relationships cultivated over nine years, the support of family, a mapped-out network of institutions, and a promised proximity and intimacy. Returning there was out of reach due to geopolitical conditions well beyond my control (humanitarian catastrophe, bombing campaigns, civil war). In the summer of 2016, I surrendered to the losses that were to come and to the research field that might unfold in Jordan and Jeddah.

My first stop was Amman. I arrived in Amman during the first week of Ramadan 1437. Like other financially-constrained graduate students, I found myself in a less than perfect sublet with very little equipment. I needed a blender, so I visited a local household items shop in Weibdeh, a quaint neighborhood. As I looked around the shop, the owner offered to help. When I asked him about a handheld grinder, he noticed my dialect and asked if I was Yemeni. He then handed me a green plastic handheld grinder that looked like something teleported from the 1980s—in fact, resembling one my mother often had me use as a child in Yemen in the 1990s whenever the electricity went out, following the 1994 civil war.

The shop owner said he had sold many handheld grinders in the last two years to Yemenis who were living in the area. He explained that some came for medical treatments while others had come in the last year due to the ongoing war. As many of them were also subletting furnished apartments, uncertain of their date of departure, they sought out some small appliances like this to retain a piece of home and continuity in a time of crisis.

My own first encounter with Yemenis in Jordan was with some girls at a mall shopping for groceries. My inability to share a clear research question drove the university girls away, as one woman shook her head and said, “You’re going to be doing this for a very long time.” I would later reunite with the young woman I met at that mall on a trip on which other medical students invited me, organized by Jordan’s astronomy club with the aim of reviving the Islamic study of the heavens. She apologized for running away and pointed out that Yemenis were more reluctant to speak to one another in Jordan. Even the medical students had split into factions, with many affirming their allegiance to the rebellion despite the fact that Jordan is part of the coalition that supports the restitution of the current president, Abdrabbuh Hadi. My own inability to disclose the research questions I had long considered for my work in Yemen indexed my own fear of enclosure.

I was also confronting very different conditions in Amman, for Jordan as a fieldsite was devoid the configuration I was expecting from Yemen, which pits hospitals against Quranic healing centers, doctors against traditional healers. Jordan also lacked the intimacy I'd grown accustomed to in Yemen, where I was bound by social ties, customs, and genealogies. I had brought research questions with me from Yemen, but found them turn against me. How can one locate the soul in medical practice, as a ground for the trace, as a faculty for enclosure, as a filter, a sensor and both a receptor and emanator of knowledge, experience, law, and training—all when speaking of the soul requires oneself to be enclosed, named, and located in ways refugees, medical practitioners, and guests (myself included) feared? In Amman and then in Jeddah, the question of body and soul now presented itself as the problem of a field.

When I arrived in Jeddah in October 2016, I thought that I was set. I was a visiting fellow at the King Faisal Center for Islamic Studies and Research and I had already corresponded with the hospitals I was interested in conducting ethnographic research at; they had responded positively, welcoming me to conduct my research. However, just as my initial attempt in Jordan was inhibited by my inability to communicate the intentions behind my project, my attempts to gain access to hospitals in Jeddah was even more difficult. Here the reputation (*sum'a*) of the hospital itself was on the line. To gain access, to be known and recognized, was more necessary than an ethics committee's approval. My reputation was necessary to attest my ethical character and orientation, but it was precisely this sort of "reputation" I lacked.

My attempt to locate the IRB office and speak with the Vice Dean of the woman's college was itself successful, except for my assumption that simply handing in paperwork would ensure its delivery and review. After weeks of expecting a reply, I made my way to the university to find that my paperwork had been lost and that my research was rejected. Soon after, my hostess asked her sister (an associate professor at the school of dentistry) to intervene on my behalf. When I resubmitted, I was simply told that, since my research resembled that of another professor at the university, they had to ensure that the research was not duplicated given the need to maintain rank among the leading research universities in the Middle East. After tracking down the professor with the presumed duplicate project, I shared my project proposal with her and she gave the IRB her blessings. When she met me, she asked which family I was staying with. She recognized that southern Yemeni (Hijazi) family and praised them, as they were part of the Ba 'Alawi sufi order and known for their piety and *amana*. She noted that she felt at ease in my presence and that she was willing to help me, for everyone needed a guide within the walls of the hospital.

In the seven months leading up to my IRB approval from the university hospital, I had been barred from the hospital for several reasons, many which lay with my lack of any trace of reputation (*sum'a*). Without *sum'a*, the hospital administration could not anticipate my actions and reactions, as there was very little other oversight. As a result, the hospital feared for its own *sum'a* by association. There was also a distaste for foreigners who benefited from the resources of the university without giving back, which deterred the administration and research faculty from allowing anyone to conduct research without faculty supervision (for example, without a commitment to faculty co-authorship of any proceeding publication). Eventually I received permission and access, given enough time and a verified *sum'a*. My application acceptance seven months later would come as a shock to me and the faculty members whom I would come to observe and meet. For them, it was evidence of my character (*akhlaq*) and divine blessing.

Sites of Reform (and Fieldwork)

Islah, “reform,” is a double-edged concept in the history of Yemen and of the Middle East at large, resurfacing as an enactment of both modernization and Islamic reform. It points to pedagogies of modernity and state projects of modernization on one hand, and to the ethical striving for Islamic reform in the encounter with modernity and colonization on the other. The modern problem-space of “reform” congealed in the late nineteenth century around the Ottoman program of *tanzimat*, the “Reorganization” of the Empire that spilled over to the Arab lands through Ottoman governance. The strategy to parallel European industrialization and modernization led to a reorganization of society that placed into question the place of Islam in relation to “progress.” The Ottoman initiatives came as attempts to resuscitate the empire that had become a raw material producer for Europe at the expense of local economies.¹ As Europe continued to thrive, while Muslim empires devolved in Southeast Asia and West Africa, Islamic movements and discourses of reform bore a complex dialectic.²

The reformist movements aimed to illuminate how Islam was compatible with reason, revising law to accord with shifting social, political, and economic conditions. Major figures of that *islah* movement were Jamal al-Din al-Afghani (d. 1897), Muhammad ‘Abduh (d. 1905), and Rashid Rida (d. 1935). The latter was highly influenced by the work of Muhammad al-Shawkani (d. 1838), a Zaidi Yemeni jurist who was the spark of the contemporary Salafi movement in Yemen. Rida drew on al-Shawkani’s openness to interpretation and his return to the original sources of law in order to address the new demands of his time.³ Whereas al-Shawkani aimed primarily to authenticate the Prophetic tradition,⁴ the spirit of his evasion of the inherited corpus was taken up by the modernists. Looking back on these movements now, the Muslim reformers were clearly reacting (sometimes apologetically) to challenges posed by European Enlightenment. On the other hand, the prophetic tradition itself promises an episodic divine renewal of its message, in light of the prophesied estrangement of Islam in the world.⁵ The challenge this poses, which has been debated well since the philosopher of history Ibn Khaldun, was to discern whether particular revival movements qualify as properly renewing the tradition and community or are vehicles for the acquisition of worldly power.⁶

Islah is also the name of a political party in Yemen, literature on which focuses on its Muslim Brotherhood origins dating back to Egypt’s presence in Yemen until 1967.⁷ Yet the *Islah* party did not simply spread the political theology of Hasan al-Banna. The party’s founder, ‘Abd al-Majid al-Zandani, a pharmacist, founded Iman University (later closed by the Houthis in 2014) for training in the Islamic sciences and exploration of Prophetic Medical cures. The party’s link to medicine was explicit (al-Zandani had purported for many years to have

¹ Tamim Ansary, *Destiny Disrupted: A History of the World through Islamic Eyes* (PublicAffairs, 2009).

² Sir John Bagot Glubb, *A Short History of the Arab Peoples* (New York: Stein and Day, 1969).

³ Brinkley Messick, *The Calligraphic State: Textual Domination and History in a Muslim Society* (Berkeley: University of California Press, 1996), 56. See also Bernard Haykel, *Revival and Reform in Islam: The legacy of Muhammad al-Shawkani* (Cambridge: Cambridge University Press, 2003).

⁴ Jonathan A.C. Brown, *Hadith: Muhammad’s Legacy in the Medieval and Modern World* (London: Oneworld Publications, 2017).

⁵ Ebrahim Moosa and SherAli Tareen, “Revival and Reform,” in *The Princeton Encyclopedia of Islamic Political Thought*, ed. Gerhard Böwering et al. (Princeton: Princeton University Press, 2012), 462-463.

⁶ Ibn Khaldun argues that the narrative of renewal and its providential promise was coopted to usurp power rather than actually resuscitate divine authority and the morality of the community (*The Muqaddimah: An Introduction to History*, trans. Franz Rosenthal, (Princeton: Princeton University Press, 2015), 22-31).

⁷ Jillian Schwedler, “The *Islah* Party in Yemen,” in *Islamic Activism: A Social Movement Theory Approach*, ed. Quintan Wiktorowicz (Indianapolis: Indiana University Press, 2004), 205.

discovered the cure to HIV through recourse to Prophetic Medicine).⁸ Many physicians I interviewed were part of the *Islah* party. More generally, the sites of traditional and biomedical medicine compete in their proximity, each marshalling different mandates for reform; there are herbal healing and *ruqiya* (Quranic healing) centers adjacent to most hospitals.

Reform discourses spread in Yemen well before the 2011 Arab Spring. In 2007 political protestors—youth, journalists, and women activists—congregated around Sana‘a University. Tawakkul Karman, who went on to win the Nobel Peace Prize, called for freedom of the press. Much of the energy of those protests and uprisings has since dissipated. Although Yemen began a national dialogue in 2013 that left many feeling hopeful, the recommendations were not implemented, plunging the country into civil unrest. This failure of the national dialogues, along with the ex-President’s alliance with the Houthis, led to the Houthi takeover of Sana‘a. The president, Abdrabbuh Hadi, fled to Saudi Arabia for refuge. A ten-country alliance supported his claim to government, leading to the ongoing onslaught on Yemen. This conflict, which began in March 2015, has destroyed hospitals, killed over 100,000 people, and dispossessed as many as three million Yemenis.

After having conducted fieldwork in two hospitals in Yemen for over six months, with over 50 physicians, residents, and patients, I turned to fieldwork in Amman, Jordan, and Jeddah, Saudi Arabia, with Yemeni migrants and refugees and diasporic communities. Moving through these three fieldsites, I discovered the echoes of the former Hijaz railroad, which connected these three spaces prior to their post-World War I consolidation as nation states. These spaces were connected not simply by their nineteenth-century topography but also by common institutions and the southern Yemeni Hadrami diaspora.

Amman, Jordan is a cosmopolitan city that is home to many refugees, including Palestinians, Syrians, Iraqis, and now Yemenis. Jordan University has attracted top students from all over the Arab world. There were at least 200 medical students from Yemen alone studying at its medical school. I was able to interview about fifty medical students, residents, and physicians there.

Jeddah, Saudi Arabia is also home to many southern Yemenis (migrants, entrepreneurs, and traders). The long history of intermarriages and the redrawing of state borders throughout the twentieth century has meant that many southern Saudis still lay claim to their Yemeni ancestry. At the university hospital I conducted over one hundred interviews with medical students, interns, nurses, residents, attending physicians, patients, and their families. I shadowed physicians during rounds and in their clinics for over nine months.

Moving through these three fieldsites over a total of twenty-four months, I sought out the echoes of the soul in medicine, in the desire for restorative justice and indigenous knowledge and healing, in the aspirations for decoloniality, for democracy, in the practice of Prophetic Medicine, and in the recognition of science in Islam. By exploring these avenues in medicine and psychology—specifically with attention toward the persisting tradition and resurgence of Prophetic Medicine, reform and self-accounting of the soul, practices of healing, and Islamic medicinal scriptural texts—my goal is to elaborate the polysemy of *islah* in the contemporary world. This serves not only as an historical exercise but as a means of understanding the flows of

⁸ “Yemeni Cleric Abd Al-Majid Al-Zindani: I Have Discovered Cures For AIDS, Heart Failure – And Obtained ‘Accreditation For A Patent’ From UN Agency For Them,” *MEMRI*, September 25, 2012, <https://www.memri.org/reports/yemeni-cleric-abd-al-majid-al-zindani-i-have-discovered-cures-aids-heart-failure---and>.

knowledge between and within contemporary traditions, especially in the context of developing scientific institutions and the struggle for democracy in the aftermath of the Arab Spring.

Aporias of Ethnography

In the seven months prior to my gaining institutional access to the hospital in Jeddah, I turned to Claude Lévi-Strauss' *Tristes Tropiques* for inspiration. Lévi-Strauss's ruminations on his struggles and the limitations to his openness to magic, novelty, and truth echoed my own struggles and my being banned from studying the soul in the hospital. Considering Lévi-Strauss's allergy to Islam and its impact on the loss of the feminine in Christianity, I was led to reflect on my own allergies to the weight of society and its institutions (the law) bearing on the individual's relation with God (the soul).

Lévi-Strauss's trials in his fieldwork and melancholic introduction to the loss of his days gives us a perspective on the monoculture today effected in the name of the Muslim Ban, the deportation of migrants, and the end of migration. Lévi-Strauss has an answer for xenophobia: the search for magic. To travel (escape) is to exit one valence of a structure and to enter another that will further illuminate universal truths—or at least, that is the fantasy. Distance and seclusion cannot produce the conditions for illumination, just as proximity and intimacy do not produce the conditions for inhabiting dreams. Lévi-Strauss writes that his dreams have “slipped through his fingers like quicksilver.”⁹ Dreams, like distance, give rise to condensed and metabolized fragmented memories. As an avid reader of Sigmund Freud and a structuralist himself, Lévi-Strauss is also speaking to the potential reach of the unconscious through dreams. His inability to penetrate his own unconscious prompts his reflection on his inability to penetrate the unconscious workings of another. His anthropological work then details the depth of structure and unconscious nature of culture itself, detailing the measure of this inability. In the end, time became his friend. As Ibn Khaldun would say, time teaches us all what we refuse to learn.

Lévi-Strauss then wishes that he had lived in the days of real journeys, to enjoy the full splendor of spectacles. He mourns the purity of a more archaic space, the lost savagery (speech and acts) of people drenched in cosmological symbolism. Yet he well knows that the purity he craves—unpolluted, unadulterated—marks his own temporal limitations. The truth of the matter is indebted to time, only to be exposed in the fullness of time, which eludes us as finite beings. He accepts that what he perceives offends him,¹⁰ but he is searching to transform, worried that what is presented before him is unworthy and yet afraid of being barred from experiences, that something will pass him by. He finds that data is not external to the anthropologists. It possesses them. Their bodies serve as hosts. Their psyche serves as filter. Their thought transforms. That is the promise of the field, the promise of travel.

In this anti-ethnography, Lévi-Strauss recalls the failure of travel writing and his own desire for a time when he could have found an untarnished, purer state of culture, space, practice, custom, or myth.¹¹ What travel does instead is confront the “unfortunate aspects of our history.”¹² Travel replicates the desire for escape, a socially sanctioned break from society, to generate the “magic” or power that is found in native rituals. Yet this magic, like a contemporary dream, is ephemeral and beyond our reach: socially, politically, geopolitically. Transformations,

⁹ Claude Lévi-Strauss, *Tristes Tropiques*, trans. John and Doreen Weightman (London: Penguin Books, 1992), 42.

¹⁰ *Ibid.*, 43.

¹¹ *Ibid.*, 37.

¹² *Ibid.*, 38.

political alliances, and hurdles have produced not only a desire for a monoculture, but also surveilled the crossing of borders and movements of objects across borders. If we find that explorers and travelers (or even anthropologists) seek power and transformation through experience from the field or the other—being a precise parallel to native rituals that involve withdrawing into the forest, where no social norms or laws exist, to generate power and enter “communication with the supernatural world”—then travel is a desire bespeaking a lack of transformative rituals.¹³ It is itself the myth of anthropology: the promise of transformation.

My own struggles with the question of transformation stemmed from my position as both an insider and an outsider—being barred, but already inside. I was told that I looked very “Saudi”. Yet the problem of how my soul was read though unspoken (in my dealings with people who are themselves dealing with the confounding issue of the soul) made it impossible to look at myself when people wanted something I could not offer. My last name was of no help. Old Arabic in origin, Hauter has a semantic migrant double and collapses our pre-Islamic ancestral Yemenite Jewish heritage and the bureaucratic erasure of naming practices that landed it as our last name when my great-grandfather reached Ellis Island in the late 1930s. My last name was untraceable. There was no echo of any sound. My legibility as an American rendered me illegible in the field, banned from the other and my own lineage. Thus, I turned to Lévi-Strauss, seeking a different form of transformation.

Lévi-Strauss desired to remember his dreams and spaces to “assert our freedom and explore the limits of sensuality.” This desire was frustrated due to the inability of Christianity and French thought to incorporate orientations from eastern traditions, including Islam. Lévi-Strauss found Islam to be the West of the East, producing several arguments for the parallelism between France and Islam in terms of their “bookish attitude”, “Utopian spirit”, and “stubborn convictions.”¹⁴ Unlike those who thought Islam is a return to nomad, desert life, Lévi-Strauss saw Islam as refracting French thought. Therefore, the advent of Islam prevented an anticipated “osmosis” between Christianity and Buddhism, which required an embrace of the female.¹⁵ For Lévi-Strauss, Christianity could have been open to the feminine only if it came after Islam, which he argued was masculine. The constrictions of his desire were thus shaped and imposed by history, suggesting a lack within Christianity that Islam fertilized and realized. The reflections in *Tristes Tropiques* only congealed after allowing the experiences and knowledge from his trip to simmer, “rolling [his] memories along the tides of [forgetfulness].” From these fragments, structures and patterns were illuminated, as if his unconscious had figured them into form, a work of magic that wasn’t readily available.

Lévi-Strauss’ relationship to Islam changed as he eventually discovered in it what Europe recovered through Marxism and ethnology. In *Race and History*, he wrote:

As long as 13 centuries ago, Islam formulated a theory that all aspects of human life—technological, economic, social and spiritual—are closely interrelated—a theory that has only recently been rediscovered in the West in certain aspects of Marxist thought and in the development of modern ethnology. We are familiar with the preeminent position in the intellectual life of the Middle Ages which the Arabs owed to this prophetic vision. The West, for all its mastery of machines, exhibits evidence of only the most elementary understanding of the use and potential resources of that supermachine, the human body.

¹³ Ibid., 9.

¹⁴ Ibid., 405.

¹⁵ Ibid., 409.

In this sphere, on the contrary, as on the related question of the connexion between the physical and the mental, the East and the Far East are several thousand years ahead.¹⁶

In this text, Islam was no longer a refraction of French thought but transcended European thought. I can only speculate that between these two texts—between Lévi-Strauss’s melancholy in *Tristes Tropiques*, tormented by an imaginal destruction of local culture by colonial expansion, and the celebration of difference in *Race and History*, due to the failure of globalization to transform the Other—was the persistence of difference and its potentiality. It is in *Race and History* that Lévi-Strauss reflects on the difference of Islam, without projecting onto it his own lack. Europe can change.

Reading across Lévi-Strauss’s two texts, I returned to the echoes of my own struggles to trace the soul amidst my ban. As a Muslim Yemeni-American woman, I have always been wary about engaging the anthropology of Islam within the context of my work with Muslim physicians. Islam is a multifarious tradition—including discourse, dream interpretations, Quranic cures, agentive forms of submission, and more.¹⁷ As a Muslim, I could take certain things for granted (for I possessed certain forms of knowledge, even if unaware of the experiences that shaped them), but also had to negotiate those forms against other expressions of the tradition. It is not that I found myself unteachable as an ethnographer, but that I was caught between seeking an openness to the experiences of others and holding onto the forms that held my practices in place. Searching for the traces of the soul, an entity we are presumed to be banned from, in the shadows of the many expressions of the ban, was not simply a question of lifting one’s soul in order to invite in another. How then could I reconcile the methods by which we ethnographers observe, translate, and convert data with the immanent risk of being discombobulated? Additionally, how could I begin to recognize in others what has been made unconscious? This dilemma recalls Jorge Luis Borges’ “Ethnographer,”¹⁸ one who sets out to learn the secret of the other, but then resolves not to carry out the pedagogical task of anthropology in demonstrating the secret. He remains an ethnographer, retaining the wisdom he gleans.

When I did gain entry into the hospital, many of my interviewees pointed to our shared tradition. Everyone from the interns and residents to the consultants and patients would gesture at the fact that I already knew (or should know) certain elaborations because I was Muslim. These aspects were alluded to, undisclosed, unspoken in the shared, embodied practice and its affective expression. Do moments like these make one unteachable? While other anthropologists suffer from the often-debilitating accusation that they will never truly know the other, I was presented with the opposite polemic: we cannot tell you, because you already know. Gathering data was not a matter of ethnographically translating the experience of the other. It was a question of repetition and returns, dreams and premonitions. It was also an aporia in thought.

Institutional Ethics and/or Trust

Ethnography is not simply the transmission of expert hidden knowledge, for knowledge is elided and evaded through various institutional injunctions and restrictions and ethical and

¹⁶ Claude Lévi-Strauss, “Race and Culture” in *Race and History* (Paris: UNESCO, 1958), 16.

¹⁷ Talal Asad, “The Idea of an Anthropology of Islam” (Washington, DC: Center for Contemporary Arab Societies, Georgetown University, 1986); Amira Mittermaier, *Dreams that Matter: Egyptian Landscapes of the Imagination* (Berkeley: University of California Press, 2010); Stefania Pandolfo, *Knot of the Soul: Madness, Psychoanalysis, Islam* (Chicago: University of Chicago Press, 2018); Saba Mahmood, *Politics of Piety: The Islamic Revival and the Feminist Subject* (Princeton: Princeton University Press, 2011).

¹⁸ Jorge Luis Borges, “The Ethnographer,” in *Collected Fictions* (New York: Penguin, 1998), 334-335.

intimate fidelities. Much of ethnography is unknowledge (*ghayb*). A deferral of knowledge is institutionalized within our very own IRB protocols and the practice itself. How then can we think with the variegated ways ethnographic work is already in a position to trace the lessons of *al-ghayb*? More importantly, how can we think of the introduction of the Internal Review Board for ethnographic fieldwork as the imposition of the law for an anticipated fear—and also consider past transgressions of medical and social scientists that placed their interlocutors in physical, political, or economic harm, who failed to be trustworthy and uphold the social/divine trust (*amana*)?

The IRB in Amman and Jeddah represented more than a committee of researchers and physicians reviewing my purpose and methods and ethical procedures and data security. In both cities I was warned that the IRB board was becoming more selective. It was not simply a problem of bureaucratic corruption but a way to protect the intellectual property of the research institute. (Both medical universities are attempting to become leading research institutions.) The IRB represented a bridge to an international community; it makes possible the contribution and transmission of knowledge. It is an institution-based committee that reviews social-behavioral, biomedical, and humanities protocols, including FDA-regulated research. These protocols not only involve the formulation for the project but include the justification, methodological grounding, and insurance of protection for recruited participants.

The Institutional Review Board is a body of scholars dedicated to the protection of human subjects. Although the IRB states that its protocols are not required for oral history, it requires anthropologists to obtain its approval due to the dynamic nature of participant observation. Ethnographic theory has historically valorized the position of the outsider, the stranger, the indisposed, the melancholic, and the oppressed, recruiting these figures to witness their own structural marginalization. Anthropologists settle within communities and adhere to groups' shifting practices (whether sincerely or otherwise). To continue sustainable engagements with others requires sacrifices and accommodations. The IRB enforces regulations that redefine the parameters of research in accordance with particular protocols to ensure participant safety, as is well clear. At the same time, treating ethnographic realities with the trust (*amana*) they require is not always identical to the institutional demands of the IRB. There are events that I cannot include in this dissertation, names that I cannot acknowledge—for the reasons of the IRB but also for distinct (if overlapping) rationalities. The ability to conduct ethnography itself comes with a whole set of possibilities, missed opportunities, and established fidelities. One cannot attend to everything or let everyone down.

The IRB reflects ethnography's constraints and purposes. An ethnography is a limited invitation into a community, a tradition, a set of practices, memories, dreams, and relationships. It is a limitation in that it does not encompass anything but only attempts to bear witness—and serve as passage. As ethnographers, we enter spaces having a set of limits bound to our practices, and eventually must recognize and adhere to shifting practices within the field. In hospitals, every physician I chose to follow opened me to other physicians but precluded yet others.

Data does not simply generate itself. The reception of data involves exchanges that may involve emotional, psychic, socio-economic, and political implications. The IRB represents the incremental limitation of human explorations and extractions. The everyday and the mundane, as much literature in medical anthropology has shown, are not a neutral or vacuous space waiting to be examined. The body and communities are circumscribed with transgressive nodal points varying in time and space but also generating further limits as methodologies become more and more transgressive. We do not enter neutral spaces nor do we neutrally walk within them.

Fieldsites are prefigured and refigured as we move through them. One can imagine a maze that reconstructs itself as a person moves through it. If one comports oneself accordingly, paths will diverge rather than enclose.

Within my fieldsites, the adjudication of sound physicians modeled that of a sound transmitter and witness. This involved being known as an honest and upright individual that others have witnessed in exchanges and transactions. They are known to bear the social/divine trust (*amana*) in their everyday speech (which already is a form of gift). *Amana* implies that individuals deliver what is given to them in the condition it was received. For me, this ranged from being entrusted with secrets to personal accounts that were meant not to bolster my ethnographic fieldwork but to aid in my instruction as a researcher and student of knowledge. In a field that is laden with many transgressive markers and socio-political sensitivities, female physicians shared with me their personal histories as counsel (*nasiha*) for my career, life, and personal developments. Others exposed and divulged information not for the sake of documentation but to further exploration of the depth of situations at hand. Physicians in Saudi Arabia and Jordan either confessed their Yemeni heritage or outed other physicians, and told me to seek the aid of my Yemeni brethren. We often laughed about it, as it underlined the complex politics of the incorporation of non-Bedouin population within the Saudi nation through citizenship that only became a main source of tension after the first Gulf War.

These moments of confession and identity politics questioned my ability to perform interpretations of inner meaning (*ta'wil*) involving a particular discernment. This included understanding human limitations in the transmission of knowledge and the ability to intuit intentions, examples, and wisdom without objectifying material forms. This question of the witness organized the relationship between evidence and authority. Things are sealed because of relations to people, institutions, and moral injunctions but also the limit internal to human adjudications. This assertion of unknowledge and my own limits echoed the formal protocols of the Internal Review Board (IRB) itself. The IRB reflects other constraints and purposes of ethnography. Its invitation entails recognition, integration, and submission to a set of laws that enables circulation of what is seen as efficacious or beneficial knowledge. Meanwhile, ethnography itself is both an invitation into and limit of a community, a tradition, a set of practices, memories, dreams, and relationships. It is a limitation in that it does not encompass anything it attempts to bear witness to; and yet it serves as a passage.

When I met with the hospital institutional review board, I stressed my adherence to the protocols of my qualitative research, which they were familiar with, but not to the extent to the depth of what I was requesting. I assured them that I was not a medical physician. I could not evaluate their physicians or assess negligence or malpractice. My participant observation would be limited to individuals willing to participate. I would not record hall or informal conversations that physicians. These long conversations and the detailed outline I submitted to them as an entirely separate applications reassured them.

The IRB application was useful step to establishing trust (*amana*) but did not guarantee it. The following ethnography is an *amana*, one I intend to deliver as a passage, a lesson (*'ibra*) for those willing to hear.

Knots

This dissertation begins with Yemen and ends with Yemen, providing a space to witness its current destruction through the movements of Yemeni migrants, refugees, and displaced medical professionals. It begins with a chapter on the pain of a psychic “knot” (*'uqda*) that

patients said formed from difficult experiences within the healthcare system in Yemen and the lack of trust (*amana*) in the physician-patient relationship. The dissertation ends with a displaced Yemeni migrant who fears the fracture of his soul/self in being denied medical care in Saudi Arabia, illuminating the end of Muslim hospitality. The role of the soul in the pursuit of physical, psychological, and spiritual wellbeing calls for a reform of not just the physical body but of society's socio-political and economic structures. The soul emerges in these chapters as an energy, a motion, and the instrument for imagining potentialities and realizing fantasies. The soul is knotting. Its force is a potentiality for life whereas its constriction is an actuality of death.

Uqda comes from the root *'-q-d*, meaning to tie, knot, contract, bond, bridge, warrant, and complicate. It relates to a family of words that include belief, magical knot, bond, creed, conviction, and opinion. *Uqda* relates to both a person's psyche and social reality with respect to truth and reason. The knot, *'aqd*, is an entwinement of memory to a past, but also a tie that produces families (marriage is itself a knotting of ties). Creed (*'aqida*) is the knot that ties a person's heart to God. A person's creed (*'aqida*) informs a person's belief (*ta'qid*), which means to be tied to a particular knowledge and anticipate rational convictions (*i'tiqadat*). Whereas choking or knotting of the soul (*'uqdat al-nafs*) displays both the death drive and incorporation of pain as a wound,¹⁹ the knot is also simultaneously a life drive and the grounding of the heart in God.

How the knot unfolds within the following scenes of reform (*islah*) in this dissertation details the importance of the deferred hope of the post-Arab Spring spirit—particularly on the question of the soul, as the Quranic verse “God does not change the state of the people unless they change what is within themselves” (Q. 13:11) reverberated across the Arab Muslim world. Throughout these chapters, amidst crisis of dispossession, pedagogical shifts, economic recession, and patients' demands for *'afiya*, I trace the question of the (re)form of the soul/self: in medico-ethical Islamic texts; in the discourse on ethical medical practice; in the reformulation of medical knowledge; in the affinity of the physician-patient relationship; in the structure of the family; and in the broader Muslim community. These unfolding scenes of reform index the psychic pain of the knotted psyche (chapter 1); the invention of a new genre of Prophetic Medicine (chapter 2); the echo of the soul in physicians' ethico-religious cultivation (chapter 3); the collapse of trust within the physician-patient relationship (chapter 4); patients' demand for wellbeing in light of the illness becoming a site of passage (chapter 5); and the fear of breakdown of the self/soul due to ethical dispossession of the Muslim community (chapter 6).

¹⁹ Pandolfo, *Knot of the Soul*, 210, 326.

Chapter 1: The Soul, The Knot, and Derangement

‘Uqda

In my initial ethnographic research in hospitals in Yemen, I tried to escape the bureaucratic and conceptual influence of local institutional evidence-based medical physicians. I had traveled to Sana’a intending to interview hospital inpatients about their thoughts on medicine and its contemporary practice there. Their words continually returned to a familiar culprit: *‘uqda*, a psychological-moral knot.¹ Immaterial and corporeal at once, the figure of *‘uqda* wove its way into many of our conversations, taking center stage as the primary reason for the lack of trust between patients and doctors in everyday exchanges. Patients spoke of the “knot” as a conceptual configuration that evoked the force that tethered particular painful memories or experiences, which in turn informed their relationships to doctors and biomedicine. As people spoke, *‘uqda* indexed a form of pain that was more pressing and elusive than what could be sought through access to bio-medical care. What some medical anthropologists might call an idiom of distress was here both a painful experience for the patients and a window for thinking about what is missing from contemporary medical practices. In the course of my fieldwork, I learned to thematize such a psychological and moral “knot,” *‘uqda*, as a conceptual tool that urgently called attention to the disappearance of multiple vibrant medico-ethical traditions that were grounded in a nexus of the body-soul.

Listening to patients and refugees who described their *‘uqda* to me and who remained unheard in the space of the hospital and in exile entailed returning to a forgotten and “outmoded” question, the question of the soul (*nafs*, *rūḥ*), becoming capable once again of thinking health and illness at the intersection of physical and metaphysical worlds. This is how I found myself turning to the classical Islamic medical tradition, looking for insight into the contemporary question of the soul in eleventh-fifteenth century medical texts. Such medical texts, including works by Ibn Sīnā (d. 1037/428H) and Ibn al-Qayyim (d. 1350/751H), circulate in Yemen as a source of healing outside the space of the hospital, even during the present catastrophe.²

This paper treats the relation of pain and madness in *Sharḥ al-fuṣūl Abūqrāṭ* (Commentary of the Aphorisms) by Ibn Abī Ṣādiq (d. 1068/470H), a younger contemporary and likely a student of Ibn Sīnā, who discussed the problem of *ikhtilāl*, or the pathological mixing of humors, as a configuration at the limit of the physical and the metaphysical, moving toward a theoretical psychology (a theory of the soul) and medico-philosophical language of the subjective experience of pain. Given the complex historical coordinates I mentioned above, my exploration of the work of medieval Islamic physicians on questions of pain, madness, and mental derangement does not seek to demonstrate an uninterrupted lineage of Islamic medicines³ down to patients in contemporary Sana’a, Yemen—even though, I would argue, these legacies can be heard by those who are willing to listen. Revisiting eleventh century texts allows us to appreciate the patients’ invocation of the *‘uqda* in twenty-first century Yemen, in as much as that

¹ See Stefania Pandolfo, *Knot of the Soul: Madness, Psychoanalysis, Islam*, (Chicago: University of Chicago Press, 2018), 114, 150, 210, 250. In her ethnographic work in Morocco alongside an Imam (a *mu’ālij shar’i*, scholar of *fiqh*, and therapist), Pandolfo considers the soul’s constriction or “knot” to demarcate a function of the soul’s potentiality, and its affective and existential states in relation what her interlocutors experience as *dhiq al nafs* (soul choking) (229).

² I am referring to the ongoing conflict in Yemen that began in March 2015.

³ I follow Manfred Ullman in his categorization of “Islamic medicine” to encompass those Muslim and non-Muslim physicians, diverse in their ethnic origins, who wrote in Arabic and lived in the sphere of Islamic culture. See Manfred Ullmann, *Islamic Medicine* (Edinburgh: Edinburgh University Press, 1978), vol. 1, xi.

invocation is pointing to a loss of what once occupied a central conceptual space. I therefore approach questions of madness and mental derangement at once from ethnographic and historical lenses, thinking of the present tensions and of the *longue durée* of Islamic scholarship on pain, the intellect, and psyche as I read Ibn Abī Šādiq's commentary on the *Hippocratic Aphorisms*.

Medicine in Contemporary Yemen

Institutional biomedical facilities emerged in Sana'a after the republican revolution of 1962⁴. Although the second Ottoman rule in Northern Yemen (1872-1918) had palpably reordered the territory "under the auspices of the *tanẓīmāt* reforms" (including a military hospital for Ottoman troops and preparation to build another in Sana'a), many of its development projects were abandoned subsequent to the Ottoman withdrawal.⁵ In the nineteenth century, the ruling Zaydi Imam's isolationist policy (seeking to protect Yemen from foreign intervention) halted all such forms of development.⁶ This enclosure of Yemen from modernizing projects may or may not have invigorated the remnants of traditional forms of healing, prophetic medicine, and Arabic medicine. Yet, medical doctors today expect to receive patients who attend *ruqya* (Qur'anic healing) centers where Prophetic medicine is still practiced, including healing through Quran recitation, herbal concoctions, and cupping (*ḥijāma*).⁷

In present day Sana'a there are *ruqya* centers for both men and women around the corner from every clinic and hospital. One may attend the center to listen to Qur'an being projected from a speaker as people await their turn for a one-on-one session with the *murqī*.⁸ Others visit the *ruqya* store, where they can buy water over which Qur'an has been recited or other *khalaṭāt* (mixed concoctions). Much as is illustrated in Peter Pormann and Emilie Savage-Smith's *Medieval Islamic Medicine*,⁹ a man in Ta'izz, Yemen, today sells medical concoctions based on Ibn Sīnā's medicine, claimed to be both natural and efficacious. Here, physical and spiritual ills and cures are not decoupled, but are inextricably bound together: a simultaneous congealment of *ḥikma* (traditional wisdom) and demonstration.

The claims to medicines within these different domains confound the division between the physical and the spiritual. The recuperation of both Ibn Sīnā and Ibn al-Qayyim (1350) signals how medical traditions have reemerged, and persisted even, in Yemen to speak to the different dimensions of the human and its composition. Whereas Ibn Sīnā is identified as a Arab-Greco physician, Ibn al-Qayyim al-Jawziyya, a physician and student of the well-known Hanbali jurist Ibn Tayyimah (d. 1328), was a key figure in inaugurating the genre of Prophetic Medicine.¹⁰ Yet, Arab-Greco and prophetic medicine were sciences that did not evolve in

⁴ The *Thawra* (Revolution) Hospital was built in Sana'a in 1968.

⁵ Thomas Kuehn, *Empire, Islam, and Politics of Difference: Ottoman Rule in Yemen, 1849-1919* (Leiden: Brill, 2011), 80, 82.

⁶ Robert Burrows, *The Yemen Arab Republic: The Politics of Development, 1962-1986* (Colorado: Westview Press, 1987), 18.

⁷ See Cynthia Myntti, "Changing Attitudes Towards Health: Some Observations from the Hujariya" in *Economy, Society and Culture in Contemporary Yemen*, edited by B.R. Pridham (London: Croom Helm, 1985), 22-40.

⁸ An Imam or Shaykh who practices *ruqya*.

⁹ Peter E. Pormann and Emilie Savage-Smith, *Medieval Islamic Medicine* (Edinburgh: Edinburgh University Press, 2007).

¹⁰ Prophetic medicine as a genre emerged later in the 14th century through the compilation of prophetic hadiths concerning physical and psycho-spiritual health by Ibn al-Qayyim al-Jawziyya and Ibn Taymiyya's circle of students, but also by scholars such as Ibn al-Dhahabī (1348), and Jalāl al-Dīn al-Khūdayrī al-Suyūfī (1505). Fazlur Rahman, 1987. *Health and medicine in the Islamic tradition, change and identity*, (New York: Crossroad, 1987), 41-49.

isolation of one another, as Ibn al-Qayyim begins his treaty on Prophetic Medicine with a discussion of the four humors, drawing on Arabo-Greek medicine for the foundation of his work.¹¹ Similarly, Prophetic Medicine, according to Fazlur Rahman, was not simply divine prescription for health, but medical cures that the Prophet Muhammed incorporated and authorized from pre-Islamic Arabic and Bedouin medicine in addition to Indian and Greek medicine possibly studied by community members.¹² It is through this living archive and its mixture that confounds the realms of the metaphysical, spiritual, and physical, all polysemous categories varying in texture in different traditions, that point to a recognition of an anthropology.

Yemenis did not in the course of my fieldwork view institutionalized evidence-based medicine as an imposed foreign object.¹³ Instead, they navigate the terrain of evidence-based medicine through discussions of the great physicians of Islamic civilization, such as Ibn Sīnā, Ibn al-Nafīs (d. 1288/870H),¹⁴ and Ibn al-Qayyim. Though these figures hail from distinct periods, genres, and regions, they are merged in the contemporary Yemeni context insofar as their work Islamicized medical traditions of their time and produced a familiar parallel to contemporary evidence-based medicine. In turn, Yemenis did not view evidenced-based medicine as a rejection of an Islamic past. On the contrary, the co-presence of *ḥukamā*, biomedical doctors, and *ruqya* centers was seen as an attempt to bring to fruition, even return to, a certain Islamic tradition. Each provides a glimpse of medico-ethical traditions that addresses health as a balance of individual temperament—encompassing body, soul, and ethical/psychic life.

The doctors, similarly, decried their own failed aspirations to live up to the figures of the *‘ālim* and *ḥakīm* (practitioners of Islamic medical wisdom), exemplified for instance by Ibn Sīnā and Ibn al-Nafīs, attributing such failures to, among other reasons, the absence of a certain Islamic curriculum and pedagogy due to the lack of sufficient state funding. During my interviews with Yemeni doctors and medical students in Yemen in 2013 and abroad in Jordan in 2016, they nonetheless laid claim to the prestige of ancient physicians by drawing on the traits of *firāsa* (discernment) and the cultivation of *ḍamīr* (conscience) to demonstrate their intuitive insights or *hads* (intuition by empiricism)¹⁵. Yemeni physicians, like their patients, described themselves as “knotted” (*mu‘taqidīn*) by memory, experience, and the fear of failure in their respective roles.¹⁶ In the space of the contemporary Yemeni hospital, this problem of knowledge is habitually overdetermined, for physicians exist at the margins of postcolonial histories and the

¹¹ Ibn Qayyim al-Jawziyya, *Medicine of the Prophet*, trans. Penelope Johnstone (Cambridge: Islamic Texts Society, 1998).

¹² Fazlur Rahman, *Health and medicine in the Islamic tradition*, 41-49.

¹³ Although patients in Yemen identified the knot (*‘uqda*) and its affective charge as having produced a tenuous web within the clinical space, they did not reduce the psychological knot to a response to the colonial expansion of biological medicine.

¹⁴ Ibn al-Nafīs wrote the earliest description of pulmonary circulation by reconceptualizing the soul. See Nahyan A. Fancy, *Science and Religion in Mamluk Egypt: Ibn Al-Nafīs, Pulmonary Transit and Bodily Resurrection* (New York: Routledge, 2013).

¹⁵ Hads is a term in Ibn Sīnā’s Psychology. See Jon McGinnis, *Avicenna* (New York: Oxford University Press, 2010), 94, 147-148, 250.

¹⁶ In turn, this affectively produces a lack of trust, deception and resentment by both parties, concealment of knowledge and divergent languages of expertise, and problems of translation between different registers of knowledge and understanding.

present moment of Islamic revival.¹⁷ Yemeni physicians are considered to possess neither Western expertise nor traditional wisdom. There is a general sentiment of fear and distrust of physicians' ability to understand physical and nonphysical causes of illnesses, given that this requires a type of knowledge that remains veiled from them. Yet the contemporary entwinement of conceptions of physical, mental, spiritual, ethical, and psychic health and illness impose an anthropology that is resonant of historical anthropologies of the human. Anthropologies found in medieval medical texts such as Ibn Abī Šādiq's promise to engage the soul metaphysically (physical, psychic, and spirit) in the pre-modern sense, but also gestures to an immateriality beyond Avicenna's that is faith based. The polysemy of the soul, and its problem for medicines, thus spans these very different historical contexts.

Madness in contemporary Yemeni institutionalized evidence-based medicine, as it relates to the *'uqda*, alludes to not just the lack of trust in physicians' prescriptive practices and their effects, but to the political and collective reality that produces a melancholic loss of a medico-ethical sense of health (medicine and psychology). Historically, madness and mental illnesses drew medieval physicians to speak to the nature, substance, and function of the soul, spirit, and intellect, for example, melancholia was seen to result from the imbalance of the humors that involved the psychic and ethical well-being of the patient.¹⁸ As madness and mental illnesses were subject to physical, metaphysical, spiritual, and psychic causes and treatments, they drew on multiple discursive practices across *'aqli* and *naqli* discourses, including physics, medicine, metaphysics/theology, hadith, and *fiqh*.¹⁹ Therefore, how did madness function to articulate body and soul, organs and psyche? Do questions of madness provoke further developments in medicine, reformulating metaphysical and psychological frameworks within a particular cosmology? And for the medieval physicians who were translating and drawing on Greek thought, was their fidelity to a unified medico-philosophical psychology tested when they encountered questions of madness and mental illness? My ethnographic work on the *'uqda* in Yemen prompts an inquiry into medieval physicians' anthropologies because they too stood at the interstices of (and strove to reconcile) different medical traditions.

This article examines how Islamic physicians historically dealt with questions of madness and its relation to the body and soul through a close reading of Ibn Abī Šādiq's eleventh-century commentary on the *Hippocratic Aphorisms*. This textual treatment allows us to better appreciate the complex historicity in contemporary Yemen of prophetic medicine, alternative medicine, and the prestige of ancient physicians. The discourse on the soul, and its polysemy, recurs today, as it did then, at the interstices of conflicting medical traditions—as remains most visible in cases that deal with inexplicable spiritual and psychical illness, requiring a more explicit understanding of the relation between the body, psyche, and soul.

¹⁷ Stefania Pandolfo, "The Knot of the Soul: Postcolonial Conundrums, Madness, and the Imagination" in *Postcolonial Disorders*, edited by Mary-Jo DelVecchio Good, Sandra Teresa Hyde, Sarah Pinto, and Byron J. Good (Berkeley: University of California Press, 2008), 329-358.

¹⁸ See Pormann, P.E. and Joosse, N.P., 2012. "Commentaries on the Hippocratic aphorisms in the Arabic tradition: the example of melancholy." *Epidemics in Context: Greek Commentaries on Hippocrates in the Arabic Tradition*, 8, p.211. and Michael W. Dols, *Majnun: The Madman in Medieval Islamic Society*, ed. Diana E. Immisch (Oxford: Clarendon Press, 1992).

¹⁹ See Michael W. Dols, *Majnun: The Madman in Medieval Islamic Society*. Also, see Omrani, A., Holtzman, N. S., Akiskal, H. S., & Ghaemi, S. N. Ibn Imran's 10th century treatise on melancholy. *Journal of affective disorders*, 141(2-3), 116-119, (2012)

Medicine in the Eleventh–Fifteenth Century

In the eleventh century, many Islamic physicians inherited a Galenic humoral schema predicated on a somatic, physiological psychology while Ibn Sīnā produced a synthesis of Galen's (d. 216) medical corpus and his natural philosophy.²⁰ Abū 'Alī al-Ḥusayn b. 'Abd Allāh Ibn Sīnā is a central figure in the historical establishment of Islamic medicine, writing the major medical text *al-Qānūn fī l-Ṭibb* ("The Canon of Medicine") that was utilized in Europe until the seventeenth century. As a generative synthesis, in both philosophical and scientific modes, of Aristotle, Galen, and others,²¹ it also aimed to persuade physicians to adopt his theoretical psychology, which was grounded in Aristotelian physics while embracing Galen's anatomy.²² In addition to his appearances in Ibn Sīnā's medical work, Galen's influence can be gleaned from the Arabic commentaries on the *Hippocratic Aphorisms*. Scholars from the three Abrahamic religions mediated, circulated, and critiqued Arabic versions of Galen's commentaries translated by Ḥunayn ibn Ishāq (d. 873) as well as each other's elaborations.²³ As both Galen and Ibn Sīnā came to play a significant role in medical writings in the post-classical period, examining some of the Arabic commentaries on the *Hippocratic Aphorisms* is an opportunity to understand the extent of that influence as well as the departures that arise. Reading the Islamic physicians' commentaries on the *Aphorisms* alongside Galen's, I was drawn in particular to Ibn Abī Šādiq's exploration of the relation of the intellect, the faculties, and the body in a case of *ikhtilāṭ al-'aql*. His novel approach to the question and his interest in the subjective experience of pain illustrated a problem-space regarding the relationship of the body, psyche, and soul that mirrored the way 'uqda knotted up similar themes for physicians in contemporary Yemen.

After the Arabic versions of Galen's commentaries, Ibn Abī Šādiq was the second-most cited commentator in other commentaries.²⁴ It comes as no surprise, then, that Ibn Abī Šādiq was considered the "second Hippocrates" (*Buqrāt al-thānī*), and an admirer of Galen.²⁵ His deployment of Galen's ideas is evident in his commentaries below, and Ibn Abī Uṣaybi'a attests to this acquaintance with his work.²⁶ A physician and historian of medicine who compiled the

²⁰ Jon McGinnis, *Avicenna*, 232–238. For Galen's influence on Islamic medicine, see Ullmann, *Islamic Medicine*, 7–40; for influence of Ibn Sīnā's work on Ibn al-Nafīs see Fancy, Nahyan. *Science and Religion in Mamluk Egypt: Ibn al-Nafīs, Pulmonary Transit, and Bodily Resurrection*. New York: Routledge, 2013.

²¹ Jon McGinnis, *Avicenna*, 228.

²² Due to medicine's strong theoretical aspects, which also aim to produce prescriptions for health, Ibn Sīnā defines medicine as "the science from which one comes to recognize the states of the human body on the part of health and the loss thereof in order to preserve the health as something realized as well as recovering it when lost" (quoted in McGinnis, *Avicenna*, 230; from *Qānūn* vol. 1 29.6–7). For Ibn Sīnā, a physician's aim is to preserve health; as a practical science, medicine does not generate theories on the nature of the soul and the human faculties. Such theories rather are developed in theoretical psychology, which is a sub-discipline of physics.

²³ From prior work conducted on some of these texts we learn that these commentaries are part of the broader Arabic tradition of exegesis on the *Aphorisms*. Further work on the Arabic commentaries will facilitate examination of how the translations were received, reformulated, transmitted, and circulated in cultural and historical context. A close reading of Ibn Abī Šādiq's commentaries and physicians' theoretical engagements with the *Aphorisms* brings us closer to an understanding of how these various readings impacted medical and non-medical literature. See Peter E. Pormann and N. Peter Joosse, "Commentaries on the Hippocratic Aphorisms in the Arabic Tradition: The Example of Melancholy," in Peter Pormann, ed., *Epidemics in Context: Greek Commentaries on Hippocrates in the Arabic Tradition, Scientia Graeco-Arabica 8* (Walter de Gruyter, 2012), 248.

²⁴ His commentaries on the Hippocratic Aphorisms were preserved and taken as a reference by many other medieval physicians such as Ibn al-Quff (d. 1286), al-Sīwāsī, and al-Kīṣī.

²⁵ Pormann and Joosse, "Commentaries on the Hippocratic Aphorisms in the Arabic Tradition," 221.

²⁶ Ibn Abī Uṣaybi'a reports that Ibn Abī Šādiq "had great enthusiasm for investigating Galen's books and investigating the recondite points and secrets of the medical art that they contain [lahu ḥirṣ bāligh fī al-taṭallu' 'alā

histories of notable physicians, Ibn Abī Uṣaybi‘a also recognizes him as one of the students of Ibn Sīnā.²⁷ However, there exists no explicit citation or reference to Ibn Sīnā’s *Qānūn* in Ibn Abī Ṣādiq’s commentary on the Aphorisms. It is this discrepancy and his philosophical enumerations that invites a closer examination of his work.

Reading aphorisms 6 (regarding the lack of sensation in a person’s physical wound, resulting from *ikhṭilāṭ al-‘aql*) and 46 in section II of the *Hippocratic Aphorisms*, I examine how Ibn Abī Ṣādiq deals with madness and its physiology. I am interested in how he might reconcile Ibn Sīnā’s body/soul dualism with Galen’s somatic psychology in questions of madness. More specifically, how might he and other commentators deal with the material effects of the excess stemming from the mixture of the elements that directly affect the rational soul (as posited in Ibn Sīnā’s *Psychology*)? With such questions in mind, I first briefly discuss how other physicians (al-Rāzī, al-Majūsī, Ibn Sīnā) understood the mental derangement (*ikhṭilāṭ al-‘aql*) and the form of *ikhṭilāṭ* that is associated with the mixing of humors. Second, I examine the way Ibn Abī Ṣādiq discusses *ikhṭilāṭ al-‘aql*, and I illustrate how he juxtaposes it to the melancholic and the worshipper²⁸: one is an experience of suffering and the other is an experience of spiritual elevation; both are defined by their inability to feel sensation due to the preoccupation of the soul. The exceptionality of these two figures is complicated by the role of the madman, who feels simultaneous physical and psychic pain. Third, I examine moments of Ibn Abī Ṣādiq’s theoretical intervention, focusing particularly on his analogy of the loss of sense by the melancholic and the worshipper. Finally, I discuss how he offers a gradation of madness and *ikhṭilāṭ al-‘aql* that oscillates between physiological processes and incorporeal spiritual and psychic effects. His attempt to understand the role of the faculties of the senses in relation to the faculties of intellect is a window into the relationship he posits between the body, the spirit (*rūḥ*), the soul (*nafs*), and the intellect (*‘aql*). Such an inquiry allows us to see how the question of pain in relation to madness further complicates the dichotomies of physiological and psychic, Avicennian immaterial and spiritual (faith based), *rūḥ* and *nafs*, and psychology and ontology—engaging the philosophical questions which Ibn Sīnā deemed the physician ill-equipped to address.

Ikhṭilāṭ al-‘aql

Michael Dols reminds us that many medieval Islamic physicians’ accounted for *ikhṭilāṭ al-‘aql* with Galen’s humoral theory.²⁹ In late antiquity, Galen considered mental derangement with fever as phrenitis³⁰ and without as mania. One brain condition of mania that manifests due

kutub Jālīnūs wamā awda‘ahu fihā min ghawāmiḍ ṣinā‘at al-ṭibb wa-asrārihā]” (*Uyūn al-anbā’ fī ṭabaqāt al-aṭibbā’*, ed. Augustus Müller [Königsberg, 1884; repr. Hants, UK: Greggs International Publishers, 1972], vol. 2, 22).

²⁷ Although Ahmed Ragab argues that Ibn Abī Uṣaybi‘a’s biography does not in fact substantiate the claim that Ibn Abī Ṣādiq was a student of Ibn Sīnā, in this chapter I examine the resonance between the two physicians. See Ahmed Ragab, *The Medieval Islamic Hospital: Medicine, Religion and Charity* (New York: Cambridge University Press, 2015), 154-158. And see Ibn Abī Uṣaybi‘a, *Uyūn al-anbā’*, vol. 2, 22-23.

²⁸ I first presented on the figure of the worshipper in Ibn Abi Sadiq’s aphorism vi after I corrected a misspelling of *taba‘ud* (distancing) to *ta‘abbud* (worship) in the Arabic manuscript. I presented a version of this paper at the Hippocratic Aphorisms Conference on April 11, 2015.

²⁹ Dols, *Majnun*, 38-47, 48-103.

³⁰ For a discussion on “phrenitis” see, Nicola N. Carpentieri, & Taro Mimura, “Arabic Commentaries on the Hippocratic Aphorisms, vi. 11: A Medieval Medical Debate on Phrenitis,” (*Oriens*, 2017), 45(1-2), 176-202.

to cold and dryness is melancholia, which Galen associated with irrational fear and depression³¹ resulting from bodily states in addition to humoral imbalance.³² In Galen, all mental disturbances are caused by some damage to the faculties of the soul, located in the brain, resulting from “humoral changes and imbalances either in the body in general or in the brain in particular.”³³ Galen drew on earlier formulations by Hippocratic writers³⁴ but borrowed heavily from Rufus of Ephesus work on Melancholia (1st century),³⁵ whose texts survived through Greek, Arabic,³⁶ and Latin. In classic Greek medicine³⁷ (4th and 5th century B.C), mental derangement was discussed alongside phrenitis, mania, and melancholia³⁸ and revolved around a set of symptoms rather than separate disease entities,³⁹ including psychological and emotional states that manifested in various physiological ailments.⁴⁰ Much of the Hippocratic corpus focused on phrenitis as a disease of the mind with psychosomatic symptoms emerging from humoral imbalances due to the excess of bile or phlegm, affecting the brain-nerve system and the psychic pneuma.⁴¹ Although mental disturbances were not conceptualized as mental illnesses with Galen and his contemporaries, these illnesses were specified by Galen as “illnesses of the brain.”⁴² This is significant insofar as it implies a turn away from symptomatology toward a psychosomatic⁴³

³¹ Marke Ahonen. *Mental Disorders in Ancient Philosophy*. (Springer Science & Business Media, 2014) Vol. 13, 149.

³² Jacques Jouanna, “The typology and aetiology of madness in ancient Greek medical and philosophical writing,” in *Mental disorders in the classical world* (Brill, 2013), 97-118.

³³ Vivian Nutton, “Galenic Madness.” *Mental Disorders in the Classical World*, (Brill, 2013), 223.

³⁴ Jouanna, “The typology and aetiology of madness in ancient Greek medical and philosophical writing,” 110. Jouanna argues that the binary etiology, depressive and hyperactive forms of madness, in Hippocrates was still found in Galen in spite of his ‘superficial tripartite typology that takes into account the effects of wetness and dryness in addition to the imbalances resulting from cold phlegm or hot bile (112, 117’).

³⁵ Peter Toohey, “Rufus of Ephesus and the Tradition of the Melancholy Thinker,” *Rufus of Ephesus, On Melancholy*, (Mohr Siebeck GmbH KG, 2008) 222.

³⁶ Peter E. Pormann, *On Melancholy: Rufus of Ephesus*, (Mohr Siebeck GmbH KG, 2008).

³⁷ Medicine that was part of the Hippocratic corpus, but also extended beyond it as some have argued that the corpus. See “On Hippocratic and non-Hippocratic medicine”

³⁸ Jacques Jouanna. “At the Roots of Melancholy: Is Greek Medicine Melancholic?.” In *Greek Medicine from Hippocrates to Galen*, (Brill, 2012), 233. According to Jouanna, melancholia as an illness predated Hippocratic medicine. Melancholia as a humoral imbalance was also distinct from the melancholic temperament, which, elsewhere in the philosophical traditions, was related to different dynamics of madness and prophecy.

³⁹ Chiara Thumiger and Singer P.N, “Introduction. Disease classification and mental illness: ancient and modern perspectives,” *Mental Illness in Ancient Medicine*, (Brill, 2018) 24: According to Thumiger and Singer, it was also a “Hippocratic style tendency to consider diseases as collections of symptoms, without problematizing the question, mental or physical, persists.” Yet the category of mental illness as such was absent from the corpus. See also Chiara Thumiger, “The early Greek medical vocabulary of insanity.” In *Mental Disorders in the Classical World*, (Brill, 2013), 61-65.

⁴⁰ Thumiger and Singer, “Introduction,” 20-24. Melancholia, mania, and phrenitis were conceptualized as disease entities post the Hippocratic corpus, as mental illness as a category was not yet conceptualized. Also see: Chiara Thumiger, “The early Greek medical vocabulary of insanity.”

⁴¹ Thumiger and Singer, “Introduction,” 2. See also, Philip Van der Eijk, “Cure and (In) curability of mental disorders in ancient medical and philosophical thought,” In *Mental Disorders in the Classical World*, (Brill, 2013), 311: “They do not, however, distinguish mental illness as a separate category. It is rather that, in their discussions of disease, they frequently also discuss disturbances of the mental, cognitive, behavioral or motor functions of the body, but they present all these mental affections as being of a physical nature and having bodily cause”; Also see Ahonen, Marke, *Mental Disorders in Ancient Philosophy*, 23-34.

⁴² Thumiger and Singer, “Introduction,” 23.

⁴³ Nutton, Vivian, “Galenic Madness,” 125.

etiology. In turn, we must continue to examine the schematization of the mad, the melancholic, and mentally deranged in the Arabic medical corpus, as a category of mental disorders.⁴⁴

In the Arabic Medical tradition, Dols examines different forms of mental disturbances arising in texts by Abū Bakr Muḥammad Ibn Zakariyyā al-Rāzī (d. 313/925), al-Majūsī (d. 982-985), and Ibn Sīnā. In al-Rāzī's *Kitāb al-Ḥāwī*, *ikhtilāṭ al-'aql* is a symptom of an injury to the brain resulting from changes in temperament associated with elemental composition.⁴⁵ He also distinguishes between *ikhtilāṭ*, which he calls serious mental derangement, and melancholia, which yields a more episodic absence of reason.⁴⁶ For al-Majūsī, melancholia caused by an excess of black bile is confusion of reason (*ikhtilāṭ al-'aql*) without fever.⁴⁷

Dols also notes that Ibn Sīnā's conclusion that mental disturbances arising from conditions in the brain is, in part, informed by Galen.⁴⁸ Many mental disturbances are caused by the mixing of humors, simple heat, or hot vapors, to name a few. In turn, they "deprive the brain of the substance of the natural spirit (*al-rūḥ*), which preserves the path of *al-'aql*."⁴⁹ One effect from such deprivation is *Ikhtilāṭ al-'aql*, which he mentioned briefly in the same section on *ikhtilāṭ al-dhihn* (reason).⁵⁰ Briefly evoking the Hippocratic Aphorism on *Ikhtilāṭ al-'aql*, Ibn Sīnā states, as a matter of fact (without further exploration), "know that if someone has extreme pain and they do not complain and do not feel then their humors are mixed. And when their urine is gold it is a sign of *ikhtilāṭ al-'aql*."⁵¹ Thereafter, Ibn Sīnā returns to focus on the mixture of humors and their impact on the brain through *the rūḥ*, illustrating his emphasis on the humoral causes of *ikhtilāṭ al-'aql*.

In his commentary on *ikhtilat al-aql*, Ibn Abī Šādiq specifically deals with the impact on the intellect of the *rūḥ al-naḥsāniyya*, the psychical pneuma. However, it is unclear how he conceives of the intellect and whether he conceives the *rūḥ* as one, or one of three pneumata,⁵² or a modification of a single pneuma following Ibn Sīnā. As developed below, Ibn Abī Šādiq does not draw on the Arabic translation of Galen's commentary on *ikhtilāṭ al-'aql* but quotes him verbatim in parts in Aphorism 46 (on simultaneous pain). Yet, surprisingly, he moves beyond Galen and evokes fragments of Ibn Sīnā's philosophy in parts of the two aphorisms while remaining ambiguous in others, and moves beyond them by analogizing the state presented by Hippocrates (namely a case of a loss of sensation due to mental derangement) to other states of *ikhtilāṭ al-'aql* in the mad (*al-majānīn*), the worshipper (*al-muta'allih*), and melancholics. However, it is unclear whether he will view *ikhtilāṭ al-'aql* as a disassociation of an immaterial

⁴⁴ To read some ongoing work, see: Nicola N. Carpentieri, & Taro Mimura, "Arabic Commentaries on the Hippocratic Aphorisms, vi. 11: A Medieval Medical Debate on Phrenitis," Peter E. Pormann and N. Peter Joosse, "Commentaries on the Hippocratic Aphorisms in the Arabic Tradition: The Example of Melancholy."

⁴⁵ Ibid., 56. See also al-Rāzī, *Kitāb al-Ḥāwī fī ṭibb* (21 vols. in 22; Hyderabad, 1955-68), i.78f.

⁴⁶ Dols, *Majnun*, 59. See also al-Rāzī, *Kitāb al-Ḥāwī fī ṭibb*, vol. 1, 208, 195ff.

⁴⁷ Ibid., 64-65. See also al-Majūsī, *Kitāb Kāmil al-Šinā'a al-Ṭibbiyya* (2 vols., Bulaq, 1294AH), vol. 1, 332 ff.

⁴⁸ Dols, *Majnun*, 86. Dols notes that Ibn Sīnā does not cite specific sources. "Some of his discussion on cerebral disturbances is parallel to Paul of Aegina's *Epitome Medicae*. An Arabic translation of Paul of Aegina's encyclopedic medical was available. Paul's work was based on Oribasius' seventy-volume encyclopedia, which contained work from Galen's *De Locis affectis*". Also see discussion on the *ikhtilāṭ al-dhn wa al-dhihyan* in Ibn Sīnā, *al-Qānūn fī al-ṭibb*, 1958, 310.

⁴⁹ Ibn Sīnā, *al-Qānūn fī al-ṭibb*, 1958, 310

⁵⁰ Ibid. 310

⁵¹ Ibid, 310

⁵² Ullmann, *Islamic Medicine*, 62-63. The *rūḥ al-naḥsāniyya* (psychic pneuma), for the Arab physicians, "arises from the animal pneuma situated in the heart" to the posterior ventricle of the brain, where it is situated, influencing movement and memory in addition to sensation.

intellect, as understood by Ibn Sīnā, or based on the material posited by Galenic physicians. That is, does Ibn Abī Šādiq attempt to understand madness beyond its causality (as an imbalance of the humors), or does his examination reformulate Ibn Sīnā's or the Galenic medical psychology?

The Interpretation of Ibn Abī Šādiq

Ibn Abī Šādiq begins the commentary:

Whosoever finds in his body a state that should be accompanied with pain such as a swelling, cut, split, and others, but does not sense the corresponding pain, his intellect is *mukhtaliṭ* (deranged). Although sensation does not come from the intellect, the substratum that serves as the place of departure for the activities of sense is the same as the intellect's. For this reason, if that place has suffered a great injury it is possible that each of the two faculties, the sense and the intellect, have confused responses. That is why it is possible that whenever the intellect is damaged the senses are damaged. And the opposite is not true such that when the intellect is [confused] then the senses will also be injured.⁵³

Here he reintroduces the question at hand: if one does not feel the pain corresponding to a bodily injury, then his mind is *mukhtaliṭ*. Before turning to a physiological explanation, Ibn Abī Šādiq opts for a theoretical explanation regarding the nature and place of the faculties to explain this physiological defect, a clear departure from other physicians of his time.⁵⁴ By evading the question of the nature of pain or physiological processes that lead to a humoral imbalance, instead establishing the originary place of the senses and intellect, he is able to account for the effects of a physiological process resulting in the dysfunction of the faculties. But a claim regarding the place of the senses and their relation to the intellect takes us out of the realm of medico-physiological psychology and into that of natural philosophy, of the anatomy of the soul and the inner and external senses.

From this opening explanation, we understand that Ibn Abī Šādiq does not argue that sensation comes from the intellect, but that both activities originate from the same place; that damage to the intellect harms sensation; that damage to sensation does not affect the intellect; and that sensation is situated in a different place than the intellect while they share a similar place of departure. In this particular case, Ibn Abī Šādiq is evading the question of pain and its generation and transmission in the body for an explanation on the nature of the sensitive faculty and intellect. This entails one of two things: either Ibn Abī Šādiq is methodologically departing from both Ibn Sīnā and Galen, in order to understand the processing of pain in relation to the function and place of the psychical faculties, or he is building or drawing upon his own medico-psychology.

For their parts, both Ibn Sīnā and Galen might have understood sensation similarly, while diverging regarding the impression of pain and intellection. This divergence is grounded in Ibn Sīnā and Galen's theoretical commitments and treatments of the faculties and their relations to the physiological impressions. It is also potentially provides insight into what might inform Ibn

⁵³ Abū al-Qāsim Ibn Abī Šādiq al-Nīsābūrī, *Sharḥ fuṣūl Abuqrāṭ. Book II, Aphorism 6*, edited by arabcommaph.

⁵⁴ For example, Hunayn Ibn Ishāq and al-Siwāsī's commentaries rely on physiological processes that lead to cessation of pain or inhibit the psychic spirits from functioning.

Abī Šādiq's explanation for the cessation and presence of pain in *ikhtilāf al- 'aql*, madmen, and melancholics.

Sensation in Ibn Sīnā's *Psychology* is the perception of the 'forms of all sensibles' that "reach" and "imprint" the organs of sense.⁵⁵ The external sense that registers pleasure and pain is touch (*lams*) while the internal sense is the estimative faculty. Touch, for Ibn Sīnā, is a faculty "distributed over the entire skin and flesh of the body. The nerves perceive what touches them and are affected when it is opposed to them in quality, and changes are then wrought in their constitution or structure."⁵⁶ He describes touch as one external sense, but suggests that it involves four faculties.⁵⁷

Pain in Ibn Sīnā's *Qānūn* and psychology, partly informed by Galen, is explicitly multiple, transmitted through the nerves or intuited by the soul.⁵⁸ Yet, Ibn Sīnā's configuration departs from Galen. Ibn Sīnā describes pain as an unnatural state that occurs to the body, which he defines in two ways: "sensation of a contrary impression" by the sense faculty or a sudden contrary mixture temperament superimposing on a constant one, which disrupts continuity.⁵⁹ Pain occurs when the sensitive faculties receive a stimulus that produces a sudden change, such as cold water in a hot bath that ceases when the body adapts to it.⁶⁰ One's natural temperament, for Ibn Sīnā, is a range within a continuum where each individual possesses a unique temperament.⁶¹ Ibn Sīnā's idea of pain as a sudden shift in temperament departs from Galen's idea of pain as a possible effect of faulty mixture and the dissolution of "continuity of the homoamorous parts and organs formed from them."⁶² Although Ibn Sīnā differed with Galen on the cause of pain,⁶³ he agreed that the nerves served as pathways to the brain carrying sense impressions of the senses, including pain,⁶⁴—implying that pain is not a quality to be objectively studied.⁶⁵ Therefore, when one considers how Ibn Sīnā discusses the sensation that registers pain

⁵⁵ Ibn Sīnā, *Avicenna's Psychology*, 27.

⁵⁶ Ibid.

⁵⁷ Ibid., 27. See also Ibn Sīnā, *al-Qānūn fī al-ṭibb*, 1958, 35

⁵⁸ The subjective nature of pain is further demonstrated in Ibn Sīnā's *Psychology*, as he also attributes the perception of pleasure and pain (*wahm*) to the estimative faculty. In addition to the body's adaptability to a sudden shift in temperament, the cessation of pain can also occur in three ways for Ibn Sīnā: an antidote placed on the wound, sleep, and detraction of the psychic faculty due to the effects of altering substances which ceases the work of the sensation faculty. For discussion on ways to relieve pain see Ibn Sīnā, *al-Qānūn fī al-ṭibb*, 200 [Book 1].

⁵⁹ See also Ibn Sīnā, *al-Qānūn fī al-ṭibb*, 1958, 54.

⁶⁰ Ibn Sīnā, *al-Qānūn fī al-ṭibb*, 54.

⁶¹ McGinnis, *Avicenna*, 233.

⁶² According to Philip De Lacy, sensation and motion for Galen are powers transmitted by the nerves. Prompted by the brain's pneuma on the continuum, the flow of power travels to the rest of the body. As the body's activities and powers are predicated on the "continuity of the homoeomorous parts and organs formed from them," an interruption of the continuum may cause pain. De Lacy cites Galen's example of a scorpion sting that pinches a nerve and travels to the rest of the body due to the skin's continuum. See De Lacy, "Galen's Concept of Continuity," *Greek, Roman and Byzantine Studies* 20, no. 4 (1979): 356, 361-362.

⁶³ Ibn Sīnā disagrees with Galen's idea of pain, noting that not all changes in temperament cause pain. See also Ibn Sīnā, *al-Qānūn fī al-ṭibb*, 1958, 54.

⁶⁴ As pain may result from an impression of a contrary quality, its impression is distributed along the nerves of the respected sense organ. See discussion on external senses in Ibn Sīnā, *Avicenna's Psychology*, 26, 27.

⁶⁵ The subjective nature of pain is further demonstrated in Ibn Sīnā's *Psychology*, as he also attributes the perception of pleasure and pain (*wahm*) to the estimative faculty. In addition to the body's adaptability to a sudden shift in temperament, the cessation of pain can also occur in three ways for Ibn Sīnā: an antidote placed on the wound, sleep, and detraction of the psychic faculty due to the effects of altering substances which ceases the work of the sensation faculty. For discussion on ways to relieve pain see Ibn Sīnā, *al-Qānūn fī al-ṭibb*, 200 [Book 1].

and the transmission of pain, Ibn Abī Šādiq's meditation on pain seems to schematize pain as a sensible impression processed by the inner senses.

Galen's commentary of Aphorism VI on *ikhtilāṭ al-'aql* is a rudimentary discussion focusing on Hippocrates's ambiguous use of the word pain and the word intellect.⁶⁶ He clarifies that Hippocrates' was not speaking of pain in general but that the word pain referred to the state that accompanies pain. Galen, then, proceeds to equate the insensible pain to the lack of sensation generated by the afflicting state, and concludes by claiming that a confused intellect is synonymous to confused understanding or thinking. In turn, Galen's commentary provides no clear indication as to what inspires Ibn Abī Šādiq to begin his own commentary with a discussion on the nature of the two faculties.

Ibn Sīnā, however, argued that the disassociation of the intellect (resulting from the imbalance of the humors due to *ikhtilāṭ*) may lead to the dysfunction of the faculties. Yet, even he does not specify it as a result of a defect of the substratum that serves as the point of departure for sensation and intellection. Whereas Galen's commentary on *ikhtilāṭ al-'aql* does not serve as his inspiration, Ibn Abī Šādiq may in fact be following the Galenic schema of the division of the faculties in his discussion of their locality.⁶⁷ Galenic physicians, according to Ibn Sīnā, understand that "the brain is the place of departure for sensation."⁶⁸ They attribute the work of sensation to the psychic faculties, which are placed in different ventricles in the brain. Whereas

⁶⁶ "Hippocrates said: Whosoever feels pain in his body and he does not feel it in most states then his '*aql*' is *mukhtaliṭ* (intellect is confused). Galen said: It is customary for Hippocrates in some of his sayings (or discussions) to say pain and mean the state that generates pain. In the book *Epidemics*, he [Hippo.] said that the earlier pains that happened in Cronon were cold whereas those that came later were hot. And it is not admissible that he meant that pains themselves were hot or cold. But that in this discussion he meant that cold and hot were the state associated with such pains. In this line of thinking, he meant the pain of the afflicting state, such as a hot swelling or tumor, swelling that is called, wound, cut, dissolution, and whatever resembles them. If the patient suffered from one of them and they did not sense its pain then his understanding is confused. There is no difference in this issue between saying intellect or understanding or reason or thinking." *Sharḥ fuṣūl Abuqrāt. Book II, Aphorism 6, Edited by arabcommaph.*

⁶⁷ According to Ullmann, Islamic physicians posited three faculties in their Galenic schema: the natural faculty (*al-quwwa al-ṭabī'iyya*), located in the liver; the animal faculty (*al-quwwa al-ḥayawāniyya*), located in the heart; and the psychical faculty (*al-quwwa al-naṣāniyya*), located in the brain. These faculties correspond to three pneumas (natural, animal, psychical) that carry out the functions of and influence the condition of the body (and so can be utilized to explain the malfunction of certain faculties). The psychical faculty executes voluntary movement, sense perception, and thought and reason. See Ullmann, *Islamic Medicine*, 62-63. In *al-Qānūn*, Ibn Sīnā discusses the Galenic physician's schema and also confirms that they further divided the psychical faculty into imagination, thought, and memory, which are located in different ventricles of the brain. See Ibn Sīnā, *al-Qānūn*, 1958, 33, 35. See also Peter E. Pormann, "Avicenna on Medical Practice, Epistemology, and the Physiology of the Inner Senses," in *Interpreting Avicenna: Critical Essays* (Cambridge: Cambridge University Press, 2013), 105.

⁶⁸ Ibn Sīnā, *al-Qānūn*, 1958, 33. In addition to Ibn Sīnā's account of the way physicians divide the faculties in *al-Qānūn*, including the localization of the faculties in the brain, see E. Ruth Harvey, *Inward Wits: Psychological Theory in the Middle Ages and the Renaissance* (Warburg Institute, 1975), 8-21. Robert E. Hall, "Intellect, Soul and Body in Ibn Sīnā: Systematic Synthesis and Development of the Aristotelian, Neoplatonic and Galenic Theories," in *Interpreting Avicenna: Science and Philosophy in Medieval Islam*, ed. Jon McGinnis (Leiden: Brill, 2004), 75-76: According to Hall, in *al-Qānūn*, Ibn Sīnā approaches the faculties in a way that aligns with his philosophical synthesis of Aristotle and Galen. Much as in the language of the physicians, Ibn Sīnā divides the faculties into three: the natural (*ṭabī'iyya*), the vital (*ḥaywāniyya*), and the psychic (*naṣāniyya*). This division continues with the psychic faculty containing a cognitive (*mudrika*) and motive (*muḥarrika*) function; the cognitive faculties are themselves the work of the internal and external senses.

Ibn Sīnā also attributes sensation's actuality to the work of the psychical faculty,⁶⁹ placing the five internal senses that process sense impression in different ventricles of the brain, as the common sense "gathers and stores an imprinted sense after its impression," he understands pain as a sudden shift in temperament transmitted by the nerves.⁷⁰

Yet, were Ibn Abī Šādiq strictly following the Galenic physician's schema, his initial designation of the seat of sensation and intellect as a way to understand pain might have begun with discussion of the pneuma's inability to reach an organ through the nerves and to maintain the psychical faculties involving sensation. Utilizing the language of the Galenic physicians, it is unclear whether he is extending their classification or drawing on Ibn Sīnā's synthesis to further explore the nature and function of the psychical faculties, internal and external senses included, and its relation to their locality and employment by the intellect. For Ibn Sīnā himself, cognition is one of the functions of the psychical faculty, but differentiates itself from intellection, a non-corporeal grasp of intelligibles.⁷¹

It is also unclear, however, how intellect (*'aql*) functions for Ibn Abī Šādiq, as Ibn Sīnā posits a theoretical and practical intellect and the relationship between the body and the rational soul in Galen's work remained unsettled⁷². These distinctions (practical versus theoretical) are not explicit in Ibn Abī Šādiq's commentary, though of course he might be implying that the practical intellect gives way to the theoretical intellect if and when the intellect is confused.⁷³ In his *Psychology* Ibn Sīnā described the "internal faculties of perception" as corporeal "physiological faculties or powers"⁷⁴ situated in different ventricles of the brain, while the activities of the intellect are not physiological.⁷⁵ Since Ibn Sīnā does not attach the intellect to a bodily organ, is Ibn Abī Šādiq referring to the governance of the inner senses by the practical intellect, therefore claiming that the power of the intellect and sensation originates in the same place in spite of sensations' seat in the brain? Whatever the case, this enables him to figure *ikhṭilāf al-'aql* as a physical phenomenon through the link between disturbances in intellection

⁶⁹ The internal senses are the five we find in his philosophy (but not as clearly explicated), placed in the three ventricles of the brain. See Ibn Sīnā, *al-Qānūn*, 1958, 33-35. See also Robert E. Hall, "Intellect, Soul and Body in Ibn Sīnā," 73-76.

⁷⁰ Ibn Sīnā, *al-Qānūn*, 1958, 35.

⁷¹ In *al-Qānūn* Ibn Sīnā states: "The remaining cognitive faculty of the soul is the faculty of human reason (*hiya l-insāniyyat al-nāṭiqa*). Since the physicians do not consider the faculty of estimation (*al-quwwa l-wahmiyya*) for the reason that we have explained, they consider even less this faculty (sc. of human reason). Moreover, their investigation is limited to the actions of the three faculties, but no other ones" (Ibn Sīnā, *al-Qānūn*, 1958, 37, quoted in Pormann, "Avicenna on Medical Practice," 105). In his *Psychology*, Ibn Sīnā explicitly argues that the human rational soul does not require a physiological organ. See Ibn Sīnā, *Avicenna's Psychology*, 50.

⁷² Peter E. Pormann, "Avicenna on Medical Practice," 102. Pormann states that Galen remains ambivalent regarding the body's relation to the rational soul. Also see Jacques Jouanna, "Does Galen Have a Medical Programme for Intellectuals and the Faculties of the Intellect?" in *Galen and the World of Knowledge*, edited by Christopher Gill, Tim Whitmarsh, and John Wilkins (Cambridge: Cambridge University Press, 2009), 190-205. Jouanna explores how the relation between the body and the soul for Galen was relevant insofar as the body's mixture impacted the intellectual faculties, and thus bore on the sphere of medicine. Although in Galen, "the faculties of the rational soul change with the state of the body no less than the faculties of the two other parts of the soul," he emphasized the importance of the balance of the humors, diet, and physical exercise to improve the rational soul (196, 200-203).

⁷³ The practical intellect could yield to the theoretical intellect. This neither confirms his extension of Ibn Sīnā nor his departure from him. The tight nexus between the soul and the body in Ibn Sīnā's works explores how the inner senses (located in the brain) are linked to the practical intellect as their governor, which itself is governed by the theoretical intellect (which is not tied to a bodily organ). Ibn Sīnā, *Avicenna's Psychology*, 37, 102.

⁷⁴ McGinnis, *Avicenna*, 112; see also Ibn Sīnā, *Avicenna's Psychology*, 31, 32.

⁷⁵ Ibn Sīnā, *Avicenna's Psychology*, 50.

and bodily sensation.

Ibn Abī Ṣādiq's ambiguity has to do with the fact that he has to account for madness that does not lead to the dysfunction of the sensitive faculty and the absence of pain later in the aphorism. What is clear from this opening statement that there is a complex relation between pain and the relationship between the faculties and their place of departure in relation to the body and soul. By arguing that the substrate which serves as the point of departure for the engagement of the sensitive faculty and the intellect and their activities is the same, Ibn Abī Ṣādiq subjects sensation to the activity of the intellect. In doing so, he attributes the loss of sensation to the *ikhtilāṭ al-'aql*, whereby damage to the locus of both sensation and intellect inhibits sensation.

However, the dysfunction of sensation does not affect the intellect, which suggests that the latter is a distinct entity (as further investigated in his discussion of the worshiper [*al-muta'allih*]).⁷⁶ This is implicit in the claim that the dysfunction of the sensation faculty is due to a supervening pain (possibly of the intellect).

This could be because the sensory faculty/sensitive power (*al-quwwa al-ḥassāsa*) responds to a greater injury as discussed in the chapter--- which begins with [when two pains occur simultaneously] (quotes another aphorism). That is because if the defect causing derangement is greater than the cause of the sensible pain, then the sensitive faculty submits to the greater injury (*al-āfa*) because if the cause is greater then it is more important.⁷⁷

Here the aphorism that Ibn Abī Ṣādiq is referencing not only indexes what he will later explain regarding the preoccupation of the spirits (*arwāḥ*) and their relation to the faculties, but signals a pain that is of another nature:

Hippocrates said: If a person experiences two distinct pains at once, and they are not from same place, the stronger of the two conceals the other. Explanation: Pain is the effect of the sensed object on the sense faculty; therefore, the weaker of the two pains is not perceived next to the stronger one because the power of sense (*al-quwwa al-ḥassāsa*) moves towards the strongest pain and it becomes preoccupied with it. This is the case for pain of the *nafs* such as distress, for the strongest conceals the weakest, unless the same thing causes them all, then one elevates the other, as in the case if the aches were in one organ. And this has been shown in relation to all the other senses. If, for example, two things are far from the eyes with one brighter than the other, then the eye sees the biggest and the brightest. The same thing with sounds, the ear hears the louder of the two. The reason for this is that the sensed object is acting upon the organ of sense, while the organ of sense is being acted upon. The sense organ preoccupies itself with the reception of the sensed object that possesses the stronger effect so that it hides the effect of the other which has a weaker effect.⁷⁸

Although earlier Ibn Abī Ṣādiq attributes the absence of sensation to a disassociation of the intellect, in his commentary on the second aphorism he introduces the possibility of a competing

⁷⁶ It is unclear whether he conceives of the intellect as immaterial, following Ibn Sīnā, or posits it as cognition, as the Islamic physicians did.

⁷⁷ Ibn Abī Ṣādiq, *Commentary*, Book II, Aphorism 6.

⁷⁸ Ibn Abī Ṣādiq, *Commentary*, Book II, Aphorism 46.

pain, a pain of the *nafs*,⁷⁹ to corroborate his claim that the power of sense (*al-quwwa al-hassāsa*) might be attending to a greater injury. Ibn Abī Šādiq's initial response corresponds to the latter half of Galen's commentary⁸⁰ on this Aphorism, forgoing Galen's physiological discussion on the relation of pain to the different parts of the body and their continuity.

In the aphorism regarding simultaneous pain, Ibn Abi Sadiq quotes verbatim Galen's discussion on the concealment of one pain by another due to the preoccupation of the power of sense, "such as the pain of the *nafs* that does not involve the body." Galen's commentary, similarly, evokes distress as an example of such pain. This relation, inspired by Galen, may also be resonant of Ibn Sīnā's writings on distress and sorrow, which are connotational attributes that are perceived by the estimative faculty and deduced by the practical intellect.⁸¹ Can we then call this "pain of the *nafs*," a psychic pain? By suggesting that the supervening pain is that of the *nafs*, he attributes the absence of the bodily pain to a divergence of the sensitive faculty. It is evident then that the pain of the *nafs* conceals other pains within the body emanating from another source. This extension is instructional as it opened up further exploration in the aphorism for Ibn Abī Šādiq whereas it served as the basis for an explanation for Galen. Although he is clearly drawing on Galen, he explores his explication further utilizing Ibn Sīnā's philosophy. Focusing on the nature of the pain and its relation the nature of sensitive faculty as opposed to following Galen's physiological explanation showcases his interest in the theoretical underpinnings of medical frameworks.

The latter half of the explanation regarding the copresence of two impressions is taken directly from Ibn Sīnā's *Psychology*, accounting for the theoretical intellect's lack of dependence on a bodily organ. Ibn Sīnā explains that organs are exhausted after continual use, which is demonstrated by the fatigue of an organ in the event of a dual impression:

The senses, after an extreme powerful sensation cannot perceive weak ones; anyone who sees a brilliant light cannot perceive a faint flow at the same time or even afterwards; likewise, anyone who hears a thunderous noise cannot hear a faint sound at the same time or even afterwards; and anyone who tastes something excessively sweet cannot taste

⁷⁹ It is unclear what Ibn Abī Šādiq means by *nafs*, because he also uses *ʿaql* (as in the previous aphorism) for the intellect and what we assume is also the rational soul.

⁸⁰ Galen, Commentary on the Hippocratic Aphorisms, Edited by arabcommaph. trans. Hunayn b. Ishāq, ed. Taro Mimura. Book II, Aphorism 46: "Hippocrates said: If there are two simultaneous pains and they are not in a single location, the stronger conceals the other. Galen said: If you were to understand "in a single location" literally, then it would not be possible under any condition for there to be two pains in a single location. If you understand [by this phrase] that a symptom (a *raqd*) is in a single location, this is possible. When I say that a symptom is in a single location, I refer to a body part that has bone in it, such as the upper arm, the forearm, the skull or the leg. If two pains are in the likes of one of these parts of the body, each of them will become more intense in harm on account of the other, nor will either of them be concealed from the patient. Thus, if the two pains are in two different locations such that, in the example, one is in the forearm and the other is in the leg, in such a condition it happens that the stronger one conceals the other. For the entire faculty of sensation accepts [impressions] from the location in which the pain is strongest, and it is occupied with it. This very thing afflicts the human in the case of distress, for distress, too, is painful impressions in the soul (*nafs*) rather than in the body. Thus, we find that the most the distress that is most powerful overwhelms the weaker one and conceals it as long as both of them do not issue from a single cause. If, however, they issue from a single cause they each one of them makes the other more intense as in the case of pains."

⁸¹ The states that arise as a result of perceived intentions and dispose a human to certain actions and passions are due to the correspondence between the internal faculties of imagination and estimation and the practical intellect. Ibn Sīnā, *Avicenna's Psychology*, 32.

anything less sweet afterwards.⁸²

This discussion on the limitation of faculties that are dependent on a bodily organ is utilized here to understand the impossible co-impression of simultaneous pain. Although pain in Ibn Sīnā's framework is a sudden shift in temperament, an intention, or divergence of the psychic faculty, Ibn Abī Šādiq deploys this discussion of simultaneous pain to further subject pain to the work of the internal senses. He clearly draws on Ibn Sīnā's exploration of the reaction of the faculties toward multiple impressions, an explanation grounded in theoretical psychology to build upon Galen's medical framework.

Further demonstrating the subordination of sensation to intellection, it is not surprising that Ibn Abī Šādiq's next example is that of *al-muta'allih*, one engaged in an exceptional state of worship, who does not sense pain despite possessing a fully functioning intellect. Thus, the inability to sense pain is not only produced by a dysfunctional intellect, it is also inhibited by the intellect's preoccupation with a higher form of intellection (such as worship). The intellect's preoccupation in both the worshipper and the melancholic is significant for considering questions of the soul in psychic pain and altered mental states.

Worship and Inattention to the Body

For Ibn Abī Šādiq, how pain is *not* received is insight into how it is generated. It is interesting then that the absence of pain becomes a ground from which he can explore questions such as the reception of non-human visionary knowledge and universal knowledge, which demonstrate how the intellect's preoccupation with the body is muted. According to Ibn Abī Šādiq, the inability to sense pain indexes that one's intellect must be preoccupied:

That is because the one entranced in worship, *al-muta'allih*, can sometimes forget his pain and does not sense it even though his intellect is fully functioning. Just like when something important occurs or is reported to someone, which distracts them from sensing intense pain because the sense faculty is diverted from sensing and attends to something more urgent.⁸³

Moving away from the possibility of a supervening pain that conceals a bodily pain, Ibn Abī Šādiq contrasts the state of *ikhtilāf* to a state of absentmindedness, preoccupation, and worship—opening up the possibility of withdrawal from the lower bodily faculties by renouncing the upper body (*badan*). One way to reconstruct Ibn Abī Šādiq's conclusion regarding the division of intellection and sensation during the activity of engrossing worship is by tracing Ibn Sīnā's differentiation between the practical intellect and theoretical intellect, and his conceptualization of the inner senses and their use by the intellect. Ibn Abī Šādiq's use of the figure of the worshipper, a state in which the soul may turn away from bodily pain during particular forms of worship, implicitly evokes Ibn Sīnā's discussions in his *Psychology* on prophecy and intuition.⁸⁴

By *al-muta'allih*, again, Ibn Abī Šādiq does not mean any ordinary worshipper, but one who's intellect can turn them away from sensing. Insofar as the soul requires the body to acquire physical forms through abstraction required for intellection, the internal faculties of perception, reception, and preservation of “sensible objects” and “non-sensible intentions” require a bodily

⁸² Ibn Sīnā, *Avicenna's Psychology*, 52.

⁸³ Ibn Abī Šādiq, *Commentary*, Book II, Aphorism 6.

⁸⁴ Ibn Sīnā, *Avicenna's Psychology*, 36.

organ.⁸⁵ As imagination and estimation are the bridge between the “material forms of sensibles and the absolutely abstract forms of intelligibles,” their passivity depends on the active predominates of the practical intellect, so that it “may have excellent morals”.⁸⁶ Serving two functions, the practical intellect governs the lower bodily faculties and “exists for the sake of the perfection and purification of the theoretical intellect”.⁸⁷ Oriented upward, away from the lower bodily faculties, as it seems to be in the case of the *al-muta'allih*, the intellect has “less and less use of the body in order to perform its proper functions.”⁸⁸ The worshipper’s turn away from the body, and Ibn Abī Šādiq’s provocation that some madmen suffering from mental derangement feel bodily pain, together suggest that he understands the intellect as a distinct entity.

For Ibn Sīnā, it is the dual nature of the intellect that suspends states such as pain, anger, and fear during intellection.⁸⁹ The soul “has two activities: an activity in relation to the body which is its government and control, and an activity in relation to itself and its principles, which is intellection”.⁹⁰ Theoretical intellection for Ibn Sīnā has several stages and various degrees; it is the contemplation of universal, intelligible forms. The capacity and speed of an individual’s theoretical intellect for acquiring knowledge, universal principles, varies. The intellect of those that possess “quickness of apprehension,” and “immediate perception” through intuition is considered *intellectus in habitu*.⁹¹ Ibn Sīnā describes an individual predisposed to prophetic inspiration as one “whose soul has such an intense purity and is firmly linked to the rational principles that he blazes with intuition, i.e. with the receptivity of inspiration coming from the active intelligence concerning everything”.⁹² An intelligence, *intellectus in actu*, thinks whenever it wills. It is also potentially *intellectus acquisitus* when it is in contact with the active intellect that knowledge is imprinted upon the soul from without.⁹³ Therefore, someone in a constant state of intellection will turn away from his lower faculties, as with Ibn Abī Šādiq’s worshipper. Functioning in the same way the person of insight does for Ibn Sīnā, both seem predisposed to conjunction with the active intelligence, as the person of insight (endowed with a “Divine Spirit”)⁹⁴ is at the height of the *intellectus in habitu* while the worshipper is in a state of humoral imbalance that diverts the intellect.

⁸⁵ Ibid., 31. See also McGinnis, *Avicenna*, 115, 124. Ibn Sīnā’s anatomy of the inner senses can be illustrated through the perception of a piece of flaky loaf of bread. One’s external senses are conduits, transmitting the flaky crust, the aroma, the warm loaf, and buttery rich taste, whereas one’s inner senses take in the images, divide and combine them, and intuit bread’s innocuous nature, its docility, as opposed to the danger emanating from seeing a wolf. As these sense impressions coalesce in the common sense (*al-ḥiss al-mushtarak*), producing a unified experience of warm and eatable bread, they are transmitted and stored in the passive imagination (*al-muṣawwira*). In the active imagination (*al-mutakhayyila*), the bread’s brownness, roundness, and fluffiness are separated from its direct sensible materiality through segmentation by way of abstraction. The active imagination turns into the cogitive (*mufakkira*) faculty in humans when it employed by the intellect and “combines and separates, giving rise to fantastical images.” The estimative faculty (*al-wahm*) receives the connotational attributes or intentions such as pleasure, pain, taste, time, and space directly received by the inner soul, while memory (*al-dhākira*) retains them. See Ibn Sīnā, *Avicenna’s Psychology*, 31 and Ibn Sīnā, *al-Qānūn*, 1958, 33.

⁸⁶ Ibn Sīnā, *Avicenna’s Psychology*, 32, 102.

⁸⁷ Ibid., 37.

⁸⁸ McGinnis, *Avicenna*, 124. Ibn Sīnā states: “It is also certain that the substratum of something can encompass infinite things cannot be a body nor a faculty in a body” (*Avicenna’s Psychology*, 50).

⁸⁹ Ibn Sīnā, *Avicenna’s Psychology*, 53.

⁹⁰ Ibid.

⁹¹ Ibid., 36.

⁹² Ibid.

⁹³ Ibid., 35.

⁹⁴ Ibid., 36.

Ibn Abī Šādiq needs then to clarify how the states of the *al-muta'allih* and the *mukhtaliṭ al-'aql* are analogous, beyond the absence of bodily sensation:

But this is applicable to *ikhtilāṭ* that occurs to the psychic faculties (*al-quwwa al-nafsāniyya*), leading to the intellect's preoccupation by that which is more important than sensing such as swelling of the brain and diaphragm. For sensation, even if it is not by means of the intellect, shares the same substratum that serves as the locus for both of their point of departure. Whenever *al-quwwa al-nafsāniyya* is diverted for something more important than sensing, due to *ikhtilāṭ*, then [one] finds within the body a corresponding pain from swelling, cuts, and laceration, they will not feel it.⁹⁵

Ibn Sīnā had argued that the weakness of the corporeal senses and powers was caused by the dissolution or dissociation of the spirit (*rūḥ*) of their organ, exemplified by particular circumstances such as sleep, illness, imbalance of bile, or fear.⁹⁶ Similarly, Ibn Abi Sadiq also stresses that the cession of sensation is caused by the preoccupation of the psychic faculty (*al-quwwa al-nafsāniyya*). Therefore, individuals affected by such conditions are in states that inhibit the soul's hold over the psychical faculties. For Ibn Sīnā, "the activity of the intellect ceases with illness only insofar that it was diverted from it since one regains its intellection of all its previous objects."⁹⁷ In a sense, during these states the soul's hold on the internal senses are weakened, emancipating them since it is not putting them to use.⁹⁸ By juxtaposing a functional state of the intellect, in the case of *al-muta'allih*, against a state of *ikhtilāṭ al-'aql* resulting from dysfunctional spirits, Ibn Abī Šādiq is resonant of Ibn Sīnā's conceptualization of the inner senses in emancipating the soul in order to explain states and conditions that inhibit bodily sensation.⁹⁹

The complexity brought about by the different physiological effects of madness and melancholia (which are themselves physiologically caused) is significant to medical anthropology's work on the mind-body duality and the place of religion in thinking through a medico-psychology. The presence of pain here is not simply bodily and is not simply registered by the mind. By evincing that pain cannot be felt in certain illnesses such as melancholia and other altered states, the modern relationship between medicine, the body, and the psyche must be reconsidered, perhaps even provincialized. For the worshipper extends his spiritual and contemplative states to the madman.

Madness, Psyche, and Body

Prior to explaining the effects of a dysfunctional *rūḥ al-nafsāniyya*, Ibn Abī Šādiq pauses in order to convey that there is an exception to the rule; for while *ikhtilāṭ al-'aql* leads to the inability to sense pain, some madmen do feel pain in their bodies. Thus, certain forms of *ikhtilāṭ al-'aql* neither preoccupy the *rūḥ al-nafsāniyya* nor distract the *quwwa al-ḥassāsa*. Therefore, we may read him to suggest that 1) not all mixing of the humors damages the seat of the sensory faculty and the intellect; 2) not all mixing of the humors inhibits the function of the faculties and

⁹⁵ Ibn Abī Šādiq, *Commentary*, Book II, Aphorism 6.

⁹⁶ Ibn Sīnā, *Avicenna's Psychology*, 53-54.

⁹⁷ Ibn Sīnā, *Avicenna's Psychology*, 53.

⁹⁸ In the case of *mukhtaliṭ al-'aql* and the *muta'allih*, the weakness of the senses allows the soul to turn away from its practical management of the body and attend to higher principles.

⁹⁹ Ibn Sīnā also states that certain emotional states can suspend certain bodily sensations and vice versa: "fear diverts the soul from hunger; appetite hinders it from anger, and anger from fear" (*Avicenna's Psychology*, 54).

spirits; 3) bodily pain could emanate from the same cause as the *ikhtilāṭ al-‘aql*; and 4) in certain forms of madness, the soul oscillates between its use of imagination and its capture by the imagination. Therefore, two conclusions emerge: some forms of *ikhtilāṭ* that lead to madness also produce secondary physiological manifestations emanating from the same cause as noted in the second aphorism; and second, some madmen suffer *ikhtilāṭ* that does not lead to the damage of the intellect and does not inhibit pain. Nonetheless, he must account for a form of *ikhtilāṭ* that does not lead to the absence of pain, which provokes his interest in accounting for the nature of the faculties and their relation to one another. Ibn Abī Šādiq does not explicate further as to why some madmen feel pain in their body. He then explains how certain forms of *ikhtilāṭ al-‘aql*, precisely melancholia, prevent sensation:

Madmen (*al-majānīn*) are also exposed to another state similar to the one we are discussing. When the spirits of the soul [*al-arwāḥ al-naḥsāniyya*] become extreme, its exposure to melancholic vapours prevents them from reaching the organs so that they may work as they should. They [madmen] do not feel many of the pains they experience. As Rufus the Great cites, a melancholic patient did not feel when he was poked in the body and when he was cauterized in his forearm. He did not believe he was being cauterized until he saw something [of his] functioning [body] burn.¹⁰⁰

Here he differentiates between *ikhtilāṭ* that redirects the *rūḥ al-naḥsāniyya* from attending to the body/the intellect, and *ikhtilāṭ* that does not.¹⁰¹ The form of *ikhtilāṭ al-‘aql* that leads to melancholia is the result of the excess of black bile, a physiological process. Ibn Abī Šādiq also follows general characterizations of melancholia previously noted by other physicians, but also correlates it to an emotional state. As noted in Pormann and Joosse’s discussion of Ibn Abī Šādiq’s commentary on melancholy and the propensity for fear and despondency, he correlates a physiological process to a feeling: “Ibn Abī Šādiq compares the fear that one feels in a dark place to the fear resulting from the darkness of the vapour in the brain,”¹⁰² an idea that can be traced back to Galen. As shown here, physiology is not a question of the body alone. Ibn Abī Šādiq explains the causal relationship between black bile and fear not in analogy to, but truly through the relationship of, fear and dark spaces. This projects a specific anthropology that allows the consideration of illnesses and health predicated not on a mind-body dualism, or on the analogical mapping or reunion of the two, but rather unproblematically treats them as entwined.

Noting that madmen suffer from multiple forms of *ikhtilāṭ* and that not every madman suffers from melancholia, Ibn Abī Šādiq seeks to account for various psychosomatic manifestations of madness and the relationship between the body, the soul, and the intellect. This relationship between the body, soul, and intellect and the importance of their balance to a balanced temperament was also considered by other physicians. Therefore, it is not surprising that physicians such as Abū Bakr Moḥammad Ibn Zakariyyā’ al-Rāzī, following Galen, prescribe activities like hunting, travel, and sports, activities that would lift the spirit through distraction

¹⁰⁰ *Ibn Abī Šādiq*, Commentary, Book II, Aphorism 6.

¹⁰¹ As mentioned above, for Ibn Sīnā, renunciation of the external body by the soul is made possible through the dissociation and dysfunction of the *rūḥ*, which minimizes the activities of the inner senses and the dependency on the external body. This is a principle that may explain Ibn Abī Šādiq’s exploration of the *rūḥ* as an integral mediator between the soul, the imagination, and the body. Whenever the soul is strong, in the case of the worshipper, it takes hold of the imagination, diverting the *rūḥ*. However, when the soul is weak, as in the case of the melancholic, the compositive imagination overpowers the senses, diverting the *arwāḥ* from attending to the corporeal body.

¹⁰² Pormann and Joosse, “Commentaries on the Hippocratic Aphorisms in the Arabic Tradition,” 225.

but also would divert those in distress from “deep thought,” stating: “the spirit, if it is emptied, thinks about profound, remote things, and if it dwells on them, it does not have the power to overcome the illnesses that sadden, distress, and worry the reason. If these signs increase and strength, it would be melancholia.”¹⁰³ In this line of reasoning, the moral temperament tied to particular actions deliberated by the practical intellect, according to Ibn Sīnā, inform the orientation of the theoretical intellect. Al-Rāzī’s conclusion that certain performance can reorient the intellect correspond to the ways physicians outlined the relationship between intellection, the coordination of the bodily faculties, moral temperament, and action.

Conclusion: Toward a Medico-Psychology

Ibn Abī Šādiq’s discussion of the place of sensation and intellection and the nature of simultaneous pains frames the intellect as at once physiologically effected and immaterial, a conclusion that is shared by Ibn Sīnā. However, the relation between the sensitive faculty, cognition, and intellection, grounded in deep theoretical debates regarding the materiality and immateriality of the rational soul and their relation to their respective organ, seems to produce a dilemma considering the two dominant psychological frameworks of his time. Therefore, in order to explore *ikhtilāf al-‘aql* and its multiple effects on (or indifference to) the external and inner senses and intellectual responses, Ibn Abī Šādiq utilizes different gradations of madness to link physiological processes to the rational intellect and the soul. In the aphorism regarding the simultaneous pains, although Ibn Abī Šādiq associates pain with the external senses such as sight and hearing and goes beyond Galen, he implicitly draws on Ibn Sīnā as he attempts to utilize the discussion of the co-impression of sensibles and overuse of a physical organ in order to speak to the relation between the place and nature of sensation and its function.

By attempting to map pain onto the process of the inner senses, arguing that its absence is due to the intellect’s turn away from the lower faculties, Ibn Abī Šādiq subjects it to formal system of abstraction, a novel medico-psychology. In doing so, Ibn Abī Šādiq allows for a physiological process to speak to principles developed in theoretical psychology. This is a practice that Ibn Sīnā frowned upon, as the practice of returning the body to its balanced natural state cannot make claims regarding its nature, its soul, and its faculties. For Ibn Sīnā, physicians seek the same causes as natural philosophers. But the theoretical principles they posit regarding the existence, number, and location of elements, temperaments, humors, powers or faculties, and spirits must be those “demonstrated in higher physical science.”¹⁰⁴ Utilizing the multiple physiological and psychic effects of different states of madness, Ibn Abī Šādiq utilizes physiological processes in order to reconceive a theoretical psychology that accounts for them. Here, madness becomes an axis of a medico-philosophical psychology.

Ibn Abī Šādiq’s commentary seeks to reconcile the fact that the internal senses are seated in the brain and that the intellect and sensation depart from the same substratum, but that intellection can also emanate without the aid of the bodily faculties. The figures of the *mukhtaliṭ al-‘aql* who cannot sense pain in his body, the madman who senses bodily pain, and the engrossed worshipper allow Ibn Abī Šādiq to explore questions within theoretical psychology that become essential to understanding the nature of the intellect and its relations to divergent forms of madness, and the relationship between the intellect and the body. Therefore, Ibn Abī Šādiq finds it necessary to explore the relation between the nature of the faculties and the

¹⁰³ Dols, *Majnun*, 55.

¹⁰⁴ McGinnis, *Avicenna*, 238. See also Ibn Sīnā, *al-Qānūn*, 1958, 33.

transmission and cessation of pain, as a way to understand the various ways the intellect or cognition and the body interact.

This discussion of Ibn Abī Ṣādiq's complex inheritance and extension of existing psychologies reveals an uncanny resonance with the contemporary Yemeni physicians with whom I opened. It provokes us to ask, what does it mean to perpetuate medicine as an objective science that encounters both spiritual and physical ills, both internal and external factors, given the porosity of the human? What form of training do such physicians require? What form of knowledge is medicine predicated upon? Are contemporary evidence-based physicians simply alleviators of bodily pain? As mentioned regarding my ethnographic work in Yemen, both patients and physicians are “knotted” (*muta 'aqqidīn*) during and prior to their interaction within the clinical space. The *'uqda*, like *ikhtilāf al-'aql*, opens up a space for a discussion on the soul and its nature not only metaphysically (as in the medieval physicians' explorations) but also psychically and spiritually (as continues in Yemen today).

Ethnographically, at stake in the physician-patient interaction is the composition and porosity of the human and the relationship between the body, psyche, and the soul. Here too the intellects, both practical and theoretical, are entwined with bodily temperament such that there is a relationship between the orientation to good morals and the balance of the humors. The debates about medical authority in the Islamic world endure,¹⁰⁵ particularly considering the place of humoral medicine in theological considerations of suffering in the soul. What then does medical and psychological anthropology have to add to such debates? When patients demand this complex anthropology be recognized, as I have seen in Yemen, the physician's expertise is unsettled, for he can lay claim to neither the knowledge nor the position of the *'ālim*. This is the scene in which the physicians attempt to reassert their authenticity and claims to modern medicine through citing the tradition of Islam and medieval physicians. The complex commentary of Ibn Abī Ṣādiq, reconceptualizing a medico-philosophical psychology due to cases of madness and mental derangement, is at once gestured toward by these same physicians and also charts another path (unheard) between the authority of medical practitioners and the theological and ethical realm of philosophical psychology.

¹⁰⁵ See Pandolfo, *Knot of the Soul*; Sherine Hamdy, *Our Bodies Belong to God: Organ Transplants, Islam, and the Struggle for Human Dignity in Egypt* (Berkeley: University of California Press, 2012); and Charles Hirschkind, *The Ethical Soundscape: Cassette Sermons and Islamic Counterpublics* (New York: Columbia University Press, 2006).

Chapter 2: Benefit and Efficacy: Methods and Limits in Science and Islam

“My aspirin does not work and my *Hakim* is dead.”

—Muzaffar Iqbal

Dalil or Ta’wil?

Professor Maha is a pediatric oncologist at a teaching hospital in Jeddah, Saudi Arabia. In addition to seeing cancer patients, she directs research on what is known as Prophetic Medicine (*tibb nabawi*). She is working on a book compiling biomedical cases that utilized evidence-based research methods demonstrating the benefits of certain medical regimens drawn from the Prophet’s teachings. When I met her, she shared with me an article written by a Muslim cardiologist in the Netherlands who played Quran recitations in the ICU for heart failure patients in order to slow their heartbeats. “It’s amazing,” she told me, raising her voice, “people are doing evidence-based research to show the marvels of Prophetic Medicine.” When I asked what “medicine” meant to her otherwise, she pointed to the fact that the medical textbooks and curriculum in the Middle East came from the West (England, United States, Canada). She began to explain, in a lecturing mode:

Look, there is Indian medicine, Chinese medicine, and other forms of medicine, but this, evidence-based medicine, is what the international community practices. Evidence-based medicine has its center in the West, but it is now practiced internationally. The world is now a village and it is held up by a methodology. Conducting research on cupping (*hijama*) and Prophetic Medicine will spread it to the scientific community. People should know the benefits. *Tibb nabawi* has benefits and it is not harmful. It is purely beneficial.

The hospital is accredited as an academic medical center both by the Joint Commission International and by Canada’s Qmentum Accreditation.¹ Physicians often cited this accreditation as a way to display the hospital’s compliance with international standard of care.² However, Dr. Maha believed that one should strive not simply to replicate these standards of care but to uncover better ones. As a pediatric oncologist, she was committed to finding alternative forms of palliative care, to discovering methods for elongating remission terms, and to better managing chronic pain. She had begun the clinic after disagreeing with her colleagues on implementing Canadian protocols for cancer patients in remission.

Professor Maha invited me to visit the Prophetic Medicine Clinic (*‘iyadat al-tibb al-nabawi*) holding clinical trials on the benefits of cupping patients with chronic conditions. I was to observe cupping sessions and to witness how patients’ progress were tracked across several months. In cupping (*hijama*), which the Prophet Muhammad prescribed as beneficial to health, a small incision is made in the skin and a suction machine evacuates blood.

¹ <https://accreditation.ca/accreditation/>.

² Many hospitals in the Middle East seek the accreditation of the Joint Commission International and other internationally recognized programs, as a way to display their compliance with and commitment to international standards. This was displayed everywhere in the hospitals, and physicians reminded their patients of this fact when the latter asked about going abroad for medical care. A majority of physicians at the hospital did both their residency and fellowships in Canada.

The Prophetic Medicine Clinic was run by Dr. Sama, an obstetrician with fifteen-years' private experience. She had trained at al-Azhar Medical University in Egypt and then moved to Saudi Arabia in 1984. Dissatisfied with biomedical models of health and care, she turned to conducting clinical research in Prophetic Medicine after working for a couple of years with a foundation devoted to uncovering the scientific miracles within the Qur'an. Inspired by this research, she returned to her private practice after her children grew up and began conducting cupping sessions for her patients. She had her patients do complete blood count tests (CBC) to show that cupping did not drop their hemoglobin levels. These tests, in addition to research from other biomedical physicians on Prophetic Medical regimens, had laid the groundwork for the "Prophetic Medicine Clinic," which opened in 2010, in this state-of-the-art facility that could rival the most sophisticated and technologically advanced hospitals in North America. Dr. Sama was later recruited to work there, where she became one of the investigators on these clinical trials. Her choice to participate in research on Prophetic Medicine was motivated by her love for research, but also by preponderant stereotypes about Arabs and Muslims being scientifically backward and medically primitive.

Critics of cupping, both within the hospital and the global biomedical community, frequently point to the decline of patients' hemoglobin levels as one of its potential harmful side effects. The practice of cupping promised the removal of toxins, but was not grounded on any concrete and demonstrated improvements in health. Documenting her patients' hemoglobin levels was the first step in countering the claims of skeptics who perceived cupping as harmful and lacking efficacy. For Dr. Sama, this form of *dalil*—proof, sign, indication, evidence, syllogism, index—was evidence of the efficacy, not the benefit, for the latter was already promised by the Prophet himself and so did not require evidence.

In this account, the benefits of Prophetic Medicine exist prior to their human acknowledgment, their apparent manifestation. The *dalil* produced for its efficacy is simply a material expression of its prior positing (*ta'wil*) in revelation. *Ta'wil*, from the trilateral root *a-w-l*, can be rendered as a return, specifically to an essence. Although in the exegesis of Qur'an and hadith it refers to specific modes of explanation, more broadly it refers to the relationship between literal (*haqiqi*) and figurative (*majazi*) levels of meaning.³ *Ta'wil* entails a demonstration of a lesson or an inner logic. However, global biomedicine merely requires *dalil*.

"What comes out [in cupping]," Dr. Sama explained, "is the bad blood between the skin and the bone. Allah only knows. Glory to God!"

A patient scheduling her next appointment overheard us and affirmed the efficacy of this practice. "My hemoglobin levels actually increased after cupping!"

Dr. Sama marveled at the inner workings of the human body and soul and acknowledged the limits of her knowledge. Thus she oriented herself toward the finitude of human knowledge and the vastness of God's knowledge, much of it in the realm of the unseen (*al-ghayb*). For Dr. Sama, cupping as a prophetic medical practice benefited patients in ways that may never be fully understood.

Prophetic Medicine as a literary genre emerged in the fourteenth century as annotated compilations of prophetic hadiths concerning physical and psycho-spiritual health. Works in this field include those by Ibn al-Qayyim al-Jawziyya (d. 1350) and Ibn Taymiyya's (d. 1328) circle of students, but also by scholars such as Ibn al-Dhahabi (d. 1348) and Jalal al-Din al-Suyuti (d. 1505). The historian Fazlur Rahman gives three possible motivations behind this development: grounding medicine in the holistic form of the human as a psycho-spiritual physical being,

³ M. Ali, *Medieval Islamic Pragmatics* (London: Routledge, 2000), 88.

presenting curative and preventive measures to the average laymen, and extolling medicine's spiritual and ethical value within the tradition.⁴ Prophetic Medicine was not simply a divine prescription for health; understood historically, it is a body of medical cures that the Prophet Muhammad incorporated and authorized from pre-Islamic Bedouins in addition to the influence of Indian and Greek medical traditions. The rise of this genre generated a scholarly debate as to whether the Prophet was a vessel exclusively for Islamic law but not other sciences pertaining to worldly crafts. Rahman argues that many hadiths regarding the permissibility of various therapies and medicines that were attributed to the prophet were developments within the tradition because disciplines such as Sufism and Islamic jurisprudence wavered on how to reconcile medical cures with submission to God's will. For instance, Ibn Khaldun (d. 1406), a contemporary of Ibn al-Qayyim and Ibn al-Dhahabi, argues in *al-Muqaddimah* that the Prophet "was not sent to teach medicine or any other ordinary matter."⁵ For Ibn Khaldun, the corpus of Prophetic Medicine was customary, not religiously stipulated. This stance was shared by many of my interlocutors who reconcile contemporary biomedicine and Islam. The presence of various medical traditions within Prophetic Medicine and the question of the Prophet's authority on worldly matters resonates with what unfolds within this ethnography: the tension between benefit and efficacy, evidence and authority, debating what the *sunna* (prophetic path) entails.

The Prophet is considered God's most perfect creation; his actions, sayings, and prescriptions are themselves both a reflection of and path to God. Therefore, knowledge of the Prophet and his prescriptions are paths of gnosis (*ma'rifa*). The Prophet's perfection and example are also understood as a mercy, sent down to his nation for guidance. God's prescriptions are meant as signs for the well-being of humans and their benefit. Yet these signs are complex in nature and at times elusive to human comprehension. Their knowledge ultimately lies with the creator himself. By extension, the closer you are to the Prophet, the nearer you are to God and the closer you are to your own self/soul (Q. 50:16). The Prophet's prescriptions, as a mercy to humanity, attend human nature and the needs of this life and the afterlife, beyond momentary and physical health (*sihha*). For my interlocutors, Prophetic Medicine brings them closer not just to what is beneficial but to what eludes us about the complexity of the human body, its soul, its spirit, and their interworking. "Benefit" here is also complicated, as it means different things for my interlocutors. Some of them believed that such insight could come from anyone, for God's signs are everywhere; others restricted it to the example of the Prophet. Some argued that his example could extend and widen the tradition; others understood the example to truncate and shrink the tradition.

Particular hadiths are invoked to point to delimit the Prophet's exemplarity for worldly crafts. It is narrated that while the Prophet was walking by some farmers, he advised them against the use of fertilizers. When word reached the Prophet that their crop failed that year, he said that his prescriptions on religious affairs should be followed while others know more of their worldly affairs.⁶ This hadith, however ambiguous, is often invoked regarding the Prophet's

⁴ Fazlur Rahman, *Health and Medicine in the Islamic Tradition, Change and Identity* (New York: Crossroad, 1987), 41-49.

⁵ Ibn Khaldun, *The Muqaddimah: An Introduction to History*, trans. Franz Rosenthal (Princeton University Press, 2015), 387.

⁶ "Narrated from Talha ibn Ubaydullah: After arriving in Medina, the Prophet (peace and blessings be upon him) passed by some people who were fecundating some date palms, so he asked them what they were doing. When they told him, he said, "I don't think that will provide any benefit," or in another narration, "It would be better if you didn't do that." So they refrained from doing it, and that year the crop was not as good. They mentioned it to him (peace and blessings be upon him), and he replied: "I am only a human: if I command you to do something in your

limited authority on worldly affairs and the extension of his authority. Yet in the field of Prophetic Medicine the Prophet's prescription of specific medical practices imbued them with his broader (atemporal) authority. This tension is encountered by my interlocutors and within the tradition, as this dissertation traces. I found myself torn with respect to these two positions and the question of the potential of the Prophet's exemplarity and its limitation. I found both positions to be equally constricting and expansive, affording depth and nuance in contrasting ways. While Dr. Sama saw Prophetic Medicine as drawing her closer to the Prophet's example, other physicians saw it as inhibiting another history and other forms of benefit.

In this chapter, I aim to understand and locate various positions on Prophetic Medicine expressed by my interlocutors in the hospital within a selective archive of Islamic scholarship and contemporary debates on the relationship between science and Islam. I found myself seeking to shadow physicians at the Prophetic Medicine Clinic after many of my interlocutors expressed opposition to non-biomedical forms of medicines and often worried that I was seeking to undermine their practice and training in evidence-based biomedicine as Muslim physicians practicing in the non-West. I shadowed interns, residents, and attendants during rounds and clinics, and participated in weekly seminars and ethics courses. I witnessed and mourned alongside families the deaths of patients who refused dialysis in early onset renal failure, so their bodies waned slowly over the course of months in the hospital. Patients who attempted to fight cancer with chemotherapy, and couldn't understand their bodies' lack of response to therapies, were considered martyrs. Others began WhatsApp groups to deter fellow patients from seeking herbal medications to illnesses that they felt required biomedical therapies. This was the complicated terrain I entered. Physicians navigated their patients' desires for *'afiya* (physical, psychological, and spiritual health) and their own place in the biomedical treatment plan as perceived instruments of God's decree. All the while, they struggle to articulate the proper relationship between biomedicine and Prophetic medicine.

Many of my interlocutors who insisted on the efficacy of evidence-based medicine were ambivalent toward the Prophetic Medicine Clinic. They believed that the scientific method was indigenous to Islam, and hence that there was religious warrant (*dalil*) for biomedicine. To be clear, this pride in their training was not a disavowal of scripture, the possibility of miracles, or the benefit of Prophetic Medicine. Instead, they drew on the Islamic tradition as a form of ethico-religious cultivation that could inform a reform (*islah*) of medicine. On the other hand, physicians such as Dr. Sama held that clinical trials on Prophetic Medical regimens were the proper form of such reform. It is in this landscape—raising questions of how physicians position themselves in relation to medical knowledge, their responsibility to the medical community, patients, the community at large, the unknown (*al-ghayb*), revelation, and knowledge yet to be uncovered—that I began to ask the questions of evidence (*dalil*), benefit (*manfi'*), and inner meaning (*ta'wil*).

This chapter is an attempt to engage with interlocutors, both in the field and in texts, that are both open and closed to encounters beyond the cosmic text, the phenomenal world, nature (*tabi'a*); beyond the demonstration of proof (*dalil*). Folded within these openings and foreclosures were traces of the perplexed contemporary nexus of science and Islam as it is lived out and imagined. My own engagements as recounted here are meant to serve as a passage, an opening, a bridge (*ibra*), transgressing the complex history of science in Islam, much of which

religion, then take it; but if I tell you to do something based on personal opinion, then [realize] that I am only human," and in another narration, "Yet if I inform you of something from Allah, then do it, for indeed I will never convey an untruth on behalf of Allah Mighty and Majestic" (Muslim §2361).

remains untold, while respecting other congealed narratives. This was the absent present informing my own ethnography, with all the anonymity and discretion entailed, which remain sealed as part of my own trust (*amana*) to my interlocutors. Doing justice in relation to this knowledge stemmed from this trace that is non-human. It is displaced to another time, another space, and of another order of existence.

Remaining true to my own relation to inner meaning (*ta'wil*) might fix my line of thinking within a particular orientation toward knowledge that is beyond the empirical, literal, and apparent. This rings true for the most part. Yet, my fidelity to the practice of ethnography tugs at the limit of my desire both to transmit knowledge that is methodologically grounded and for that knowledge to become an opening and a passage (*'ibra*). This is not to make the unseen (*al-ghayb*) present—which is beyond me and beyond this text—but to acknowledge the relationship between knowledge and attunement, revelation and concealment. As a result, my efforts are in counterpoint to linear histories of classification, methods, and inquiries; they are an attempt to disclose the lessons of sealed knowledge.

The Prophetic Medicine Clinic

On any given day within the clinic, when the cupping sessions end, Nurse X helps patients dress and then Dr. Sama examines their vitals. Dr. Sama usually takes their blood pressure and examines their hands and temperature. She then instructs patients to rest and not to eat meat for three days. Patients rarely spoke with me before or after their cupping sessions. The very few who did were excited to share the ways it helped them manage their chronic pain. Many left in haste, as the reason behind their visit could involve spells (*sihr*) or the evil eye (*'ayn*) and so was a private matter. Patients in other clinics (internal medicine, obstetrics) were much more interactive, sharing with me their stories and progress, and would often praise their physicians and biomedical therapies.

During our second week, Dr. Sama sat beside the computer while the nurse prepared the patient for her cupping session. The nurse, trained as a surgical nurse, recounted how she began secretly giving people cupping sessions in the Emergency Room of the hospital. She laughed at her own description of these sessions as secret—why should they be, when after all cupping is the Prophet's tradition (*sunna*). Practicing a *sunna* in a hospital authorizes itself rather than requiring authorization. Both Nurse Halima and Dr. Sama noted that when they first began the clinic no one really cared. However, when people started to fill the Prophetic Medicine Clinic, a war was waged on it by the pharmacologists and other physicians.

Other challenges emerged as Dr. Sama attempted to publish about her project. Although the results of the cupping clinical trials were eventually published in a magazine called *Alternative Medicine*, they were rejected by scientific journals. Many of the peer reviews requested her team omit the citations of Prophetic hadiths and Quranic verses, which she explained were there to show the practices' scriptural basis. She explained that otherwise they adhered to the journals' standard format and clinical methods.

"I love research. It is a pleasure (*mut'a*) for me. You research to arrive at a result and realize a goal. Our goal is big. Our goal is to drink from the hands of the Prophet. In the Quran, the fetus is discussed before the sonogram was even invented. God described it in detail," she declared, implying the text's divine provenance. To drink from the Prophet's hands is to benefit from a knowledge that is unknown (*ghayb*), partaking in the realm of the invisible or non-manifest, a knowledge that she compared to the Quran's knowledge of the fetus prior to

technological advancement. For Dr. Sama, revelation transcends human knowledge; to engage it is to benefit from the vessel of God, from a knowledge that is non-human, atemporal, and divine.

The resistance to Prophetic Medicine that Dr. Sama encountered from the other physicians and from the scientific journals had fundamentally to do with questions of authority, benefit, efficacy, and proof. In her view, Prophetic Medicine is open to the operation of the unknown (*al-ghayb*), which bestows benefits that exceed the fleeting health of the body. At stake in this contest over Prophetic Medicine was whether it can or should be subject to biomedical assessments of efficacy.

Before I met Dr. Sama and began shadowing her in the Prophetic Medicine Clinic, I had spent months in other clinics: nephrology, obstetrics and gynecology, oncology, radiology oncology, endocrinology, neurology, and even psychiatry. Although the oncologists were the first to welcome me and my research, and take me under their wings, I witnessed how nervous they were when patients discussed utilizing herbs, honey, and other regimens to strengthen their immune system. As long as their patients continued their biomedical therapies, oncologists did not deter them from utilizing alternative regimens (although many of these physicians began WhatsApp support groups to deter patients' enthusiasm for miracle cures). Yet the same tolerance was not prevalent in the nephrology and endocrinology clinics. Patients who were at risk of complete renal failure and would often resort to chewing Arabic gum and using other remedies to regain the function of their kidneys, driving their nephrologists to their wits' end. In turn, the nephrologists would spend hours in the clinic explaining the inefficacy of such remedies. They were afraid of their patients' deviations from their medications and dialysis. They discouraged any usage or self-experimenting of any herbs or therapeutic regimens outside their prescriptions and even hired a full-time patient educator dedicated to explaining nephrological issues and remedies.

Moving between the clinics, I often felt caught. I understood the logic behind the nephrologists' and endocrinologists' anxiety about the body's reaction to experimentations, but then also understood the benefit Dr. Sama spoke of in Prophetic Medical regimens, when she appealed to more than just the body. The absence of evidence (*dalil*) incited fear in the nephrologists while for Dr. Sama that absence was the scriptural presence of *al-ghayb*, a reality unseen but felt and expressed. Physicians wielded revelation to different ends, as it became the site for physiological and psychic transformations. My interlocutors' orientations toward *al-ghayb*, the completeness of God's knowledge, and the finitude of human knowledge accounted for the different positions on the Prophetic Medicine Clinic within the hospital and its relation to evidence (*dalil*).

In order to make my way to the clinics, I had to pass through a connecting corridor that bridges the hospital, the medical school, and the clinics. On the right walls of the corridors were flatscreen TVs that highlight the hospital's latest scientific research and achievements. On the left wall were four giant posters of the Islamic Golden Age that medical students, interns, and residents routinely ignore. These posters highlighted the physicians of Islamic civilization, the historic hospitals Muslims established, and the many scientific inventions of Muslim scientists. This monument to a scientific past resonated with the physicians who viewed scientific methodology as indigenous to Islam and evidence-based medicine as emerging out of developments made in medieval Islam. As I shadowed interns, residents, and attendants during rounds and clinics, and participated in weekly seminars and ethics courses, I observed how my interlocutors referred (for example) to Ibn Sina's *Canon of Medicine*, al-Zahrawi's medical encyclopedia on surgical tools, and Ibn al-Nafis's earliest description of pulmonary circulation.

This past was newly celebrated, due in part to a decline in government scholarships to send students abroad, the loss of exceptional scholars to Western institutions, and some physicians' disillusionment with Western medical training and knowledge. Many of my interlocutors spoke about the Quranic injunction to seek knowledge, insisting that all knowledge belongs to God. It is these same physicians who bear witness to the benefit of Prophetic Medicine, the reality of the unseen,⁷ and the force of magic (*sihr*) and the evil eye (*'ayn*)—and also refuse to subject it to clinical trials.

As I made my way to the Prophetic Medicine Clinic, I steered clear of the overflow of patients outside the waiting rooms of the internal medical clinic, obstetrics, oncology, and ENT. As I got closer, the foot traffic wound down, seeming near abandoned in contrast with the other busy clinics. Inside the diagnosis room, Qur'an was playing from the speakers, and Nurse Halima and Dr. Sama spoke softly as the patient laid on their stomach awaiting the evacuation of their blood. Each patient took a two-hour appointment; as few as two to three patients a day were seen in this two-day clinic. All appointments were made through referrals from clinical physicians who "avow" the practice. Many of the patients suffer from chronic pain and come from various subspecialties, including gynecology, nephrology, rheumatology, endocrinology, oncology, and ENT. Patients sent to the Prophetic Medicine Clinic were those whose biomedical therapies either failed or were generally detrimental to their overall health. The Prophetic Medicine Clinic had thus become a space that embraced *al-ghayb* and its uncertainty.

Open to providing patients with alternative forms of care which addressed unresolved health uncertainties, these same physicians (such as Professor Maha, the director) had begun to serve as the PIs (principle investigators) to some of the clinical research. Other physicians began supporting the Prophetic clinic after they found cupping to cure them of their own ailments. Nurse Halima recounted that a prominent physician, who complained of his inability to pray standing due to knee problems, could do so five times a day after starting cupping sessions. The physician felt lighter than ever, even "floating" through the hospitals during his rounds. This feeling of flying, Nurse Halima explained, was an *i'jaz 'ilmi* (scientific marvel). Another physician, who initially staunchly opposed the Prophetic Medicine Clinic, was converted to its benefits after cupping relieved her chronic migraines. She is now one of the clinic's advocates and even tried to protect it from other professors' attempts to shut it down. How these stories unfolded reminded me of the conversion story of the Prophet's companion 'Umar Ibn al-Khattab. On his way to kill the Prophet Muhammad, he was diverted by an encounter with his sister in which he heard verses of the Qur'an that filtered through his heart. He went on to become the warrior-protector of the Prophet. Given the benefit of the Prophetic Medicine Clinic which so many of its proponents had personally experienced, it was no surprise to them that people filled the clinic weeks before Ramadan in order to ready themselves for the long night prayers.

Yet, as stated above, contestations over the Prophetic Medicine Clinic was not simply a championing of revelation on the one hand and rejection of it on the other. Rather, some felt that privileging the historical literature on Prophetic Medicine obscured the history of Greco-Arabic medicine and the broader Islamic medical tradition.⁸ Others opposed the Prophetic Medicine Clinic for inappropriately subjecting Prophetic Medicine to clinical trials and Western scientific skepticism. They held that it was absurd to offer proofs for Prophetic wisdom. While one might argue that Dr. Sama was falling prey to the rationalization of contemporary science, I am reticent

⁷ Nils Bubandt, Mikkel Rytter, and Christian Suhr, "A Second Look at Invisibility: *al-Ghayb*, Islam, Ethnography," *Contemporary Islam* 13, no. 1 (2019): 1-16.

⁸ P. E. Pormann & E. Savage-Smith, *Medieval Islamic Medicine* (Washington, DC: 2007).

to dismiss her efforts as simply a form of false consciousness, for the question of evidence emerges even in the authentication of the Prophetic tradition.

In the Sunni tradition, the way of the Prophet (*sunna*) is articulated from authenticated hadiths (Prophetic narrations); scholarly interpretations; the practice of the pious community of Medina; and principles of Islamic law, ethics, and theology. Texts devoted to Prophetic Medicine were assembled as a collection of authenticated hadiths, following the eighth-century refinement of a three-tier method of hadith criticism and authentication. This process considered the chain of transmission leading back to the Prophet (*isnad*) as evidence (*dalil*); the probity and reliability of the narrators; and the corroboration of other narrations. This sifting of hadiths led to the composition of the six collections that comprise the Sunni hadith canon. Hadiths serve as maxims for law, creed, and ethics and as mediums of direct connection to the Prophet; they shape politics, mysticism, and medicine. Already from the eighth century AH, the hadith collection known as *Sahih Bukhari* was “read as cure for illness from Egypt to India.”⁹ In this way, the recitation of hadiths themselves were seen as a beneficial cure.

How one chooses to practice, transmit, and develop a medical practice of the Prophet matters in respect to one’s envelopment within God’s path, to fulfilling God’s communal or individual obligation to serve the community and maintain one’s wellbeing (*‘afiya*), and to the path to the afterlife. I may benefit momentarily by muting my body with sedatives as a blessing from God; I may attempt to understand the underlying cause as a way to understand my body holistically, heeding the prophetic injunction to care for my soul and body. As the spiritual and the medical are deeply entwined in Islam, one understands that what one consumes orally, visually, and aurally informs not only one’s disposition and orientation but materially forms one’s physiology. A soul submits (whence the lexical meaning of *islam*) to prescriptions through a balance of the body’s physical, psychic, and spiritual dimensions. To submit is to also leap into the unknown (*al-ghayb*), taking a guide through the history of exemplars and the unsealing of God’s signs.

In subsequent meetings, Dr. Sama and I sat at the opposite side of the diagnosis room near the computers while Nurse Halima massaged the patient, prepared them for cupping, and watched over them as they laid on the table. We delved deeper into the question of nature (*tabi‘a*), psychosomatic illness, and “the form of the human.” We began the session by joking about the weirdness of the days with Dr. Sama offering me a cupping session, as I was feeling unbalanced. Cupping was a better option than taking pharmaceuticals, she argued. Pharmaceuticals have harmful effects that are worse than their benefits whereas natural treatments benefit a human without harm.

She then said, “The whole world is turning to nature (*tabi‘a*) because the [medical] prescriptions nowadays are more harmful than beneficial.”

I turned to Dr. Sama and asked what she would like to see from this shift to *tabi‘a*. Dr. Sama continued:

Human interactions (*mu‘amalat*) as complete (*mutakamil*, in accordance with the being’s perfection). Not just with [another with] a body, but a body with a spirit/soul (*ruh*). A human is a thing ensouled (*nafsiyya*¹⁰). There are unknown illnesses now called

⁹ Jonathan A.C. Brown, *The Canonization of al-Bukhārī and Muslim: The Formation and Function of the Sunnī Hadīth Canon* (Leiden: Brill, 2007), 340-345.

¹⁰ See chapter 4 for the discourse around *nafsiyya* that is mobilized as a form of egocentrism or a form of enslavement to one’s *nafs* or desire.

psychosomatic diseases. They come from sadness, shortcomings, and the effects of wars. [They need to be treated with] concern and care for the patients' conditions of the soul (*halat nafsiyya*). They are treating [such cases] with Qur'an, treating cancer patients with Qur'an. There are a lot of cures aside from pharmaceuticals, which they use in order to rest the patient's soul (*nafs*). If the *nafs* rests, then it will be receptive to the cure (*'ilaj*). Perhaps the reason behind the illness is the state of their *nafs* itself. Remember the verse that says, it is through the remembrance of Allah that the hearts find ease? Here we have the cure for every illness; we have Prophetic Medicine; we have the Qur'anic cures. There is much research on these.

We were interrupted again. This time the cupping patient turned to Dr. Sama to write up her progress. The patient affirmed that she still felt pain in her neck and her joints from rheumatoid arthritis, but that cupping helped with her asthma. While she waited for Dr. Sama to schedule her next appointment, I asked what brought her to the Prophetic Medicine Clinic. She said that two years of pain medications had not worked to reduce the inflammation in her eyes and joints; only cupping had helped, six years ago. Dr. Sama asked Nurse Halima to turn the Qur'an recording back on, and resumed our conversation by addressing an important topic she wanted to discuss: the gaps in western medicine, since they failed to acknowledge illnesses of the *ruh*. She continued:

Spiritual malaises (*al-amrad al-ruhiyya*) are widespread because of corruption (*fasad*). I have read in books about [such illnesses]. I have also seen from experience. Spells (*sihr*)¹¹ are known from [patients'] involuntary movement. You don't know the cause. All the [diagnostic] tests are normal [but] the patient cannot control themselves. They can cry with the voice of a man. [Yet] I know these causes because of experience (*khibra*).

Dr. Sama's observations of patients complaining of involuntary movements and nightmares included hallucinations of animals, scary figures, and insects. As a result, she began to instruct them to eat seven 'ajwa dates (the black Medinan dates which the Prophet used to eat), to recite the Quranic chapter "the Cow" (which deals with witchcraft), and to recite the litanies of morning and evening for protection from the evil that God has created.

As we continued our conversation about what she considered spiritual illnesses, I asked how she knew when it was the evil eye or magic. She explained:

From the evil eye, something really weird happens. When you cup and there is red blood, there is also foam, like soap. You will see it in the top of the cup, like air bubbles. This is only from my experience. There are others that do a liturgical cure (*ruqiya*) and have a dialogic exchange (*hiwar*) between them and the jinn. These are signs. This is from their knowledge. But none of us have written about this. These are huge gaps in Western medicine, as it does not admit this (*mu'tarif*). What is even sadder is that our kids who are educated in biomedicine often respond by saying, what is this superstition and myth? But we have a chapter in the Quran called "the Jinn." Do they not acknowledge that much? (...) Biomedicine will not acknowledge the reality [of the evil eye and magic].

¹¹ *Sihr* is a targeted conjuring or spell that involves the mediation of a jinn who is then knotted with the person, in order to achieve a particular purpose at hand.

Nurse Halima gasped, “Just like that woman who had asthma when I told her it was [caused by] the evil eye!”

“How does one know?” I asked again.

“People know. There is knowledge (*‘ilm*) of this. But in biomedicine, they only acknowledge what they see. They deal with humans as if they are simply matter, like you said,” Dr. Sama responded.

“Well,” I commented, “There are those physicians who do acknowledge [these things] but don’t know what they’re supposed to do.”

Dr. Sama clarified:

We are not talking about education. We are talking about foundation. They do not acknowledge that this reality (*haqiqa*) is present. This is a problem. Why? When you go to the hospital or the emergency room....One time I went into the ER before I knew about cupping. Dr. Maha was there with me. I thought I was going to die! I felt weird symptoms. All labs were normal. All the investigations were normal, but I felt like I was going to die. The doctor gave me some drugs. He was still a young resident. This was a reality he couldn’t consider. They don’t try to find a solution. The easiest thing that they can do is give a patient a sedative. This is not a treatment, it’s sedation. A person screams and you are constricting their breath. This is something inhuman in biomedicine. They don’t acknowledge these illnesses though they are present and pervasive all over the world. They are also living with devils (*shayatin*), the devils among human and jinn, in the West too.

From her own near-death experiences to those of her patients, Dr. Sama was frustrated with medical experts’ refusal to acknowledge spiritual illnesses and the entwinement of the physical, non-physical, and spiritual components of the human. She hoped that the biomedical turn to “nature” (*tabi‘a*) or alternative treatments expressed a longing for the redress of the whole human being (one complete with a soul). Although she acknowledges psychosomatic illnesses, she argued that Prophetic Medical practices transform patients: organically, psychically, and spiritually. Throughout the Muslim world, psychiatrists, biomedical physicians, and scholars of Islamic jurisprudence (*fuqaha*) struggle to discern physiological illnesses (*amrad udu’iyya*) from psychological illnesses (*amrad nafsiyya*) and spiritual illnesses (*amrad ruhiyya*).¹² Similarly, she considers the state of the soul as not only the origin of organic illnesses but critical to the human’s complete recovery and remission. For Dr. Sama, spiritual illnesses have physiological and psychological effects; they may be caused by organic illnesses but can also produce them. These exist in a state of dynamic interplay. The state of the soul is also important for the

¹² Stefania Pandolfo, *Knot of the Soul: Madness, Psychoanalysis, Islam* (Chicago: University of Chicago Press, 2018), 305-322. Pandolfo’s work follows the therapeutic, spiritual, and medical practices of a Moroccan Imam, focusing on the liturgical cure of the *ruqya* (Quranic recitation). *Ruqya* is the very practice Dr. Sama references as supplementing the knowledge utilized to decipher the signs of spiritual illnesses. For Pandolfo’s Imam, as for Dr. Sama, the nesting of jinn within the body could very well be the cause behind the growing cancer in some of his patients: a tumor was also considered by Dr. Sama to be an effect of the state of the soul, of magic, of the evil eye, and of war and sorrow. These effects transform the body’s physiology and may be heard through the loss of bodily movement, through the screams and voices that are not one’s own. What is at stake for Dr. Sama is the irreducibility of spiritual illnesses to psychosomatic expressions, a debate Pandolfo also follows in Morocco as psychiatrists, physicians, and scholars of Islamic jurisprudence struggle to distinguish organic, psychological, and spiritual illnesses.

patient's receptivity to medical therapies. Just as Ibn al-Qayyim utilized humoral medicine, the medicine of his time, to discuss how bodily humors affected the soul and how the soul shifted the balance of bodily humors,¹³ we find Dr. Sama utilizing contemporary biomedical methods to demonstrate this very relationship between the body and the soul through her clinical trials. Therefore, Prophetic Medical practices are not simply treatment regimens but a continuous engagement with an integral reality that entails reform (*islah*) of the modern medical corpus.

In the Qur'an, nature (*tabi'a*) is posited as a field of potential: it is the site of the signs of God's cosmic text, there for humans to uncover.¹⁴ Both the revelation of the Qur'an and the creation of nature represent the inexhaustible words, signs, and wisdom of God. Nature is a creation of God that is autonomous but not autocratic, for it does not "contain its own ultimacy or final rationale as an integral part of its being."¹⁵ A human investigation of nature might render its laws and composition, generating data, but fail to unseal the wisdom of God. Prophetic medicine is beneficial for Dr. Sama and Prof. Maha as it is authorized by the Prophet, granting it a non-human wisdom that is atemporal and exceeds the finitude of human inquiry, science, and thought. For medical knowledge to be beneficial, *naḥḥ*, it must produce an effective antidote, to be conducive to health. This is in the same way that the supplication for knowledge is one for a knowledge that is beneficial, *naḥḥ*.¹⁶

Dr. Sama desires to cleave to Prophetic Medicine in order to remain close to the human nature,¹⁷ rather than easily relying on the chemical concoctions of biomedicine. Her approach to the possibility of reform—*islah* of medicine, of body, and of soul—was an attempt to reimburse the human with the nature of the souls, in all its inclinations and compulsions, as linked to its creational foundation (affirming its reality). This would redress a gap in biomedicine that is metabolized by students who (according to Dr. Sama) deny their own tradition. How she positioned the confession of reality (*i'tiraf al-haqiqah*) can be read in multiple ways, especially in relation to the figure of the student dedicated to seeking knowledge (*talib al-'ilm*). In order to study, in Dr. Sama's conception, a seeker must acknowledge and admit reality; they must lift a barrier in order to attest a particular reality of existence. Seeking knowledge in this way is likened to a movement, akin to embarking on a journey to uncover or reach reality: *i'tiraf* comes from the trilateral root '*ayn-ra'-fa*', meaning to know or to make known. To know in this sense

¹³ Ibn Qayyim al-Jawziyya, *Medicine of the Prophet*, trans. Penelope Johnstone (Cambridge: Islamic Texts Society, 1998).

¹⁴ In *The Wisdom of the World: The Human Experience of the Universe in Western Thought* (Chicago: University of Chicago Press, 2003), Rémi Brague notes that in the Qur'an the Human's "harmonious form" goes hand in hand with the signs that guide it. The human's perfected form grants faculties, senses, and intelligence to decipher these signs, as located in the soul and in the world. The signification of the sign is a tool for memory (*dhikr*) (58-59). The inhabitants of the world are all connected through Allah and the connections are "through nature as divine goods," where the signs are placed for "men of judgment" (58). The renewal of the earth too is a sign and site for the production of signs. The interwoven relationship between the creation of the earth and the heavens, the signs that they emanate, the signs that rest in the soul, and the physical composition of the human reaffirm the implication of a coming into being with knowledge that initially began with Adam learning "the Names" in Heaven. Coming into being with knowledge transcends this world, temporally and spatially, arising within the eternal world, within paradise where God teaches Adam knowledge.

¹⁵ Fazlur Rahman, *Major Themes of the Quran* (Chicago: University of Chicago, 2009), 69-71.

¹⁶ The Messenger of Allah, peace and blessings be upon him, said, "Ask Allah for beneficial knowledge and seek refuge in Allah from knowledge without benefit." Sunan Ibn Mājah 3843

¹⁷ Dr. Sama's linking of nature to Prophetic Medicine is an argument already found in Ibn Khaldun's *al-Muqaddimah*, as he considers Bedouin medicine the closest to nature. *The Muqaddimah: An Introduction to History*, trans. Franz Rosenthal, (Princeton: Princeton University Press, 2015), 324-327.

is to embody and become a vessel for such knowledge. How Dr. Sama links *i'tiraf* to *haqiqa* indexes the multiplicity of her methods of and attunement toward inquiry, for *i'tiraf* is also the admittance of *ma'rifa*, a mode of knowing receptive to divine knowledge of reality.¹⁸ *Ma'rifa* is experiential knowledge acquired through reflection (reason), unveiling (heart), or scripture (reception), but it is also latent knowledge. *Ma'rifa* is a form of knowing through, and of, God and is often linked to the *ta'wil* (inner understanding) of events and knowledge withdrawn into the realm of the unseen (*al-ghayb*)—for instance, as presented in the story of Moses and Khidr (cf. Q. 18).¹⁹

Ta'wil as a form of *ma'rifa* is what some scholars of science and Islam²⁰ have argued is lost in the modern division of the sciences. Following Seyyed Hossein Nasr, Osman Bakar depicts the world envisioned by the Sufi tradition as composed of three realms: the material, psychic, and spiritual. In this world, the study of nature was understood as a book of symbols, an examination that went beyond logical, mathematical, or empirical analysis.²¹ Such inquiry required a leap beyond the manifest or apparent signs toward a form of *ta'wil*. The *ta'wil* of knowledge predicated on seeking divine origins comes from an orientation toward inner reality. There is “a whole set of terms used in Islamic epistemology to describe this direct perception of the inner reality of things: *dhawq* [taste], *ishraq* [illumination], *mukashafa* [unveiling], *hads* [empirical intuition], and *firasah* [insight]. These are terms which all imply the knower’s direct experience of the things known.”²² This approach thus methodologically couples the “hierarchy of man’s faculties of knowing and the hierarchy of the universe” with regard to the principles governing that relationship.²³ However, contemporary sciences reduce the inquiry of nature and its study to an autonomous and disparate domain. Bakar finds that contemporary science has divorced the material and psychic natural world from the spiritual world. The Islamic cosmological configuration is therefore lost in the structure of contemporary sciences.²⁴ (Of course, not all scholars of Islam and science deem the possibility of *ta'wil* to be lost in this way, as I revisit below.)

For Dr. Sama, *tabi'a* was not simply manifest knowledge, for the forms of knowledge can vary by degree in their relation to reality (*haqiqa*). Students/seekers can derive knowledge of

¹⁸ Reza Shah-Kazemi, “The Notion and Significance of *Ma'rifa* in Sufism,” *Journal of Islamic Studies* 13, no. 2 (2002): 155-181. Cf. William Chittick, *Ibn al-Arabi's Metaphysics of Imagination: The Sufi Path of Knowledge* (Albany: State University of New York, 1989).

¹⁹ While on a journey with the enigmatic figure Khidr, Moses calls into question the reasoning behind Khidr’s actions: sinking a ship, killing a child, and hiding orphans’ treasure. Even as a prophet, Moses could not fathom the reasons behind events that did not correspond to his perceptions of justice and mercy. Khidr informed Musa that knowledge regarding these events was unseen (*ghayb*), still veiled from him. This *ghayb* required an account, a *ta'wil*, in the form of divine knowledge that even his patience could not withstand, that his judgment could not suspend. He then informed him of the *ta'wil* of the events by revealing the understanding behind them, while indicating that other figures (non-prophets) possess other forms of knowledge.

²⁰ See Seyyed Hossein Nasr, *The Need for a Sacred Science* (London: Routledge, 2005); Seyyed Hossein Nasr, *Science and Civilization in Islam* (Cambridge, MA: Harvard University Press, 1968), 158; and Seyyed Hossein Nasr and Muzaffar Iqbal, *Islam, Science, Muslims and Technology* (Kuala Lumpur: Islamic Book Trust, 2007).

²¹ Osman Bakar, *The History and Philosophy of Islamic Science* (Cambridge, UK: Islamic Texts Society, 1999), 67-69.

²² *Ibid.*, 38

²³ *Ibid.*, 19. Nahyan Fancy argues that Bakar conflates the cosmologies of Islamic philosophy, Sufism, and traditionalists. See his review in *Review of Middle East Studies* 37, no. 1 (Summer 2003): 129-131.

²⁴ Bakar argues that even though a plurality in methodology is acknowledged in the 20th century, knowledge produced in the contemporary paradigm, even by Muslim scholars, is still predicated only on a material and psychic reality (*The History and Philosophy of Islamic Science*, 15).

nature by way of evidence (*dalil*). Dr. Sama's call for the acknowledgment of deeper reality and the concomitant return to nature does not itself entail the availability or acquisition of God's signs, meaning that the possibility of complete knowledge (of the object, of the logic of God's will and intention, and of the true nature of existence) is still deferred. Her gesture to gnosis (*ma'rifa*) of reality indicated the diversity of her orientation, for she differentiated between engagement with the unseen (*al-ghayb*) and the unveiling of divine reason. Yet proximity to God through establishing the ontological stature of knowledge is not a goal she shares with scholars of science and Islam. Whereas they are focused on a project of an Islamically-oriented knowledge, Dr. Sama simply points to a different attunement to knowledge. Dr. Sama prefers to leave the logic of the inner workings of nature to the realm of *al-ghayb*, but still demands acknowledgement of another order and bearing witness to an absent presence.

In order to further this examination of proximity to God's ordinances and nature, she delineated her methods for gleaning the Prophet's medical prescriptions from the hadith traditions. Rather than sifting through the entire hadith corpus, which ranges into the hundreds of thousands of reports, she first examined the *isnad* (chain of transmission/citation) and then the *matn* (base text) of texts in the Sunni canon of six authenticated hadith collections.²⁵ In this approach she mimics the method utilized by traditional revivalists and reformers²⁶ that were committed to a principle of reform (*islah*). In this case, her *islah* of biomedicine is also contributing to expanding and reimagining the genre of Prophetic Medicine itself.

Dr. Sama and professor Maha envisioned a reform of medicine as a revival of Prophetic Medicine. This desire to contribute a beneficial knowledge is distinct from the criteria of biomedical efficacy, a disjuncture that became clear when their findings (however discrete and measurable, and grounded in their clinical trials) were rejected by editors of scientific journals due to their citation of hadiths. This raised alarms about the methodological hegemony at play and the affront to scripture. The physicians' distinction between evidence and authority, efficacy and benefit, exemplified their sense of revival and renewal as a vehicle of medical reform. As it is posited by Professor Maha, this was not only an opportunity to envelop Prophetic Medicine within global medical discourse but an obligation to the community, to the human form itself as the integrated body and soul. More broadly, this notion of communal obligation helps ground the promised medical reform within the greater archive of the Islamic discursive tradition.

The Islamic juridical concept of communal obligation was developed within Imam Shafi'i's (d. 820) legal school and applied more broadly to the study of knowledge, for instance by the scholar Abu Hamid al-Ghazali (d. 1111). In his *Book of Knowledge*, al-Ghazali classifies knowledge into prescribed, proscribed, praiseworthy, blameworthy, and permissible types. This differentiates between sciences that are an obligation upon each individual (*fard 'ayn*) and those that are an obligation upon the community (*fard al-kifaya*). Al-Ghazali thus extended these five jurisprudential categories to the pursuit of all knowledge. Critiquing what he saw as an unnecessary concentration of scholars of exoteric *shari'a* sciences, al-Ghazali cautions against neglecting the sciences of the hereafter, the knowledge of the ills and cures of the heart/soul, and the sciences that would attend to the community's direct needs. His intervention—as part of his magnum opus the *Revival of the Religious Sciences*—also came following the translation

²⁵ For a longer discussion on the canonization of authentic hadiths, see Jonathan A.C. Brown, *Hadith: Muhammad's Legacy in the Medieval and Modern World* (London: Oneworld Publications, 2017).

²⁶ Salafis similarly question the proof-text basis of the interpretations of revelation and seek to be immediately rooted in revelation, reaching for a self-directed encounter with hadiths. This consists in re-examining the chains of transmission within the six Sunni canonical hadith collections.

movement (8th to 10th century) and his refutation of Muslim philosophers and dialectical theologians imbibing Greek philosophy to the extent of reformulating key theological principles. At the same time, Muslim legal scholars' apathy in engaging non-shari'a disciplines led to his work on the classifications of knowledge. Although al-Ghazali's classifications are still cited and transmitted by some contemporary jurists and scholars, while they are rethought by others in relation to other developments in the Islamic tradition, my interlocutors reprise the question of benefit and the relationship between the knowledge of medicine and knowledge of the hereafter.

Admonishing the Muslim community for the lack of physicians in the community, as a necessity for the preservation of the body and the community as a whole, al-Ghazali argued that "the physician can come closer to God through his knowledge and would be rewarded for it because he labors for God."²⁷ Therefore, he classifies medicine as a communal obligation, one that can be satisfied so long as it is fulfilled by certain individuals within the community. The distinction between beneficial and efficacious stems from the qualification of all knowledge in terms of "function," "needs," and the "unity" of the community.²⁸

Classifying certain knowledge as praiseworthy in terms of function, need, and proximity to the divine challenge historians' conventional accounts of the medieval Islamic classification of knowledge, as divided into transmitted and rational sciences. This also recalls how the classification of knowledge within the Islamic medieval world developed as it encountered, absorbed, and transformed knowledge from other traditions and disciplines, raising ethical, eschatological, and apocalyptic concerns. In this way scientific knowledge is implicated in the question of truth and God's knowledge, displacing the question of science and religion as merely a matter of belief and evidence. Therefore, it was not surprising that many of my interlocutors' orientations to all knowledge was in terms of the obligation of all individuals to search and uncover God's knowledge, whether withdrawn or potentially known (*al-ghayb*, *al-tabi'a*).

In this light, it was not surprising to me that after several weeks of shadowing and observing her in the Prophetic Clinic, Dr. Sama solicited the intentions behind my own research and orientation toward knowledge. Attempting to assuage her alarm that my Western gaze would invalidate the benefits of non-biomedical medicine, I spoke of my desire to shed light on the contributions of Islamic medicine, Prophetic Medicine, and Islamic thought. Immediately offended by my use of the word 'thought', she interjected to refuse the coupling of human knowledge ("thought") and the divine revelation ("Islam"). This proved to be one of the few moments when the terms of our dialogue were non-negotiable. Dr. Sama was not only inviting me (*da'wa*) to her hermeneutic position but also ensuring that I understood that God's speech is uncreated and independent of its human interpretation. "This is not 'thought'. We did not think God's knowledge. We are merely pursuing experiments to affirm (*ithbat*) what is already known as truth and benefit, as we don't always know what is beneficial. Thought is something we think and we create."

I asked, "Is what you are doing producing knowledge?"

"No," she replied. "This is from the [divine] injunctions (*awamir*) and prohibitions (*nahy*)."
Dr. Sama distinguished between the historical Islamic discursive tradition and God's atemporal uncreated speech. The latter entails a reading (*ta'wil*) that refers to the realm of the unseen (*al-ghayb*). Thus medicine might be temporarily and temporally efficacious, but as a product of

²⁷ Abu Hamid al-Ghazzali, *The Book of Knowledge*, trans. Nabih Amin Faris (Lahore: Sh. Muhammad Ashraf, 1970), 57.

²⁸ Muzaffar Iqbal, *Science and Islam* (Greenwood Publishing Group, 2007).

human thought it withers in its illusion of long-term benefit. Human thought is limited by the finitude of human knowledge, while God's knowledge is expansive and signifying.

For modern Salafis as for other reformers, the permanence of God's speech opens up the possibility of a return of and to nature, to existence as intended by its creator, a return made possible through direct engagement with revelation: a reform (*islah*). This stance regarding the uncreated nature of God's speech was upheld by Imam Ahmad bin Hanbal (d. 855)²⁹ and later elaborated by his eponymous school of thought. Ibn Taymiyya refused the methodological use of Greek logic and (what he saw as) the subordination of revelation to human reason,³⁰ arguing that God's speech is to be understood internal to its structure. If one is to interpret the language of the Qur'an, it must be examined through the speaker's habit, an extra-linguistic, context-dependent theory of interpretation of revelation. Understanding the intention of the text, they argued for understanding God and the Prophet's speech through contextual evidence rather than looking at established definition to interpret revelation. Although reformists of various types (as in the broad tradition called Salafism, whether modernist or traditionalist³¹) have been pinned as literalists who refuse extended interpretations (*ta'wil*), ridding the scriptural texts of their cultural and metaphorical properties, they simply espoused an alternative theory of communication.

Ibn Taymiyya disregarded *ta'wil* as a method of contextualization and interpretation in order to set limits on human language and speech.³² Scholars argue that Ibn Taymiyya's stance against the use of Greek logic and cosmology to make theological arguments liberated Islamic theology from the demand to fit into a single cosmology, thereby also expanding the conditions of inquiry. Beyond their antipathy toward emanative theologies, the rational theology of the broadly-understood *Salafiyya* movement also made provisions for bodily resurrection, God's anthropomorphic features, and divine powers as described in the Qur'an. (These elements were otherwise made metaphorical by rational theologians who required logical proofs for truth and certainty of knowledge.) Read this way, Ibn Taymiyya and Ibn al-Qayyim's theories of communication rival certain trends in modern pragmatics and parallel Ludwig Wittgenstein's

²⁹ When Imam Ahmed was reproached by rationalist theologians that claimed that God's speech was created, he refuted their arguments and was imprisoned.

³⁰ Ibn Taymiyya's stern opposition to philosophy and his reformation of traditionalism by way of a rational theology was also due to what he saw as a necessary decoupling between faith and knowledge, so that lay belief is not bound to a grasp of natural philosophy or logical proofs. A believer does not need to know the logic behind God's being and arguments for his oneness, as were generated to debate Christian and Jewish philosophers. He argued that the faith of the believer is as steady as the mountain while the faith of a philosopher is like a kite that goes where the wind blows. Understanding Ibn Taymiyya's rational theology allows us to make sense of how some of my interlocutors reconcile Islam and biomedicine while others, such as Dr. Sama, follow the textual-communicative principles of Ibn al-Qayyim to call for medical reform (*islah*). See Sait Ozervarli, "The Qur'anic Rational Theology of Ibn Taymiyya and his Criticism of the *Mutakallimun*," in *Ibn Taymiyya and His Times*, ed. Yossef Rapoport and Shahab Ahmad (London: Oxford University Press, 2015).

³¹ These categories are not fixed and are here used heuristically. See Brown, *The Canonization of al-Bukhārī and Muslim*, 340-345; and Brown, *Hadith*.

³² He did this mainly to render God's anthropomorphic attributes and powers in the Qur'an as metaphorical, in order to reconcile theological arguments grounded in a rational Greco-Arab metaphysical system—but also for his novel pragmatic contextualist theory that establishes conditions of interpretation across time and space. See Wael B. Hallaq, *Ibn Taymiyya against the Greek Logicians* (Oxford: Clarendon Press, 1993), xxiii: "Ibn Taymiyya's unrelenting attack on the philosophers was in fact double edged. On the one hand, by refuting philosophical logic he advanced his critique of the metaphysical doctrines of falsafa, and, on the other, by undermining logic in general and the realist theories of essences and universals in particular, he sought to shake the dogmatic foundations of mystical pantheism."

arguments on language use.³³ To break from Greek logic is also to break from Greek metaphysics in scientific inquiry. Therefore, the theory of textual communication is important not only for determining the proper relationship between sound revelation and sound reason, but also the interpretation of other texts (the cosmic text: *tabi 'a*). For *Salafiyya*, the sciences must be grounded in an explicitly monotheistic cosmology that does not bind physics to a particular metaphysical schema, so as not to reify God or his creations.³⁴ In this line of thinking, medieval science was grounded in a study of physics tied to an Arabo-Greek metaphysics utilizing Arabo-Greek logic; when it fell, so did its science. (Such a relationship between monotheism and contemporary scientific methodology has been variously argued by sociologists of science³⁵ and Claude Lévi-Strauss.³⁶)

For many of my interlocutors, all knowledge belongs to God. It is not spatially and temporally proper to any one faith or people. People uncover God's knowledge, whether in the revelation or in creation. When I asked medical students and physicians in Yemen, Jordan, and Saudi Arabia what knowledge medicine was predicated upon, they answered, "Nature (*tabi 'a*)."

This knowledge is neither static nor ultimate, but it is evolving, developing, and lacking. What has been uncovered is present and what is yet to come is withdrawn (*al-ghayb*). Therefore, as Muslims, they are motivated to uncover God's knowledge (rather than discover it). It is incumbent upon Muslims to search and follow the divine signs (*ayat/dalil*) to presence an absent present, as per the Quranic injunction.³⁷ Many of my interlocutors were able to recuperate divine signs from contemporary biomedicine and sciences.

The journal editors' refusal to allow the citation of hadiths in my interlocutors' reports of their clinical trials disregards how the hadiths are deployed: not as evidence of the efficacy of cupping but as authorizing the practice. My interlocutors' recovery of *al-ghayb* from both contemporary scientific knowledge and Prophetic Medicine indicates a complex epistemological configuration—as has always been the case in the history of Islamic civilization encountering other scientific traditions.

Reform of Medicine, Reform of Sunnah

The question of evidence (*dalil*) complicated matters for physicians conducting research on and in the Prophetic Medical tradition, who hoped to publish their findings in scientific journals. It is not simply a matter of the cosmological reconfiguration of contemporary sciences that led to the editors' refusal to admit revelation as a form of scientific knowledge. It is more than a contemporary dilemma of experiential knowledge and its verifiability or falsification and demonstration of evidence and efficacy in medical prescription. More broadly it evinces an allergy to a plurality of methods and a possible variety of modes of knowing.

³³ Ali, *Medieval Islamic Pragmatics*, 88. See also Abdur Rahman Mustafa, "Ibn Taymiyya and Wittgenstein on Language," *Muslim World* 108 (2018): 465-491.

³⁴ Ismail Al Faruqi, "The Essence of Religious Experience in Islam," *Numen* 20, no. 3 (1973): 186-201.

³⁵ Steve Fuller, *Science vs. Religion? Intelligent Design and the Problem of Evolution* (Cambridge: Polity, 2007).

³⁶ See Claude Lévi-Strauss, *Myth and Meaning* (London: Routledge, 2013). Also see Lévi-Strauss, *Structural Anthropology*, trans. Monique Layton (Chicago: University of Chicago Press, 1976), 2:41: "For is it not the myth of the exclusive dignity of human nature, which subjected nature itself to a first mutilation, one from which other mutilations were inevitably to ensue? We started by cutting man off from nature and establishing him in an absolute reign. We believed ourselves to have thus erased his most unassailable characteristic: that he is first a living being. Remaining blind to this common property, we gave free rein to all excesses."

³⁷ Iqbal, *Science and Islam*, 31.

In Islamic history, the question of *dalil* emerged within the nascent Muslim community following the death of the Prophet as a concern for the veracity and reliability in the chain of transmission, thus linking questions of knowledge to justice, modes of knowing, and conditions for transmission. (Dr. Sama's usage of hadith to reform medicine was thus an echo of the ways engagements with the scriptural tradition have informed previous Muslim revival and reform movements.) Revelation was transmitted orally, as was the Prophet's practice; only later were the methods of establishing reliable and verifiable data fully developed. The juridical schools elaborated their own hermeneutical priorities in relation to the sources of shari'a.³⁸

The desire to transcribe and assemble the revelation (Qur'an and hadith) after the death of the Prophet was borne of an anxiety for the shifting conditions of transmission. Prophetic prescriptions were generated from community engagements (*hiwarat*) in addition to companions witnessing and embodying the Prophet's everyday example. The deaths of many Qur'an reciters and transmitters in battle and the early civil wars (*fitna*) contributed to deep contests of authority, including fabrications of hadiths laying claim to the leadership of the Muslim community. These factors too gathered attention to the modes of verification, transcription, and authentication of Quranic verses and Prophetic narrations.³⁹

The law emanating from the Prophet, by way of revelation and through the presence and absence of his hyperbolic speech, bodily practices, and its embodiment in the Medinan community, was thus generated out of communal effort to preserve and transmit. The field of ethics was drawn into this methodological ambit as well, for the rigor of a transmission depended on its chain of narrators (*isnad*) in their ethical character. Since the Prophetic example mediates the interpretation of the Qur'an and subordinates reason to the tradition, reformers and revivalists turned to or away from the institutionalized methodologies of their time to interpret and apply hadith. The place of reason in interpretations of God's speech and the prophetic tradition and its extension across space and time and into various domains and disciplines (including medical science) became a site of discursive formations and contention.

Recurring historical movements of revival and reform shifted the locus of hadith studies away from Iran, Iraq, and Syria; they also put the older methods in question. Reformers sought direct access to the signs of God unmediated by the scholastic hermeneutics.⁴⁰ Meanwhile, Sunni traditionalists invoked God's promise to preserve the revelation beyond human agency and capacity.⁴¹ Each of these invoked providential sanction for their methods and paths.

Contemporary re-engagements with the textual traditions are not simply a reaction to modernity but are a repetition of an anxiety over the spiritual fortitude of the Muslim community, the status of the knowledge of guidance, and the conditions of transmission: what Ibn Khaldun considered "changes of states" (*tabaddul al-ahwal*).⁴² Calls for the production of

³⁸ Brown, *Hadith*, 163.

³⁹ Ingrid Mattson, *The Story of the Qur'an: Its History and Place in Muslim Life* (John Wiley & Sons, 2012).

⁴⁰ Brown, *Hadith*, 275-285.

⁴¹ Both traditionalists and Salafis polemically recall a prophetic narration warning the community of innovations that misguide the community.

⁴² Such revival movements can be read through the lens of Ibn Khaldun's *al-Muqqadimah*, as the historian anticipated the challenges of transmission of the tradition amidst socio-political instability and loss of group feeling/spiritual fortitude (*'asabiyya*). His work is a rumination on the devolved Muslim polities in the fourteenth century, the withering prestige of the Prophet's authority, and the methodological import of authenticating historical accounts and the passage of their lessons. His presentation of the patterns of history is predicated upon modes of knowing in order to transform one's relation to the lessons and examples of events, as the necessary condition for stability, justice, and transmission of a tradition. Whereas the first community received the lessons directly from the Prophet, the lessons behind these dialogic exchanges (*hiwarat*) were not likewise guaranteed in their transmission

knowledge according to Islamic epistemology within the broad Salafi revivalist movement (e.g., by thinkers such as Muhammad ‘Abduh, Rashid Rida, and Muhammed al-Ghazali)⁴³ occurred throughout the Muslim world alongside the rise of *ruqiya* healers and reprisals of Prophetic Medicine. These movements of reform (*islah*), of purifying Islam, are no more or less “novel” than those which preceded them in the medieval period, when Islam encountered competing foreign sciences. The latter too transformed methodologies and hermeneutics, both shari‘a and non-shari‘a disciplines, amid shifting conditions of transmission. Whereas various pre-Islamic traditions and sciences were absorbed and authorized by the Prophet (e.g., astronomy, or Bedouin medicine being incorporated as Prophetic Medicine), shifting historical conditions produced a gap—the space of adjudication—as to how the tradition would encounter further knowledge. From Abu Hamid al-Ghazali’s refutation of the philosophers to his reprisal of Islamic theology and philosophy through Sufism with the *Revival of the Religious Sciences*; Ibn Sina’s reconfiguration of Galenic humoral medicine to accommodate Aristotle’s philosophy;⁴⁴ Ibn Taymiyya’s refutation of logic and championing of a theological rationalism; to Ibn Khaldun’s call for a critical examination of history—each were moments of general anxiety toward the changing times, the hierarchy of knowledge, and differing methods of inquiry.

Reformers’ own socio-cultural realities have also been examined as catalysts for their intellectual pursuits. For example, the Mongol invasion impacted Ibn Taymiyya’s thought and his antagonism to foreign cosmologies;⁴⁵ the bubonic plague’s devastation of the Muslim world and Roman Empire and the expulsion of Muslims and Jews from Muslim Spain informed Ibn Khaldun’s cyclical theory of history; and al-Afghani and Muhammad ‘Abduh’s modernism in relation to the European Enlightenment and Scientific Revolution was colored by the dearth of Muslim scientific scholarship.⁴⁶ These various ruptures were often viewed as symptoms of apocalyptic reckoning and psycho-spiritual diminution, leading the revivalists to examine these events of decline in relation to the guiding knowledge of their time. However reactionary these Muslim reformers may have been, contemporary scholars of Islam also stress the “semi-sacrosanct nature” of the Islamic discursive tradition in relation to which they had approached current problems.⁴⁷

More importantly, as the Muslim world devolved, the sites of the Islamic sciences were further displaced.⁴⁸ Tamim Ansary argues that Muslims “made their great scientific discoveries just as their social order started crumbling, whereas the West made its great scientific discoveries just as its long-crumbles social order was starting to recover in the wake of a religious reformation that broke the grip of church dogma on human thought, empowering individuals to

across space and time. That justice and wisdom are conditions for the transmission of knowledge and preservation of authority is a sentiment shared by many contemporary reformists. ()

⁴³ E.g., Ismail Raji al-Faruqi, *Tawhid: Its Implications for Thought and Life* (Kuala Lumpur: IIIT, 1982).

⁴⁴ Jon McGinnis, *Avicenna* (New York: Oxford University Press, 2010), 228.

⁴⁵ D. Little, “Did Ibn Taymiyya Have a Screw Loose?” *Studia Islamica* 41 (1975): 93-111.

⁴⁶ See Muhammad Abduh, *The Theology of Unity* (Kuala Lumpur: Islamic Book Trust, 2004); E.E. Shahin, *Through Muslim Eyes: M. Rashid Rida and the West* (International Institute of Islamic Thought, 1993).

⁴⁷ Ebrahim Moosa and SherAli Tareen, “Revival and Reform,” in *The Princeton Encyclopedia of Islamic Political Thought*, eds. Gerhard Böwering et al. (Princeton: Princeton University Press, 2012), 463. The divinely sanctioned centennial renewal and the melancholic impending estrangement of Islam in the world informs much of Sunni political theology. As in the famous hadith found in *Sahih Muslim*, “Islam began as something strange and will revert to being strange as it began, so give glad tidings to the strangers.”

⁴⁸ See F. Speziale, *Soufisme, religion et médecine en Islam indien* (Karthala Editions, 2010); Asad Q. Ahmed, “Post-Classical Philosophical Commentaries/Glosses: Innovation in the Margins,” *Oriens* 41, nos. 3-4 (2013): 317-348.

speculate freely.”⁴⁹ Perhaps it is this disintegration of the social order that resonated with the *islah* revivalists and what they understand as the promise of the episodic renewal of Islam. The political and economic decline within much of the Muslim world is a symptom of the place of Islam in organizing society. Therefore, recover politically, economically, and socially, the place of Islam as an organizing force of the community must be revived.

The contemporary Salafi proclamation that “plain readings of the proof texts suggest that renewal will not only resuscitate the body politic of both community and society but also heal and restore the brokenness of the moral order”⁵⁰ is not to be taken literally. This proximity to the prophet often takes an intellectual and theological valence, but possesses an important affective one as well. To rid Muslims of intermediary interpreters and interpretations gave reformers access to the speech of God and its embodiment in the Prophet. For traditionalist reformers, this takes place through the proof text (*dalil*) as supported by the transmission (*isnad*), by way of the validity of its witnesses. The evidentiary text (hadith-cum-transmission produces a phenomenological proximity to the Prophet, as a vessel for God; a presence that otherwise has withered across time and space. For the *Salafiyyah* modernists (e.g., ‘Abduh, Rida, Khan), in contrast, the revelation was a vessel for inquiry into the cosmic text (*tabi’a*), a regeneration of engagement with the divine through the creational signs, indeed as through the various humanist sciences that emerged in post-Enlightenment Europe. Both forms of inquiry, traditionalist as modernist, are demonstrative of authoritative proximity and communal benefit and regeneration. Placing the *dalil* in doubt is a form of reinhabiting the space of discursive formation and revival of the Prophet’s practice (*sunna*).

Toward a Plurality in Methods

Over the past few decades, historians of science have written much about paradigmatic and epistemic shifts within the sciences.⁵¹ It was not the intention of this chapter to interrogate this question in relation to the relationship of Islam and science. Rather, I examine how some contemporary scholars of this field have reflected on its history, how that historical relationship informed contemporary scholars’ orientations toward contemporary sciences, and how contemporary Muslim physicians embody the multiplicity of this field. This is in light of the complex historical engagements between Muslim scholars such as Ibn Taymiyya and Aristotelian and Neoplatonic methods of inquiry.

Contemporary scholars of Islam and science recognize the waning of materialism in the sciences and the necessity of plural methods. A modest review of this literature illustrates that scholars differ not only in their conception of what is lost, absent, or lacking in contemporary science, but also regarding what is recuperable. For scholars who find contemporary science devoid of extended meaning (*ta’wil*), Islam and science were always historically entwined. For example, Osman Bakar and Seyyed Hossein Nasr acknowledge a plurality in the methods of medieval disciplines. Although Bakar’s account of Islamic knowledge obfuscates its Greek foundations, it nonetheless grounds its provocation for an Islamic orientation toward knowledge in esoteric practices of understanding *haqiqa* (true reality) and epistemological doubt,

⁴⁹ Tamim Ansary, *Destiny Disrupted: A History of the World through Islamic Eyes* (Philadelphia: PublicAffairs, 2009), 212.

⁵⁰ Moosa and Tareen, “Revival and Reform,” 462.

⁵¹ Michel Foucault, *The Order of Things* (London: Routledge, 2005); Thomas S. Kuhn, *The Structure of Scientific Revolutions* (Chicago: University of Chicago Press, 2012).

cosmology, and modes of knowing.⁵² Muzaffar Iqbal also evokes the plurality of methods that flourished until the sixteenth century and the casting out of other traditions due to the epistemological hegemony of contemporary sciences, as consolidated through the colonial-era transformation of *madrassa* pedagogy. Iqbal recognizes that only by returning to primary sources from the lost tradition can Muslims revolutionize contemporary sciences in similar fashion to the translation movement of the eighth century. Meanwhile, scholars like Syed Muhammad Naquib al-Attas link the myopia of contemporary science and philosophy to a denial of the existence of God and to reducing authority and intuition to human reason and experience.⁵³

On the other hand, figures like Tariq Ramadan do not speak of a recuperable method or tradition, but call for a synthesis to reconcile the gap between the revelatory text and the contemporary context. Such a synthesis would be achieved by deriving Islamic law in sustained conversation with the sciences, much like the field of bioethics emerges between medicine, law, and policy.⁵⁴ Recuperating the ethical dimensions of the sciences is an attempt to remedy the gap between the generated knowledge of contemporary sciences and their mobility in Muslim everyday life. Meanwhile, those scholars who follow the work of the late Muhammad al-Ghazali (d. 1996) understand jurisprudence as a structuring form of thought and philosophy that should be recuperated and undergird all disciplines. As a result, practitioners from social sciences, biological sciences, and biomedical sciences can also generate the *fiqh* (thought/philosophical orientation) of their various specialties.⁵⁵ This is achieved primarily by applying the purposes, goals, and intentions of *shari‘a* (*maqasid*), and extending them to these disciplines.

Across these examples, the scholars’ diagnoses are deeply entwined with their readings of the historical relationship between Islam and science. Some scholars’ conclusions regarding the epistemological hegemony of contemporary disciplines, resulting from shifts in scientific paradigms, are in tandem with much of the literature in medical anthropology on the epistemologies of biomedicine and its encounters with other traditions.⁵⁶ Medical anthropologists have also explored the inextricable relation between biomedical practice, competing knowledges, and knowledge production.⁵⁷

⁵² See Fancy’s review of Bakar, *The History and Philosophy of Science in Review of Middle East Studies* 37, no. 1 (Summer 2003): 129-131.

⁵³ Iqbal, *Science and Islam*, 178. The post-Renaissance translation of sciences from Arabic to Latin erased the signs of their original Arabic origins. This cultural amnesia led to the complete evasion of the plurality of Arabic sciences, as simply a preserver of Greek knowledge, and too the dilution of its developments and novelty. In the example of medicine, what was informed by Chinese and Indian medicine became (in the European rendition) solely the practice of Galenic medicine.

⁵⁴ Tariq Ramadan, *Radical Reform: Islamic Ethics and Liberation* (New York: Oxford University Press, 2009).

⁵⁵ See Jasser Auda, *Maqasid al-Shari‘ah as Philosophy of Islamic Law: A Systems Approach* (London: International Institute of Islamic Thought, 2008) and Basma Abdelgafar, *Public Policy: Beyond Traditional Jurisprudence, A Maqasid Approach* (London: International Institute of Islamic Thought, 2018).

⁵⁶ D.R. Gordon, “Tenacious Assumptions in Western Medicine,” in *Biomedicine Examined* (Dordrecht: Springer, 1988), 19-56; S.A. Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania* (Indianapolis: Indiana University Press, 2011).

⁵⁷ For example, working on the technical grounding of Chinese medicine, Judith Farquhar evades epistemologically grounded arguments of knowledge production by focusing on ways practical knowledge is a nexus of cosmological, ethical, and political relations that attempts to envelop both human and non-human knowledge. Ann Marie Mol’s ethnography of atherosclerosis also points to how medical knowledge and reality of a disease is an enactment of medical practices and techniques, which, in turn, produce multiple realities of the diseased body. Mol, *The Body Multiple: Ontology in Medical Practice* (Durham: Duke University Press, 2002). Cf. Jean M. Langford, “Medical Eschatologies: The Christian Spirit of Hospital Protocol,” *Journal of Medical Anthropology* 35, no. 3 (2016): 236-

This orientation toward inquiry in medicine as one that informs different modes of knowing, the ontological realities of knowledge, and plurality of methods shifts the question of science and religion from one of “multiple epistemologies” to one of limits in methods and modes of knowing. Epistemological arguments already impose questions of validity, verifiability, and falsification. Yet it is important to note that although physicians such as Dr. Sama reprise Prophetic Medicine following Ibn al-Qayyim’s compilations, physicians who do reconcile Islam and contemporary biomedicine can be understood to follow Ibn Taymiyya and Ibn al-Qayyim’s methods of liberating knowledge from any a priori metaphysics.

Dr. Sama’s orientation toward *islah*, *dalil*, and *ta’wil* does not fit neatly into these debates. She is not satisfied with the contemporary emergence of Islamic bioethics as a form of reconfiguring certain medical prescriptions for the Muslim patient, nor would she call for a *ta’wil* (inner meaning of the divine cause) of biomedicine in order to produce a putatively Islamic medical knowledge. She called for an acknowledgement of reality (*haqiqa*) as a receptivity and openness to revelation. This affirmation indexes the presence of an absence, of a reality that can be sought but does not need to be represented, an attunement to the non-human dimension of knowledge. Her team’s insistence on citing hadiths in scientific journal articles distinguished evidence from authorization, benefit from efficacy, thought from God’s speech, and true reality from manifest appearance. This insistence is an echo of a desire for a “plurality of method,” variegated “modes of knowing,” and emphasis on a particular “order of things and their relations.”⁵⁸

The question of *al-ghayb* for my interlocutors was not simply in relation to knowledge production as an end in itself. Their methods, multiply oriented with respect to divine knowledge, opened to the desire to know the ontological reality of existence (for the traditionalists, rational theologians, and philosophers) but also its deferral to God (for the *Salafiyya*). The questions of research and knowledge were reconfigured toward such knowledge ultimately serving as a medium, a form of attunement and reorientation.

246; Judith Farquhar, *Knowing Practice: The Clinical Encounter of Chinese Medicine* (Boulder: Westview Press, 1994); Veena Das, *Affliction: Health, Disease, Poverty* (New York: Fordham University Press, 2015).

⁵⁸ Iqbal, *Science and Islam*, 67; Bakar, *The History and Philosophy of Islamic Science*, 20-22.

Chapter 3: Echoes of (Re)Form: The Body of the Soul and the Soul's Body

In her absence I created her image: out of the earthly
the hidden heavenly commences. I am here weighing
the expanse with the Jahili (pre-Islamic) odes...
and absence is the guide, it is the guide.
—Mahmoud Darwish (trans. Fady Joudeh)

Ethics punishes the individual relatively much less for his faults than for his misfortune.
—Jacques Lacan, *The Ethics of Psychoanalysis*, 89

Amana

It was nearing 7 p.m. The infectious disease clinic at the University Hospital in Jeddah, Saudi Arabia closes at 4 p.m. Yet Professor Hakeem remained to see his patients. We had returned from sunset (*maghrib*) prayer and two women still remained in the infectious disease clinic. A grandmother concerned for her granddaughter's TB diagnosis, sitting in the chair opposite the physician's desk and waiting for a medical report in order to have the entire family tested, asked the 45-year-old woman loitering near the door what was stressing her about her upcoming delivery. The pregnant woman unabashedly replied, "I just need a refill for my prescription for my virus," concealing her HIV diagnosis. While we waited for the physician to return from stepping into the other room, the pregnant woman looked at me and said, "You will learn a lot from Dr. Hakeem. He works with such sincerity (*ikhlas*), may God preserve him. Do you see any other physician around [working even after the clinic closed]? He has upheld the divine trust (*amana*)."

In the hospital Professor Hakeem was known to be trustworthy (*amin*). Expressions of his *amana* came in many forms. He kept his clinic open until he saw every patient. He took breaks for prayers during rounds. His student described these interruptions as translucent. "When the call to prayer (*adhan*) goes off on the loud speaker, he stops as if an electric shock coursed through his body. He turns toward the elevator and goes straight to prayer." Many marveled that he often led the congregational prayer despite his busy schedule. He was often difficult to find in the hospital, even though he was often there for more than twelve hours, as he was either in the ER, in the wards, or the infectious disease isolation ward. He had a light, almost gray beard, was soft-spoken and of moderate height, and walked around as gentle as a whisper. I witnessed his relentless drive firsthand when he ran every diagnostic test possible on an unconscious Yemeni refugee abandoned in the ER. Since no one knew his history nor did he have any ID on him, Professor Hakeem refused to start him on any antibiotics until he ruled out major issues. He admitted him under an alias so that he could be treated. He even conducted the spinal tap himself that morning when the patient was still waiting for a bed in one of the ER's makeshift ICU beds. Professor Hakeem started a matchmaking service for unwed HIV-positive patients that had difficulty finding a spouse due the stigma of the virus. His reasoning for such initiatives was to prevent social corruption. He quoted that the Prophet warned, "If there comes to you one with whose character and religious commitment you are pleased, then marry (your daughter or female relative under your care) to him (i.e. without regard for other social or class distinctions), for if you do not do that there will be *fitna* (strife) in the land and widespread corruption."¹ For many physicians and students in the hospital, Professor Hakeem was prophetic. His orientation toward

¹ Sunan Ibn Majah, Vol. 3, Book 9, Hadith 1967.

amana also accounted for his exceptional medical talents, and other physicians described his talent was innate. He was one of the best infectious disease physicians there; others sent their patients to him to distinguish symptoms of tuberculosis from those of cancer. He was known in the hospital as the most trustworthy physician with great clinical sense, but was entirely unaware of his reputation.

Having shadowed his clinic for over six months, I witnessed his exceptional talent. Yet the relation of *amana* to ethics and knowledge seen in his case, and its contingent reliance on a physician's reformation and habituation of their soul, was something younger physicians did not want to leave to chance. Not everyone can be Professor Hakeem. This was a risk they desired to remediate through enforcement of the hospital's legal apparatus, albeit one they wanted to imbue with Islamic ethics.

The linking of bioethics and medical professionalism to the soul and knowledge was brought up when I applied to the Internal Review Board of the hospital for permission to conduct research and was denied access due to the opacity of my soul. The IRB flagged my research project as duplicating that of the young radiology oncologist, whom I call Dr. Ilham, and did not want a western researcher conducting the same project. I met with her, and upon learning that she was working on her Master's thesis on Muslim bioethics, I clarified that my research objective was not to produce a Muslim manual on medical bioethics. When we met, Dr. Ilham felt reassured that I was staying with a Hadrami (southern Yemeni) family that descended from the Prophet. After meeting me, she was astonished that I spoke Arabic and demonstrated some knowledge in the history of Islamic medicine.

She described her motivations for writing her Master's thesis. For her, bioethics were created by Muslim medieval physicians. Yet, the ethical protocols of the hospital were humanist-based as they were adopted by the Canadian organization that accredited their hospital. The hospital's laws were foreign in form, but rarely implemented. Patients never filed malpractice suits and physicians either ruined the reputation of one another or covered up the mistakes of their colleagues. She stressed that while it is in the practice of Muslims to defer judgment and punishment to God, the ethics of the physician cannot be left to religion when its instruction was slowly dissipating. The fact that pedagogical shifts have removed Islamic curriculum from schools and that many physicians were not disciplined for their transgressions led her to become an organizing force among the younger physicians to enforce legal regulations she would modify Islamically. The law was now necessary. The reliance on a physician's ethical cultivation of their soul was too risky. They felt this way in spite of the fact their own ethical assessments occurred when patients and colleagues threatened them with God's judgment. These younger physicians looking to enforce institutional hospital protocols faced much resistance by older physicians who preferred to focus on affirming ethical norms through interpersonal relations. This tension produced a gap within the hospital between the ethical and the legal.

I begin this chapter with a meditation on the divine trust as a way to reorient us toward the discussions on ethics, habituation, and expertise/experience (*khibra*) I had with my interlocutors in my three field sites. The figure of *amana* emerges within the Qur'an as that divine trust which the sky, the earth, and the mountains each refused to bear, but which was nonetheless taken up by humans. "We did indeed offer the Trust to the Heavens and the Earth and the Mountains; but they refused to bear it, being afraid thereof, but man undertook it; He was indeed unjust and ignorant" (Q. 33:72). Such human bearing of trust gives way to the *mithaq*, the first covenant Adam took from God. Although Adam and Eve were brought to the *dunya* (lower

earth) upon their transgression, they were also then appointed as vicegerents (*khulafa'*) of the earth.

There is much exegesis in the Sunni tradition² on this verse, especially with respect to the clause of man's inevitable injustice or ignorance. Humans are here distinguished from all other creatures as a sign of the *amana*. In several verses in the Quran, other creatures are said to worship, glorify, and prostrate to God unconditionally.³ In contrast, as a result of receiving the *amana* and being entrusted and granted culpability as vicegerents of the earth, humans desire and possess free will to choose to worship God, and received the ability to discern with their intellect. This *amana* also informs a particular relation that a person has to the earth and all creation, including other humans. All these relations are something a person is *entrusted* with: she is not the possessor, but must establish or reproduce the *amana* by returning the entrusted and circulating it.

Therefore, an ethic unfolds as a relation between desire and the law and their circulation. A person desires as a function of the law and returns it as a divine trust with which one has been entrusted. As such, the person is tasked with establishing justice and order on earth with respect to all of God's creations. Such a task is the burden of the *amana*. Many of the prophets, from Adam to Moses to Muhammad, were described in scripture as trust-worthy (those who bear the *amana*).⁴ They were exemplars of how one should practice justice in labor, possessions, and relations to others.

The verse describes the human being undertaking such a grand and burdensome task in ignorance, ignorant of its consequences, perhaps even reckless, for it requires something demanding. Many Sunni exegetes note that the trust is the religion, the law. In the Prophetic tradition, the Prophet Muhammad stressed the role of *amana*—whether one upholds it, returns and circulates it—as a testament of one's faith.⁵ Faith itself is knotted into one's ability to deliver the trust. Just as a person possesses free will as a result of desire, so it must return and circulate in exchange. This conception of the law as both within the self (through the primordial covenant, as some suggest as *fitra* or innate disposition) and coming from without the self and circulating, is knotting.⁶ As such, the law is not imposed to provoke its inevitable transgression. Rather, it is through the law that a person is enabled to act and desire, and it must be reciprocated in relation to the divine trust. A person must reproduce that space of desire for others as law.

A law that promises the ability to desire and will is also one that implies a limit. It is this limit that the receiver must both discern and return. The Quranic verse both reproaches and praises humans: for undertaking the trust and for underestimating its responsibility. As a divine trust, a person must know the divine to carry the *amana*. Yet the question of the divine in Islam

² Most of my interlocutors were Sunni Muslims. Henry Corbin states that in Shia exegesis the *amana* refers to the "divine secrets, to the esoteric aspect of prophecy that the holy Imams passed on to their initiates." See Corbin, *History of Islamic Philosophy* (London: Routledge, 2014), 37.

³ For example, "Have they not observed things that Allah has created, [how] their shadows incline to the right and to the left, making prostration unto Allah, and they are lowly? And to Allah prostrate all that is in the heavens and all that is in the earth, of the live moving creatures and the angels, and they are not proud. They fear their Lord above them, and they do what they are commanded" (Q. 16:48-50).

⁴ For example, "O my father, hire him (i.e. Moses), for the best to be hired is one who is strong and trustworthy" (Q. 28:26).

⁵ Anas Ibn Malik reported: "Whenever the Prophet, peace and blessings upon him, preached to his companions, he would say: "The person who does not keep trust has no faith, and the person who does not respect his covenant (and promise) has no religion" (Musnad Ahmad 11975).

⁶ Stefania Pandolfo, *Knot of the Soul: Madness, Psychoanalysis, Islam* (Chicago: University of Chicago Press, 2018).

is ultimately withdrawn to the realm of the *ghayb*, unseen and unknown. It is through the signs that one can come to a proximate relation. Whether unity with the divine is possible has long been debated within the Islamic tradition, including through the present,⁷ but the key here is that through the effort to know God a relation opens up which then structures one's relation to the world and to other humans. This turn to think about ethics is not simply a relation between desire and action (as conceived by Sigmund Freud and rethought by Jacques Lacan), but one that takes into consideration unknowledge and desire, through *amana*, as a means to the law.

In this chapter, I argue that ethics raises the question of epistemology. For my interlocutors, medicine was not purely knowledge (*'ilm*) but engaged unknowledge in practice and ethical relations; the ongoing sincere and intentional accumulation of knowledge in order to aspire to be a good doctor was contingent on a person's rectitude or innate talent. A physicians' capacity for knowledge was both from God as a provision (innate) or by being open to God through habituation. Yet, physicians and medical students were ambivalent as to whether there was a relationship between knowledge and the law due to innate talents. For my interlocutors, all knowledge is God's knowledge, which opened ethics to unknowledge. Physicians were clear that there are two forms of knowledge: *'ilm al-tabi'a* (knowledge of nature) and *'ilm al-ghayb* (knowledge of the unseen). They recognized the limit to their own knowledge, for they were trained only in the knowledge of nature. Yet the stance toward *'ilm al-ghayb* was split. Prophetic traditions emphasize that God sent down both the disease and the cure, which for some physicians meant that some knowledge is potentially knowable.⁸ Others claimed that the lack of absolute knowledge is the very limit of the phenomenal world. Learning, rectifying, and practicing knowledge required sincerity and intention. This exploration entails an examination of the ethico-religious concepts cited above (*amana*, *damir*, *hads*, *firasa*) which involve the body, the soul, and reformation through self-accounting.

In Part I of this chapter, I explore the cultivation of ethics alongside failure and predisposition in order to consider the habituation of the (physician's) body in relation to the soul's capacity (and incapacity). This will yield an understanding of the body not only as a 'natural tool,' but as a limited tool in relation to time, aesthetics, affect, power, and knowledge.⁹ More importantly, as the habituation of the body-soul and its role in the acquisition of knowledge is at times tied to *din*¹⁰ and nearness to God, the question of the evil physician and the relative expertise of non-Muslim physicians led my interlocutors to consider the role of innate talent as blessing of God (*rizq*) irrespective of a person's *din*.¹¹ The notion of the divine possessing all knowledge decoupled knowledge from belief and ethics from practice. Thus, God could give medical expertise to whomever God wills, irrespective of their creed or character.

⁷ Reza Shah-Kazemi, "The notion and significance of *Ma 'rifa* in Sufism." *Journal of Islamic Studies* 13, no. 2 (2002): 155-181.

⁸ Sunan Abi Dawud 3874: "The Prophet, peace and blessings upon him, said: Allah has sent down both the disease and the cure, and He has appointed a cure for every disease, so treat yourselves medically, but use nothing unlawful."

⁹ Marcel Mauss, "Techniques of the Body," *Economy and Society* 2, no. 1 (1973): 70-88.

¹⁰ I am not deploying any particular English equivalent, for *din* is sometimes translated into piety, faith, religion, or outward expression of faith. I hope a definition of *din* will emerge out of the descriptions my interlocutors give for how they conceive it. For *din* as piety, see Lara Deeb, *An Enchanted Modern: Gender and Public Piety in Shi'i Lebanon* (Princeton: Princeton University Press, 2011).

¹¹ To call your talent or medical expertise and knowledge your *rizq* means that what you come to embody or possess is a provision, endowment, or blessing from God as your livelihood, subsistence, fortune, or boon.

Part II of this chapter further delves into the problem of innateness, for tremendous innate talent is no guarantee of physicians habituating good rather than evil. I explore this fear of the evil physician through the bioethical and medical professionalization initiatives of younger attending physicians in the hospital. The overwhelming consensus that much of a physician's practice was dependent on their *din* made certain physicians wary of risks. I examine the ways this second generation of physicians, mostly trained in the West, called for the reinforcement of a legal apparatuses within the hospital. This new system would undermine the current relational network that is mostly reinforced by reputation (*sum'a*) based on accountability (*hisba*), family lineage, practices of hospitality, and evidence of sincerity in interaction (*mu'amala*). These concepts (*mu'amala*, *hisba*, *amana*) orbit jurisprudential rules around financial exchange within markets. In an ethical register, they open up to an accounting of the self (*muhāsabat al-naḥs*), which wrestles with the question of unknowledge and God's judgment. The ethical relationship to unknowledge was an irresolvable tension, as physicians wanted to reinforce the law but feared its potential injustice when viewed from the perspective of divine law and upholding the *amana*.

Consideration of ethics in relation to knowledge, habituation, predisposition, and innateness has been explored by medical anthropologists and anthropologists of religion, but has yet to occur in conversation across these two subfields. I explore whether these initiatives succeed in encompassing the field of the soul and desire, returning to debates in social theory and anthropology regarding the body, the soul, and their containment, but also engaging the ethics of psychoanalysis regarding the role of unknowledge in the pursuit of the Good and ethics. For what opens up the soul to reform is not self-mastery through traditional virtue ethics nor a self-governable body, but rather an ethics toward unknowledge fueled by the threat of God's eschatological judgment. The physicians' reformation of the soul through an engagement with the other and unknowledge decenters the question of the good, making their orientation incompatible with traditional (Aristotelian) ethics. *Amana* is not about self-mastery; this is not entirely commensurable with the paradigm of virtue ethics.¹²

I also return to Michel Foucault's work in *Discipline and Punish* to further demonstrate how my interlocutors' (as well as Ibn Khaldun's) delimitation of the body rejects the conception of the modern soul as a self-governable body. Nor is this merely a contrast between self-governable bodies in "the West" and traditional virtue-ethics cultivating the Muslim soul. Rather, what is at stake in my field site is resistance to the enforcement of the law and its potential injustice on those most vulnerable, through the imposition of surveillance and punishment (explicitly along the models of western institutional hospitals). What Foucault presents is precisely what Professor Hakeem fears: the discipline of those unable to evade the law and libertine self-work of those who can. In the US, this can be seen as the enjoyment of the elite and the discipline and imprisonment of black and brown bodies. It is this injustice of the law—the humiliation of those who err, the extinction of their desire—that Professor Hakeem is attempting to avoid as he outlines an orientation to the law akin to contemporary forms of restorative justice.

The Good Physician

I first encountered explicit thematizations of ethico-religious concepts—divine trust (*amana*), conscience (*damir*), sincerity (*ikhlas*), discernment (*firasa*), and empirical intuition (*hads*)—while conducting fieldwork in Sana'a, Yemen in 2013. I had heard that physicians took on a prominent place there in the Arab Spring protests. These physicians sought to rectify the

¹² Cf. Amira Mittermaier, "Dreams from Elsewhere: Muslim Subjectivities beyond the Trope of Self-cultivation," *Journal of the Royal Anthropological Institute* 18, no. 2 (June 2012): 247-265.

loss of the divine trust and of conscience in the judiciary and executive systems. This collective loss mirrored the loss of trust in the therapeutic relationship between physicians and patients, as patients spoke of the *'uqda*, a psychological-moral “knot” that evoked an unrestrained force, binding/releasing painful memories or experiences, which in turn informed their relationships to physicians and biomedicine. In turn, the physicians felt equally knotted, for they could not felicitously appeal to the figure of the traditional healer (*hakim*) nor that of the western physician. Neither would be adequate to redressing the loss they faced. The physicians instead laid claim to the Islamic tradition, drawing on a constellation of ethico-religious concepts to ground their returns to the divine trust (*amana*) in medical practice with conscience (*damir*). Whereas public and individual grievances regarding the faltering system of accountability, trust, and care in healthcare are not expressed in the same ways in Amman, Sana'a, and Jeddah, the circulation of these terms in their hospitals and clinics gestures toward a discourse on the body of the soul and the soul of the body who heals. This entailed further explication: what ensures that a soul will practice *amana* and *damir*, given the lack of accountability and oversight, rampant corruption, and nepotism (*wisata*)? This question was further exacerbated the need for courses in ethics as many physicians were found culpable for patients' bad outcomes.

Across my fieldwork in Amman and Jeddah, these concepts emerged in my conversations, interviews, and participant observations with physicians, residents, and medical students around the question of what makes a good physician. When I asked what makes a good physician, they immediately raised the relationship between the body and the soul.¹³ A good physician then was one who was trustworthy (upheld *amana*), applied his intellect (*'aql*) to the study of medicine, understood his limitations, followed procedure, listened and interpreted clearly, has good character, is observant and cooperative, and researches with a view to conscience and the divine trust. Physicians' dress, demeanor, mannerism, remembrance of God (or lack thereof), prayer, punctuality, dedication, and trust in interacting with patients played a major role in defining and refining his expertise (*khibra*) and wisdom (*hikma*)—but may not always refine their medical skills and *hads* (empirical intuition). A physician's dedication to maintaining “updated” knowledge, acquiring experience, and honing their expertise were inextricable from discussions on characteristics (*akhlaq*) and manners (*adab*),¹⁴ natural predisposition (*fitra*), and education (*tarbiya*). These came to be extensions and expressions of the physician's divine trust (*amana*), conscience (*damir*), and sincerity (*ikhlas*), which were still always related to the ongoing modulation of their desire. That desire in itself is further intensified or decompensated by its surrounding landscape and other desiring persons. This ethical complex

¹³ There is a long history within Muslim societies of seeking the ethical through the relation of the soul to bodily ailments and its relations to ways of knowing. In the medieval period, the *hakim* (wiseman/healer) was foremost a scholar of the sciences, a theologian, and a philosopher. The *hakim*'s concern for bodily ailments was often secondary to a concern for the nature of the soul and its faculties, developed in theoretical psychology (study of the soul). The figure of the doctor was thus immediately engaged in the question of the hierarchy of sciences and the type of knowledge that facilitates holistic health. The *hakim*'s concern for health prevention also implied a regimen for the proper discipline of the soul to maintain the balance of the body through its *akhlaq* (characteristics/virtues). This regimen—not only for the patient, but also for the *hakim*—served to habituate their intellects. My chapter asks, how do contemporary doctors interpolate this once-vibrant tradition and bring this body of knowledge to their medical practice? In what ways are their articulations of medical ethics and practice informed by ethico-religious concepts and discourse?

¹⁴ This term comes from the word *khuluq*, meaning creation; thus ethics is tied to one's created disposition. To possess *amana* is part of one's *akhlaq*. *Adab*, on the other hand, refers to one's manners and behavior in interaction with others. To respond well to situations is part of your *adab*, while your disposition is reflective of your *akhlaq*.

led to the puzzling figure, discussed with my interlocutors, of physicians who were exceptionally talented but also corrupt, negligible, and evil.

My interlocutors linked ethics to the soul not in simply in cosmological or noetic terms but through the ambivalence of a doctor's "reputation" (*sum'a*, lit. echo), her predispositions (*fitra*), and her character (*akhlaq*). From the way they approach and court their future partner in medical school, to whether they pray on time in the hospital prayer spaces, to how they receive their patients and give out their personal phone number, to the extended reputation of their family—all these factors and more lead into how a physician retains and gains patients and earns their trust. As such it raised the question of divine trust and a physician's relation to the law. For physicians in Jordan, this revolved around the faculty of conscience; in Saudi and Yemen, around the weight of the divine trust. Yet, much of the discourse around how a physician in training interpreted or cultivated knowledge vacillated between a person's innate talents, predisposition, and habituation.

Sum'a, reputation, comes from the verb *sama'a* (to hear). Your reputation in this sense includes the echoes of your lineage, traces your steps to your neighbors and neighborhood mosque, accounts for the extension of your limbs in your dealings with others, encloses your secrets, your legacy. What one hears from your lips, from others' lips, what others think they hear, what others hear from your home, from your family, from your colleagues, from your neighbors, all either affirms your *sum'a* or calls it into question. Your "reputation" is echoes of yourself and your lineage. It is not an archive built up in space but across time and in relation to *shari'a*-grounded ethics in particular modes and media of exchange. (I also found myself implicated in this network of echoes as I struggled to obtain IRB approval there for nine months.)

Many of the conversations around the 'good physician', the display of character, and patient relations emerged during rounds, courses, and in the clinic. I conducted around 50 interviews in Jordan and in Yemen and worked closely with twenty physicians in the teaching hospital in Jeddah. My year and a half long fieldwork in Jeddah yielded about 200 interviews with patients, medical students, residents, and attendings. I shadowed physicians in their hospital rounds, attended their day-long clinics, interviewed them, and learned alongside their medical students and residents. Much of the data in this chapter comes from long open-ended interviews I conducted with physicians from all three field sites.

In each field site, my interlocutors were Yemeni, Saudi, Palestinian, and Syrian. In addition to Yemenis trained in Yemen, Syria, and abroad, you find Palestinian, Iraqi, Egyptian, and Syrian physicians in Yemen. In Jordan, you will find Yemeni, Egyptian, Palestinian, Syrian, and Iraqi physicians and medical students. You also find Yemeni, Egyptian, Palestinian, Pakistani, and Syrian physicians in Saudi Arabia. When it came to the internal discourse on ethics, their national identity weighed less than their university and place of training, their subspecialty, and their rank. Those who studied in Syria and Jordan frequently navigated the question of ethics through what I will show is an ecumenical discourse around cultivation and *din* through *damir* (conscience) and *hads* (empirical intuition). Those trained in Saudi and Yemen were instructed in the Hadith tradition and emphasized *amana* and *firasa*, even if they were also trained abroad.¹⁵

The following exchanges (*hiwarat*) between the physicians, residents, medical students offer a set of debates that illuminate not only the complex discourse around

¹⁵ The physicians trained abroad had to deal with Muslim/non-Muslim relations on their own, in a way that did not resemble the interfaith approach of the Levant.

innateness/cultivation and the body/soul but also the debated promise of moral reform through the law. The different selves of each individual over the course of their life and their contradictions attested to the journey of the soul. What unfolded was a schism between the conception of the good physician and what secured and reinforced that ideal. More importantly, as the figure of the ideal physician emerged, it was itself submerged in the murky waters of the soul and the law. My intention in this chapter is not to outline an Islamic ethics of medical practice or to objectify the relation between the soul/self (*nafs*), the intellect, and moral temperament. Although there were serious questions regarding the system of accountability (of discipline and punishment) that accompanied these questions, they entailed the need for further social scientific and humanistic research in biomedical ethics. Instead I hope to offer a space of meditation that allows the complexity of such debates to unfold, to hear what their contradicting speech affords and the pain they index, which ultimately regards restorative justice in the phenomenal world.

Part I: Clinical Sense, Discipline, and the Law

Many physicians in Yemen, Jeddah, and Amman were staunch empiricists, as their training in evidence-based medicine was necessary to their claim to global expertise. However, the question of the empirical was marred by philosophical debates regarding intellect (*'aql*), soul/self (*nafs/ruh*), character (*akhlaq, adab*), all emerging around the concepts of *amana*, *damir*, *hads*, and *firasa*. Was clinical sense innate or habituated? If habituated were they disciplined by instruction or through the imposition of the law? This internal discourse was also knotted within a local discourse regarding one's reputation (*sum'a*), namely whether you came from a family of physicians and scholars, your family's position within the community, and its hospitality.

Attending physicians in medicine, oncology, and infectious disease emphasized the importance of cultivating clinical sense, *hads*, and social and emotional intelligence. Surgeons and radiologists stressed innate dexterity and the roles of the imagination and visualization. On the other hand, medical students and residents, whom I discuss later, were preoccupied with questions of discernment in relation to patients and the accumulation of practicable generalized knowledge.

Medical students emphasized *amana*, grounded in the fear of God, in relation to their studies and training. They spoke of some working hard while others were lax in their study. Some noted that many of their top performing students were Quran memorizers. Either gained through practice or a divine talent, many had a photographic memory. This question of innate capabilities was not limited to the intellect but applied to a student's moral temperament as well. During one of my first rounds with a nephrology attending physician, a medical student was praised for his bedside manner with a cancer patient suffering from kidney failure. The attending said that the patient was impressed and felt at ease with the medical student. She turned to me and said, "See, character (*akhlaq*)! That I cannot teach students. They just either have it or they don't."

Medical students in Amman noted that in their ethics course "Breaking Bad News" their professors invoked the examples of ancient physicians. They exhorted them not to deal with their patient as a machine, but as a total human. Students were reminded that they were responsible not solely for human bodies but also for their spirits (*arwah*), so as to awaken (*aniba*) their consciences by instilling a sense of responsibility beyond the materiality of the body, beyond the present world (*dunya*). This accountability projects a life beyond this world and recalls a

different, eschatological temporality.¹⁶ A good doctor then is one who practices with conscience and cultivates empirical intuition, who is neither an opportunist nor insolent; he adheres to the Hippocratic oath and avoids shortcuts.

Residents, on the other hand, usually sought out figures like Professor Hakeem, who was passionate about teaching, the infectious disease attending physician that the HIV patient stressed returned the *amana*. One resident commented, “other physicians return from abroad and don’t want to share their knowledge and teach. Yet that’s the whole point of them being sent away, to learn what is of use and to transmit it.” Unlike Hakeem, few attendings shared their knowledge upon returning from abroad; some hoarded it, as if it were not meant to be redistributed. Everyone observed who prayed and who didn’t. People noticed if you smiled or if you were depressed or whether you greeted the other colleagues or staff with peace and blessings. Physicians agreed that a physician’s *sum‘a* was very important. No one wanted to be known as a grifter. Families mattered.

Medical students and residents even observed my habits. The fact I spoke Arabic and prayed in the many prayer spaces in the hospital was bewildering. The fact that I demonstrated basic forms of *adab* led many physicians to inquire about my upbringing in a society that was not conducive to maintaining a Muslim natural disposition (*fitra*). I also was not immune to advice (*nasiha*) and was invited to reciprocate. In many of my interviews, physicians would ask my opinion regarding related matters such as relationality to patients or the soundness of religious advice. One gynecologist advised me to pray to God for the kind of husband that I want but also for what I do not know I might want, as so much knowledge is unknown/unseen (*ghayb*). Everything relating to my character, family life, and religious practice was examined as I moved about within hospitals.

In rounds, in the hospital, and in clinics, Professor Hakeem reminded students that clinical sense is essential to understanding presentations of infectious disease. I later sat in his office to ask the professor how one develops such clinical sense; whether there is there a contradiction between what can be taught versus what must be acquired; and what type of student excels. He replied at length:

Students need intensive training and experience. They usually have to develop their own clinical sense. It cannot be taught. It is acquired by experience. For example: if you read about TB (tuberculosis), [you read that] it may present with fever, weight loss, and, when you examine the sputum, the organism. A doctor with no clinical sense follows the book exactly. If someone presents with cough without fever and the sputum is negative for TB they would not consider him as a potential case. This [clinical sense] does not follow the criteria in the book. But with time, they will learn that a majority of patients who present to us, actually do not follow the book. Only 20% of the patients we see in our practice have the typical features taught, and 80% usually present atypically. These atypicalities will be learned over time. In the future, when you have a patient with a cough with no other features, you do a chest X-Ray and suspect TB. This is what we call clinical sense. You learn with time and with error. You learn the diagnosis the hard way.

Experience cannot be taught. You can tell people your experience. But for others to develop the skills, they have to experience it themselves. If they have not gone through

¹⁶ Jane Idelman Smith and Yvonne Yazbeck Haddad, *The Islamic Understanding of Death and Resurrection* (Oxford University Press, 2002).

such an experience, it will not stick in their subconscious. By telling them the facts, it does not mean they will have good clinical sense. In medicine, in particular, we try to teach people through experience, as scholars did in the old days. Not what is taught in books. We teach them what is present in real life. A book cannot give you the atypical features. These typical features, only apply to 20%. You have to be guided by a good experienced physician. It is important to train in medicine; you have to train clinically.

I am not happy with most of the students. Most of them don't appreciate what we say in rounds and what we try to teach them. Usually they do not know what they want to do yet and don't pay attention. I tend to say it and watch for those who have grasped it. I try to ask questions of those who did not grasp it in order for them to pay attention.

Professor Hakeem stressed that clinical reality is different from books. A clinical sense was cultivated through experience and failure. It was also a person's own. He went on to explain that many students (including himself) did not seek out infectious diseases as a specialty until they experience such diseases firsthand. He found that students who were interested in the field and desired to know more were usually the most teachable. Many fellows who worked with him, including endocrinologists and hematologists, changed their careers to infectious disease after their experience with him. I joked that he was 'converting' them into this subfield, to which he laughed and agreed. According to him, the shifting clinical features of organisms in addition to the fact that many infectious diseases are curable are some of the reasons that drew other physicians to the subspecialty.

Professor Hakeem stressed that ultimately a physician must have trust in God and seek out the reasons known to us. One's faith must be in God. He gave examples of the Prophet conducting observational research and that one must seek both natural and material reasons. When I asked him whether trust in the physician had to do with *din*, he explained that it is more complicated. Although people often reduce *din* to external features such as keeping a beard or wearing one's *thawb* above one's ankle, he noted that it had to do with prayer, character, and one's interactions with others.

On the other hand, Dr. Ilham, unlike other oncologists, focused less on clinical sense and more on a physician's ability to be socially and emotionally intelligent. And to possess insight (*firasa*).

It is not just experience/expertise (*khibra*). There is a social intelligence and divine talent (*mawhiba*) [also involved]. You must distill (*halili*) whoever is in front of you by the eye and by speech. I need time to understand this human being, to get the truth of the patient. There is [the role of] insight. You succeed by seeing lots of cases and gaining confidence in your will to do so after repetitions. I try to take a lot of feedback from my patient.

Dr. Ilham situated social intelligence and divine talent as lying beyond *khibrah*, which is a concept that alludes to a particular form of experience, expertise, and appraisal. She stressed that what patients looked for was not the physician's compassion. Patients did not want *shafaqah* (tenderness, mercy). They need the physician's social and emotional intelligence to investigate the root of the problem, which requires coordination of the physician, family, and patient around the illness.

Nader El-Bizri explains that to speak of experience in Arabic one would have to reference a “family of terms” that range from *tajriba* (test) and *i’tibar* (unravel/reading of signs) to *khibra* (apprise/expertise). Experience is not simply the acquisition of knowledge or accumulation of observation, but there is a specific type of unveiling of knowledge and understanding that transcends observation. It involved the practice of reading and deciphering the signs amidst use of knowledge unfolding onto interaction such as the relationship of patient and doctor.¹⁷

Another oncologist also stressed that “knowledge is important, but not everything. Emotional intelligence is necessary.” What my interlocutors considered emotional and social intelligence concerned both the ability to read the patient and a relation toward the patient and his relatives. A physician needed to be punctual and genuinely interested in the case of the patient. The oncologist stressed:

The patient is ill and is not in any ideal mood. They are usually emotionally frustrated. A physician must be skillful in how to communicate with them and their family. A physician must be able to read body language, and modify their tone if needed.

The oncologist stressed that the skills to read body language, mood, and temperament of the patient were difficult to teach medical students. In Yemen, physicians also stressed the importance of drawing out people’s characteristics (*tafasil*). The word *tafasil* is derived from the word *fasl*, which means joints, so the patient is seen as the amalgamation of their joints. Similarly, *halili* translates to solve, dissolve, analyze, redeem, allow, and permit. It means both to analyze by letting something dissolve to its root, but also allowing and putting up with something. The physician emphasized that this is crucial especially in oncology, where you cannot cure but seek to prepare a treatment that is receptive and effective. The oncologists were often concerned with the patient’s state of mind: according to them, cancer was a journey for both the patient and the physician. They required both the trust of the patient and his family, whom they believe live out a drama with the patient at home.

¹⁷ Within the Arab/Islamic tradition one must also understand experience’s etymological, Quranic, philosophical, and epistemological dimensions. Experience can refer to an affective encounter or a methodological and practical encounter, but there is no semantic equivalence in Arabic for the English word experience. Epistemologically, Alhazen’s *Optics* (1027) influenced many philosophers’ explication of experience linking it to sense-perception, inductive method, and cognition, which can be seen in the writings of Avicenna and al-Ghazālī (Nader El-Bizri, “Experience in the Arabic Language,” *Keywords: Experience* (2006): 50-51, 55, 57). Additionally, the Quranic dimension links religious experience to “testimonial vision” and “emotive feelings” that extends beyond the realm of ritual and practice. El-Bizri showcases various verses from the Quran that fuse the senses (seeing and hearing) with the heart and reason. Seeing and hearing entail an ability to recognize signs by way of the heart that, in turn, allows one to grasp “reality” and “reason”. According to him, sense perception “conjoins with the workings of the heart in affirming one’s pious belief and the assertion of one’s devotion” that result in the production of good deeds (53). The variegated connotations of experience point to the distinction within the history of ideas in Islam between “the people of rational inquiry” that practice mediation of the intellect and “people of unveiling that rely on mystical experience” for the assertion of knowledge (54). Ibn Rushd, one of the first commentators on Aristotelian metaphysics following Ibn Sina, stated: “for every Muslim the law (revelation) has provided a way to truth suitable to his nature through demonstrative, dialectic or rhetorical method” (51). Ibn Sina came to be critiqued and somewhat appropriated by al-Ghazali, who at first held that the metaphysicians’ reliance on reason and demonstrative proofs fell into contradiction, but then years later incorporated philosophy into his work on mysticism. See Abu Hamid al-Ghazali, *The Incoherence of the Philosophers: A Parallel English-Arabic Text*, trans. Michael E. Marmura (Provo, UT: Brigham Young University Press 1997), xv.

Conscience (*Damir*) and Insight (*Firasa*)

In Amman, physicians and medical students stressed the importance of conscience (*damir*) as an orientation to perfecting one's medical education and practice. *Damir* is not (cannot be) cultivated in medical school. *Damir* stems from one's upbringing and discipline, according to proper ethical conduct (*tarbiya*) and divine trust (*amana*). A lack of *damir* can hinder medical expertise (*khibra*) by sapping a person's resolve to learn and practice. A physician's *damir* must not be asleep. The way to sustain one's *damir* is through a rigorous self-examination, accounting for the self's actions and intentions (*muhasabat al-nafs*). When I asked many physicians I interviewed to further elaborate on the nature of this self-accounting, they stressed that it is adjudicated by a person's consistent, habituated remembrance of God. Accounting for the self is an accounting to God: "conscience (*damir*) requires tending to God (*mura'at allah*); and you will know when you have made a good choice because your heart will accept the decision you make." The modulation operationalized by *damir* illustrated the function of the heart as recipient of the consequence of action and as evaluator of one's intentions through its orientation to the divine.

Damir is a faculty that receives and creates action; it is a filter (as formed through *shari'a* disciplines) for the enclosure of experience and information (as a recipient of the individual's choices). It is a selective emanator of action, reflecting the complex of the self, soul, and collective and ethical consciousness. Although *damir* is not a term that appears in the Qur'an or exegetical texts, it is defined in the Sufi (mystical) literature as thought and the interior; in grammar, it refers to the usage of pronouns. While some argue that its contemporary usage to mean "moral consciousness" is derived from the Arabic Bible, in this context it stands between one's individual choices and God's laws.¹⁸ *Damir* is also a general function of someone's care for God and his laws, available as a capacity to everyone.

What distinguishes a truly gifted doctor is *hads* (intuition by evidence, as per Ibn Sīnā), which the physicians define as medical sense or medical judgment. A physician's *hads* explains his awareness and quickness. Physicians in Amman explained that in their medical seminars their professors emphasized the *hads* of ancient physicians such as Ibn Sina, who would diagnose patients by reading their pulse. They note that *hads* is a type of discernment (*firasa*) known as an attribute of those Arabs who could anticipate a guest traveling from far away, and their state and health upon their arrival, as narrated in children's tales. It is also defined by the Prophet Muhammad as "natural insight" and the ability to see with the "light of God." In his *Marvels of the Heart*, the twelfth-century Islamic theologian and legal scholar al-Ghazali cites this hadith with reference to the ability to clearly discern and receive God's signs by way of the heart.¹⁹ Al-Ghazali describes the heart as a field for activities, including knowledge acquisition and discernment. Once empty of the remembrance of God, the heart will become a field for one's passions, desires, and evil promptings, mirroring the imbibed sensational imprints from the desiring world, foreclosing the spiritual world. Ibn al-Qayyim, a fourteenth-century physician and theologian, describes *firasa* as the ability to see with the light of God and "a sense of visual acumen, perception and insight," a form of discernment that involves the visualization and reading of signs given to those capable of receiving God's light (*mutawassimin*), a station held

¹⁸ Oddbjørn Leirvik, "Conscience in Arabic and the Semantic History of 'Ḍamīr'," *Journal of Arabic and Islamic Studies* (2009): 18-36.

¹⁹ Abu Hamid al-Ghazali, *The Marvels of the Heart: Book 21 of the Revival of the Religious Sciences*, trans. Walter James Skellie (Louisville, KY: Fons Vitae, 2010), 69.

by theologians, prophets, and saints.²⁰ They are those who reflect, interpret, and receive the lessons and intentions of signs. *Hads* is the self-discipline of sensing others. As an extension of *firasa*, *hads* foregrounds the role of the soul and the imagination in the reception and interpretation of empirical knowledge.

All the physicians and medical students agreed upon the importance of *damir* and *hads*, considering the latter a natural (*fitri*) inclination of the soul and the former a disposition that can wane over time if not habituated. In Jeddah, many physicians noted that *muraqabat allah* was, far from being a private spiritual practice, almost necessary to ethical medical practice due to the lack of bureaucratic oversight. It forms one of the hospital's values embossed on their plaque insignia (see below).

In Jordan, the multi-faith Arabic community emphasized the contingent relationship between *muraqabat allah* and *damir*. Belief and knowledge are extricable. How else could physicians make sense of the flourishing medical sciences in the non-Muslim West? Some of my interlocutors noted that intellect (*'aql*) did not rely on belief, as it is an independent provision and blessing from God. Like my interlocutors in Saudi, they held that conscience (*damir*) did depend on faith—but noted that belief in God is shared by the three Abrahamic religions, and so was not exclusive to Muslims. Even so, *damir* expands and constricts alongside the soul. Thus what appears as an expression of personal medical talent is a facet of this broader moral psychology.

The Unteachable: Hads and Imagination

For many of the surgeons and radiologists I spoke to, the question of innateness was less about one's intuition or intelligence than one's imagination. Radiologists argued that one's visual acumen is not something that one learns in medical school. Anyone can read an X-ray, but only a select few have the ability to see through it. Some radiologists I worked with spoke of their training learning to read architectural maps with their engineer fathers, while others spoke about their early interests in computer graphics. Dr. Noor, a famous cardio-surgeon in Jeddah, explained that some students have excellent innate dexterity while others require more training (habituation). However, what he could not teach his interns and residents was the ability to visualize surgeries beforehand. Dr. Noor explained that in order to succeed in cardio-surgery one must be able to visualize the procedure, everything from the moment you cut the tissue to rerouting the valves and blood flow. Surgeons mentor and encourage those who have natural dexterity and habituate such skills in others, but ultimately the ability to visualize procedures (e.g., by closing their eyes and walking through the procedure beforehand) was impossible to teach. In the end, it was those medical students and residents who were unsuccessful in visualizing procedures that dropped out of the program or changed specialties.

Therefore, continued Dr. Noor: "You have to have passion. If you don't you will not pursue cardio-surgery, where you find yourself in the Operating Room for nine hours." Dr. Anwar links imagination with passion. The ways in which a surgeon may guide his way through another's body precedes his act. It lies in an architectural design that is mapped out utilizing his imagination and visualizing every step. This form of preconception is also enhanced with empirical work, leading us back to Ibn Sina's concept of *hads*, an intuition that is practically honed but which may also precede it.

²⁰ Ibn Qayyim al-Jawziyyah, "The Station of *Firasa*," *Steps of the Followers*, accessible at http://privat.bahnhof.se/wb042294/Texter/firasa_ibnqayyim-en.html.

In Ibn Sina's psychology, the imagination is a bridge between the "material forms of sensibles (sensory data) and the absolutely abstract forms of intelligibles (abstract forms)."²¹ Imagination, served by the five senses, works alongside the faculty of estimation (*al-wahm*), which imprints intentions directly onto the soul.²² It takes stored images from memory and abstracts, composes, retains, and recalls, combining and separating images, "giving rise to fantastical images."²³ Both faculties depend on the active predomination of the practical intellect, which puts the imagination into work for the theoretical intellect, so that it "may have excellent morals."²⁴ Serving two functions, the practical intellect governs the lower bodily faculties and "exists for the sake of the perfection and purification of the theoretical intellect."²⁵ Ibn Sina, like the cardiologist above, thus links imagination and intuition with ways of knowing. The intellect of those who possess "quickness of apprehension" and "immediate perception" through intuition is considered *intellectus in habitu*.²⁶ Ibn Sina calls this form of intuition *hads*, the ability to bypass the middle term in a syllogism.²⁷ This ability can be both instructed or indicative of a purity of the soul by way of connection with the active intellect.²⁸ Ibn Sina follows Aristotle in considering the heart the seat of the imagination, in contrast to Galen who places it within the brain.²⁹ It is thus befitting that a cardiologist leads us to the imagination.

Commentaries on whether *hads* is an innate ability (as in the case of prophets) or if it is cultivated preceded Ibn Sina and continued to be debated in the tradition.³⁰ It is then not surprising that these debates persist, occurring in different registers and among laymen and practitioners alike.

The first time I encountered the concept of *hads* (intuition by empiricism) was in spring 2016 with a Yemeni physician in the US. I met her at a Yemeni wedding in Oakland, California after I had qualified for doctoral candidacy. I was sitting at a table of aunties when they began to joke about my reluctance to get married in order to focus on my doctoral research. One woman I did not recognize praised my efforts. One of my mother's closest friends then pointed out that our camaraderie stemmed from the fact that this woman was herself a physician, and she mentioned that my research was on medicine and physicians in Yemen. I passed this woman my information and later visited her at her home in east Oakland. I learned that she had been trained in Syria and had practiced in Yemen. In our conversation about what characterizes a good doctor, Dr. Sahar introduced the concepts of *amana* and *hads*. When I asked her which of these two drives a good doctor, she answered by turning to the opposite figure: the corrupt doctor. She explained that a physician's ethical conduct has external and internal causes. She continued:

Corruption (*fasad*) occurs at the level of the social. When the social is corrupt, the doctor has space to commit corrupt acts. [This is the case] when the law comes from the outside.

²¹ Ibn Sina, *Avicenna's Psychology*, ed. Fazlur Rahman (New York: Oxford University Press, 1952), 19.

²² *Ibid.*, 37, 81.

²³ Jon McGinnis, *Avicenna* (New York: Oxford University Press, 2010), 115; Ibn Sina, *Avicenna's Psychology*, 77.

²⁴ Ibn Sina, *Avicenna's Psychology*, 32

²⁵ *Ibid.*, 37.

²⁶ *Ibid.*, 36.

²⁷ "If a person can acquire knowledge from within himself, this strong capacity is called 'intuition.' It is so strong in certain people that they do not need great effort, or instruction and actualization, in order to make contact with the active intelligence" (Ibn Sina, *Avicenna's Psychology*, 35-36).

²⁸ *Ibid.*, 69.

²⁹ *Ibid.*, 79.

³⁰ Herbert Alan Davidson, *Alfarabi, Avicenna, and Averroes on Intellect: Their Cosmologies, Theories of the Active Intellect, and Theories of Human Intellect* (New York: Oxford University Press, 1992).

A good doctor in the USA might be corrupt in Jordan and be utterly ruthless in Yemen, where there is little supervision. Then there is [the factor of] a doctor's faith (*iman*) in his purpose. His faith in his commitment to uphold the rights of humanity.³¹

I then asked Dr. Sahar if *amana* and *hads* are related. No, she replied: two doctors can each intend or be obliged to do well by their patient but differ in their *hads*. Both want to uphold their *amana* to their patient, but their intuition drives them to different conclusions based on their evidence. It does not necessarily mean that if one betrays the divine trust, that they will have a poor *hads*. "Of course, criminal doctors, organ traffickers, are the most talented! This is a divine (*rabbani*) talent, they just choose to use it for evil." Dr. Sahar had learned medicine in Syria, which has long boasted historical Christian communities. Her particular understanding of human intuition (as a divine talent that does not inform nor is affected by one's moral temperament) may reflect a more ecumenical framework, in which God's endowments and knowledge is spread throughout the earth to people of many communities. This approach in turn leads us to link the field of the soul with that of the city and the corruption of the social.

Dr. Ilham in Jeddah also did not see a relationship between *din* and medical excellence. There are a many great physicians lacking in *din*:

There are people who are great physicians and their *din* is not great. Their skills are tied to God's favor, blessing, grace (*ni'ma*). God is generous, as in his attributes: he is the most giving (*al-'ata*). Whether we are grateful or not, God gives. This is both a blessing (*sharaf*) and tribulation (*ibtala*). All success is from God. Our gratitude then determines our relationship to God, to the afterlife, and his judgment.

With Dr. Sahar and Dr. Ilham, the qualities and characteristics of the good doctor (*firasa*, *hads*) emerge as coordinates to steer one's heart away from external stimuli perpetuated by corruption (*fasad*). However, failing to acknowledge such a blessing from God is a form of trial. These divinely-acquired skills oppose the figure of the opportunist physician lured by greed and by an indifference to social ties and to *shari'a*-grounded ethics. Both Dr. Sahar and Dr. Ilham argue that evil is not a disposition but habituated that may not remove your innate blessing. They argue for an innate disposition that leads to habituation of a skill in spite of one's desires for corruption and susceptibility to betray the divine trust. Their talent is a sign of God and their deferred judgment is also a sign of God.

Intellect ('*Aql*) and Self/Soul (*Nafs*)

In spite of the ways a physician's heart and ethics informs his practice, physicians still granted intelligence ('*aql*) a primary role in a person's training and acquisition of medical knowledge. The fact that physicians and medical students nonetheless produce a coherent discourse on conscience (*damir*) points to the limits and transgressive nature of the field of medicine, which interpolates doctors as the double of the double of God—saints and prophets—

³¹ Whereas public and individual grievances regarding the faltering system of accountability, trust, and care in physicians and the healthcare system are not expressed in the same ways in Amman, Sana'a, and Jeddah, the circulation of these terms in their hospitals and clinics gestures toward an ambivalence toward the loss of the figure of the trustworthy, knowledgeable, disciplined, soulful healer (*hakim*) who embodied the once-vibrant Islamic medical tradition. This loss was attributed to the lack of effective systems of accountability, to corruption, and to nepotism (*wisata*).

invoking the light of God.³² Within the clinic, *damir* reflects a larger field of crisis and struggle for justice, care, and resolution. According to the medical students, the heart or soul bears witness to socio-political ills that have contributed to the lack of formative upbringing (*tarbiya*), which closes the heart's door to the spiritual world and to the presencing of God through one's *damir*.

Although these concepts orbit the discourse of the soul, my interlocutors could not directly pinpoint the role of the soul of those who heal bodies. Certain physicians and medical students were skeptical of the role of the soul in the practice of medicine, stating that the relationship between a person's intellect (*'aql*) and heart (*qalb*) is the topic of philosophical debate dating back centuries (and so need not bear directly on contemporary medicine). One student cited Imam al-Shafi'i (d. 840) saying that your intellect is seated in your heart. However, modern medicine has shown that damage to your brain (not heart) can affect your intellect. The student explained, "we accept [the soul's] existence as I can feel her through my heart and soul. An understanding between two hearts unites them (*al-qulub 'ind ba'diha*)."

By accepting the soul's existence but remaining silent regarding its nature, function, and relation to intuition, innate disposition, and conscience (all topics they more readily broached), these students expressed an ambivalence regarding the soul. This ambivalence enabled them to reserve a possible return, reprisal, or encounter with the field of the soul.

In the Qur'an, the terms *'aql*, *nafs*, and *ruh* are interchangeable for the soul, spirit, and intellect. They are distinguished in the exegetical traditions and Arabic philosophy. The philosophers, paralleling Greek psychology, assigned the *'aql* to the theoretical intellect, the *ruh* to the spirit, and *nafs* to the lower desiring soul. In Ibn Sina's work, a person has a disembodied theoretical intellect, a practical intellect linking body and soul, and a body. Ibn Sina's theoretical soul is linked to both the practical intellect, gaining data from the external senses, and the body, but also imprinting knowledge directly through the estimative faculty (one not found in Aristotle's *Psychology*).³³ The estimative faculty intuitively information directly onto the soul, so that a person feels emotions such as fear prior to an encounter of danger. As *hads* is both innate and empirically formed, the relationship between the soul and the body is both informed by and disarticulated from a moral temperament.

In al-Ghazali's work, by contrast, the heart is the seat of the soul as both physical and tenuous subtle spiritual substance. The heart mobilizes both the higher desires of the soul and the lower desires (including lust and anger) as its army. The body is a vehicle for the soul as a source of knowledge and passion is necessary to the cultivation of the soul, so that a moral temperament is necessary for the perfection of the soul and intellect. Al-Ghazali's embodied intellect and Ibn Sina's disembodied intellect are merely some examples of the different relationships between the body, the soul, and moral temperament present within the Islamic tradition that found their way into my conversations with my interlocutors.

It is precisely these polysemous dissections of the soul that makes possible the discourses that render the various elaborations of the good physician, the skillful evil physician, and the potential for cultivation. More importantly, it is the potential for the self-reformation of the soul by heeding the divine trust that redirects the question of evil away from a person's individual soul to the societal structures that foster or permit corruption. Reformation of the soul as envisioned by my interlocutors was an ongoing self-accounting that is possible through the openness to the other.

³² *Mushfi'* comes from the word *shaf'* which means double and intercessor. See Chapter 6 for a longer discussion.

³³ McGinnis, *Avicenna*, 98-100.

Knowing God, the Other, & Myself through the Other

The presence of religious discourse and practice did not mean that physicians could utilize it instrumentally within clinics or rounds. When supplications and reminders were invoked it was done subtly: the *basmala* (“in the name of God”) when beginning to work, supplicating for patients’ well-being, supplicating or repeating the testimony of faith (*shahada*) for a patient who was passing away without relatives nearby to do so.³⁴

Dr. Ilham was clear that her clinic was not a place to negotiate *din*. She said, “when I say [to my patients] ‘We surely have not given you but of little knowledge.’ This is an exemplary verse (*ibra*).³⁵ The patient understands that they must strengthen their relationship with God.” Dr. Ilham utilized these simple reminders with her patients. They were also her way of demonstrating her own commitments and relation to her unknowledge and God’s absolute knowledge. Her own *din* and ethical cultivation came from witnessing her patients’ states. As she said, they taught her many lessons, they formed a school for perfecting the soul (*ihsan*). With her patients Dr. Ilham observes God and as a result feels reciprocally observed by God. *Muraqaba*, meaning to watch or guard, is a meditative practice by which a person becomes mindful of God. Explaining what this practice of introspection entailed, Dr. Ilham stated:

I fear God with my patients. I observe God (*muraqabat allah*), my *din*, my revelation absolutely. My *din* does not forget me. I think God sees me. My patients’ reception of me comes from the honor (*sharaf*) of God, which is a blessing from God. I have no hand in it. This is provision (*baraka*) from Allah. The patient must also take their rights. The patient comes and he doesn’t know much. He has so much faith in God. We are also brothers and sisters in Islam. This is a divine trust (*amana*). The *din* is the movement of the person. I lived in the West and I was never astonished by their ethics or morality. Ethics come from religion first of all. The hadith states, ‘Enjoin what is good and forbid what is evil.’ This is how we spread ethics. We are ethical because we are Muslim. We are human because we are Muslim. We are not selfish, because the Prophet said ‘none of you will believe until you love for your brother what you love for yourself.’ ‘If anyone of you does work, then perfect it.’ That’s professionalism. This is my drive. I work more for my afterlife (*akhira*) than my present world (*dunya*).

The set of hadiths that Dr. Ilham recited from memory came from the forty hadiths compiled by the Sunni jurist and hadith scholar al-Nawawi (d. 1277).³⁶ When I asked the medical students and residents in both Saudi Arabia and Yemen of what their ethical curriculum comprised, they answered with exegesis on the prophetic tradition. Many of the hadiths that are deployed throughout my interviews with these physicians (at least those instructed in medical schools and universities in southern Arabia) were from al-Nawawi’s compilation. The latter text itself is meant to present a comprehensive ethical guide from authenticated reliable transmissions of the

³⁴ Sachiko Murata and William C. Chittick, *The Vision of Islam* (New York: Paragon House, 1994), 61, 112.

³⁵ ‘*Ibra*’ means a passage to serve as an opening and a ‘bridge,’ but also a transgression of border, as the exemplar is the condition by which a lesson is imparted in the very elision of its transmission. See Muhsin Mahdi, *Ibn Khaldun's Philosophy of History: A Study in the Philosophic Foundations of the Science of Culture* (New York: Routledge, 2015), 64-68.

³⁶ For one of many editions, see Yahya al-Nawawi, *Al-Nawawi's Forty Hadiths and Commentary* (Lulu Press, Inc., 2014).

Prophetic tradition that address general issues in one's daily life. It is considered a distillation of the foundations of the path to the law (*shari'a*).

Dr. Ilham stressed that she knew God through her patients. She witnessed God's bounty through the patients:

It is a school of patients: faith (*iman*), divine decree and destiny (*qada wa qadr*), the love of tribulation (*ibtala*)... My patients tell me [as in the hadith recorded by Tirmidhi], 'Doctor, God gave me this trial because he loves me.' Then I think to myself, how do I work on my self/soul toward perfection (*ihsan*)? The patients affect my *din*.

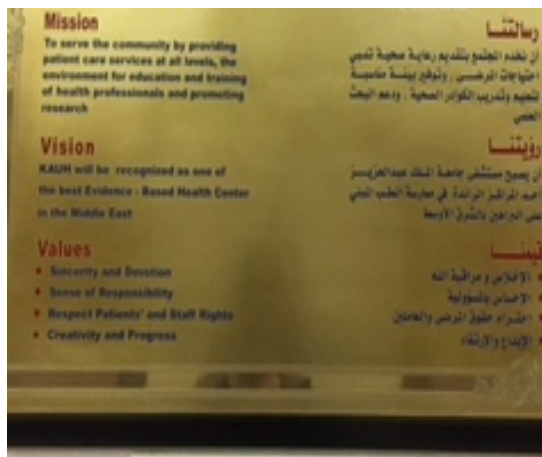
After pausing for a second, she quoted a verse from the Qur'an:

When he attains full strength and reaches forty years, he says: My Lord! Grant me the power and ability that I may be grateful for Your favor which You have bestowed upon me and upon my parents, and that I may do righteous good deeds, such as please You, and make my off-spring good. Truly, I have turned to You in repentance, and truly, I am one of the Muslims. (Q. 46:15)

For the majority of the physicians, whether it is about understanding the illness, coordinating affinity, or reassuring the patient, attending physicians emphasized that ethics was about knowing and learning from the other. The work on the self was inextricable from the other. The verse of the Qur'an that Dr. Ilham references marks the age of forty as the age of maturity from which a person must recognize their blessings, express gratitude to God, but also continuously turn to God, for righteousness itself is a blessing from God.

Patients were not the only reminders; the entire hospital was laced with hadiths, supplications, and verses of the Quran. Walking through the hospitals, one finds Qurans laying in nurses' stations and patients' bedside tables. In Yemen, the ED room of the Modern German Hospital had the phrase the "wisdom is Yemen, but the Expertise is German." As directors walk around with trainees (nurses and physicians) they remind them to invoke God in supplications as a reminder and redress. In the hospital in Jeddah, these reminders are engraved and embossed supplications plastered across walls, elevator mirrors, halls, and columns. They include supplications to praise the Prophet Muhammad and to praise God's greatness. In every elevator, the Quranic verse that stands beside the university seal reminds a person that "If you fall ill then God will cure you." There are also supplications for seeking refuge from one's transgression against oneself and for "God to increase my knowledge". There are even reminders that one's gaze is a form of power and one must seek refuge from it by invoking the power and strength of God. The hospital is filled with verses and signs for supplication as a means for the remembrance of God.





Hospital Values

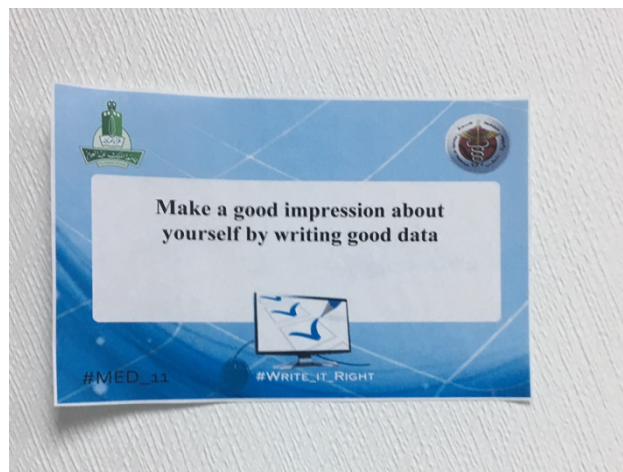
Sincerity and Devotion (*muraqabat allah*)

Sense of Responsibility

Respect Patients' and Staff Rights

Creativity and Progress

The remembrance of God invokes the presence of a veiled watchful gaze that invites everyone within the space to consider their intentions, actions, and relationality toward one another. Just as everyone is invited to observe God, they are also reciprocally observed by him. It places one's position and certainty of their desire, the law, and enactments in doubt, as the divine is an expression of one's limit in knowledge and consciousnesses. It reminds one that God is all powerful, and simultaneously calls into question one's limit, desire, and incapacity in addition to one's influence and detriment.



"If someone sees of his fellow or himself something he adores, thank God for the blessing, for the Evil Eye is true."



“Remember Allah” (Jeddah, Saudi Arabia)



“O Allah, I have wronged myself a great deal, and no one expiates bad deeds except you. Forgive me and have mercy on me, for you are the Oft-Forgiving, Oft-Merciful.” (Jeddah, Saudi Arabia)



Quranic exegesis outside an office (Jeddah, Saudi Arabia)



Quran in the Nurse's Station (Jeddah, Saudi Arabia)



Your presentation is important to your patient (Jeddah, Saudi Arabia)



“Lord grant me knowledge” (Jeddah, Saudi Arabia)

Interlude

The Limits of the Body, the Limits of the Modern Soul

How my interlocutors understand the predisposition of a capacity to knowledge troubles the centralization of the body as site of knowledge in contemporary social theory. The hospitals at which I conducted my fieldwork are all accredited by Western institutions and adopt the latter's protocols in order to meet international standards. Yet, these laws are either evaded or not enforced. This foreign medical regime and its lack of implementation led a group of younger physicians to argue that a forceful imposition of the external (state) law was necessary. Their organizing force was met with much resistance from older faculty who understood the habituation of the law as a question of reforming the soul from within (rather than the requiring discipline and punishment). These alternative conceptions mark the limits of the body in its relationship to the soul: the limit of the body in social theory to account for habituation and discipline. It is precisely with this limit in mind that I return to contemporary social theory on the body, as a generator of knowledge and redirector of desire through discipline. These, I argue, reinscribe a split between the body and soul that does not exist in my field site.

In the opening paragraphs of "Techniques of the Body", Marcel Mauss begins an inquiry on the body spurred by his inability to learn a new style of swimming.³⁷ Similarly, in the closing chapters of *al-Muqaddimah*, Ibn Khaldun speaks to his inability to write poetry.³⁸ Both authors, writing at different moments in history, index a limit of cultivation. Mauss placed that limit on the body; Ibn Khaldun accounts for it by the soul and its inability to perfect more than one craft, however willing the body. This limitation opens onto the notion of a "least" body, which I here explore by rereading Michel Foucault on body and soul.

For Ibn Khaldun, the honing of a craft works in relation to the state of the soul, desire, and the law. Most importantly, the question of the soul is integral insofar it is necessitated by the question of the human and their crafts (formative practices sedimented and received by the powers, passions, and desires of the soul). To better understand the relationship between different habituations of bodies and souls in relation to the environment and building/civilization, Ibn Khaldun contrasts the innate predisposition (*fitra*) of the nomad and the formed soul of the city-dweller. The fortitude and discipline of the Bedouin requires very little habituation compared to the appetitive and intellectual souls of the sedentary. This comparison illustrates how the social organization of a people determines the predisposition of their bodies and souls. Arguing that the human is a product of his habits rather than of his ancestors, Ibn Khaldun observes that while all humans are born with a divinely-endowed natural disposition (*fitra*), the desert-dwellers have remained closer in their habits to this *fitra*. *Fitra* is thus not merely a potentiality but also bears a relationship to the various possible habits.

The Arabic word which Ibn Khaldun employs to explain habituation as a repetition of habit is '*ada*', from a root meaning to return and to repeat. An '*ada*' or habit is a return (regardless of whether one is the subject or object of the return). A propensity to repeat is implied, rather than a conscious decision. A habit is a repeated activity, as too are custom and tradition ('*adat*'). These activities entail a particular form of pedagogy and method but also a form of reception,

³⁷ Marcel Mauss, "Techniques of the Body," *Economy and society* 2, no. 1 (1973): 70-88.

³⁸ Despite his knowledge of poetry, Qur'an, and Arabic, Ibn Khaldun concludes that scientific poems and rules of literary composition "filled his memory and harmed the habit" that he was prepared for through the Qur'an and the tradition. Ibn Khaldun, *The Muqaddimah: An Introduction to History*, trans. Franz Rosenthal (Princeton: Princeton University Press, 2015), 452.

including conditions such as building, the body, the soul, and certain modes of cooperation. Once a habit has been imprinted on the soul, a disposition/habitus (*malaka*) toward a craft emerges and, over time, limits its capacity to be imprinted with another craft to the same extent and depth (hence Ibn Khaldun's difficulty with poetry). The question of habits, habitus, and disposition is not simply of a body, structuring structures, and a field, but also depends on the craft, 'techne,' which a person learns through repetition.³⁹ Crafts, for Ibn Khaldun, subject and form the soul.

The body, in Ibn Khaldun's framework, is bound by the limitations of the soul. Once a craft is formed in the soul, the repetition enacted by the body cannot inscribe a new major habit because of its requirements of duration and memory. Habits are distinct: good habits can override bad ones, but new habits cannot co-exist with longstanding ones that have already been perfected. Once someone has a habit firmly rooted in their soul, they cannot master another without the difficult work of supplanting the former. The inability to habituate a new craft, lacking the capacity of the soul to acquire new patterns, is a corporeal limit.⁴⁰ According to Pierre Bourdieu, the failure of habitus or the emergence of misfires are redirected patterns of thought, but also signal resistance from new conditions of actualization. Insofar the body serves as a site of potential imprints on the soul, it is still dependent on conditions of actualization (the capacity of the soul). Ibn Khaldun limits the body's capacity as a repository and generator of knowledge. However, his understanding of the human, framing habits as corporeal rather than as inhibitors, moves away from a conception of a non-corporeal intellect or intelligible knowledge. The intellect is partly corporeal and requires the discipline of instruction.

According to Ibn Khaldun, *fitra* is the condition in which humans are closest to God; as a person desires (aspires) to hone a craft, she is simultaneously subjected (dependent) to it. Desire is both the engine for repetition and simultaneously restrained by such discipline; it is precisely the mechanism for the return to *fitra*. It is similar to the way *amana* reestablishes the tie of the knot to God. Although this is not fully elaborated by Ibn Khaldun, the fact that over time the dispensation of the law across generations becomes unjust points to the fact that the law can accord with *fitra*. This duality of *fitra* (ground and law, potentiality and actuality) allows for the distinction he makes between the just and unjust law.⁴¹ The divine proximity achieved through law must contain some semblance of the initial state of *fitra* wielded from within, for otherwise the law would simply extinguish the space of desire for the other by refusing to uphold the *amana*.

As Dr. Hakeem indicates above, the external law is necessary when the innate law fails. As I will show in part II of this chapter, he also argues that there is a limit to law (which is why he refused the wielding of the law in the way Dr. Ilham desired). His concern for the life of the next generation echoes that of the Imam in Stefania Pandolfo's *Knot of the Soul*, leading her to

³⁹ One can master a craft, but the multiplicity of available crafts may also lead one merely to their consumption. Mastering a craft also requires restraint in the consumption of other crafts, for indulging these desires leads to the loss of the fortitude of the soul.

⁴⁰ Taking into consideration the role of the body in the habituation of a craft or habits in general and their sedimentation in the soul, it can be concluded that good habits can inhibit other good habits from developing. The soul can inhibit the corporeal accrual of habits as "the soul has been impressed by a habit, it is no longer in its natural state, and it is less prepared (to master another habit), because it has taken on a certain imprint." Yet, one must also distinguish among habits, as Ibn Khaldun recognizes the possibility for the sedentary to reform. Thus the body cannot overextend the soul as it continues to learn and acquire further practical knowledge.

⁴¹ Ibn Khaldun, *al-Muqaddimah*, 95. If coercive domination instills fear, it breaks their fortitude and obliterates their power of resistance (*mana'a*) because of the apathy that develops in the soul (*nafs*) of the oppressed.

also return to Ibn Khaldun's warning against the domination which breaks desire, the engine necessary for the circuit. Pandolfo writes:

In Ibn Khaldun's fourteenth century politico-medical formulation, at issue is a form of domination that rules through coercion and humiliation (*bi-l-qahr*), by disabling, breaking, and instilling fear (*al-ikhāfa*). A form of domination that abducts the desire to resist (*tudhhibu al-mana 'at 'anhum*), by growing in the soul/nafs of the oppressed the deathly vice of apathy (*limā yakūnu min al-takāsul fī al-nufūs al- muḍṭahida*). Resonating with Ibn Khaldun's depiction, "soul choking" is a form of disablement that "breaks the soul," comparable to the intrusion and incorporation of a gaze that murders the self and "sends off the soul" into a realm of the ghostly and the undead. In this sense, it can be conceptualized as a form of failed mourning.⁴²

This notion of the external law as a potentially destructive and less effective means of discipline is taken for granted in Michel Foucault's *Discipline and Punish*. Foucault collapses into the figure of the docile or self-governing body the habits informed by the disciplinary techniques of external laws, the "methods of punishment, supervision, and constraint."⁴³ Since the classical age, Foucault argues, the body is an "object and target of power" that is ritualized through its modern soul.⁴⁴ The shift from the tortured body (sovereignty) to the docile body (discipline) made the body unavailable to self-mastery.

To explain the emergence of the modern soul, Foucault juxtaposes the duplication of the condemned man's body and of the king's body (Kantorowitz). In the Middle Ages, the king embodied the "physical yet intangible support of the kingdom."⁴⁵ By virtue of divine ordinance through judicial theology, the king wields his power through the duplication of his physical and mortal body. The king's duplicate body is a result of the surplus of power (immortal and dominating) provided by divine right. The king's duplicate body is an icon that is recognized and ritually imbued with a set of "demands of the crown."⁴⁶ Beyond the physical mortal body of the present king, the duplicate theological body links all kings across time through the theological excess (surplus power) that is neither external nor internal to the transitory body. The duplicate body of the king determines not only who and when countrymen die, but also who and when can they be exposed to death, as in the case of conscription. In contrast to the king's two bodies, the body of the condemned man was "the least body." The shift in methods of punishment, correction, and regulation uplifted the physical body of the condemned man away from the guillotine and into the enclosed pedagogical space of the prison. According to Foucault, the surplus power of the king's theological body becomes displaced onto the condemned man's body in the prison. The double of the condemned man's body effected by such surplus power is a "non-corporeal" entity, the modern soul.⁴⁷ Whereas the king's surplus power releases the

⁴² Pandolfo, *Knot of the Soul*, 241

⁴³ Michel Foucault, *Discipline and Punish: The Birth of the Prison* (New York: Vintage, 2012), 29.

⁴⁴ *Ibid.*, 139.

⁴⁵ *Ibid.*, 29.

⁴⁶ *Ibid.*, 28-29.

⁴⁷ *Ibid.*, 29. According to Foucault, the *modern soul* is distinct from the soul in Christian theology, resulting from *the condemned man's least body*. The modern soul is not born of "sin and subject to punishment," but "born out of methods of punishment, supervision, and constraint." Foucault argues that the modern soul is neither an "illusion nor an ideological effect," but a "technology of power over the body," suggesting that the effects of a non-corporeal,

kingdom's hold on the king's body, the modern soul imprisons the condemned body, regulating it from within, inverting its older force and producing a least body.

The least body of the condemned man results from the loss of the older juridical theology, a periodization which Foucault takes as fact. In locating the power of governance in the theological-political body, Foucault traces the displacement and implantation of that regulating power. The ritual hold of the modern soul on the condemned man's least body produces what I argue is a modern least soul. Foucault envisions an individual who moves through institutions, gaining instruction and being disciplined and punished. Yet this least body is not generic; it is particular to the prison society whose techniques of power rely on total institutions of pedagogy and discipline. The modern soul travels through various institutions, accruing disciplinary practices and techniques in order to produce a certain docility at the expense of others. Although Foucault's self-governable subject is an extension of the prison's institutional gaze, I would like to also suggest that outside the prison, the body escapes the hold of the modern soul.

My reading of Foucault shows how the least body is not necessarily prefigured outside the prison, for individuals can subvert the very pedagogical and disciplinary techniques that provide its conditions of possibility. The figure of the panopticon that leads many prisoners to internalize the authoritative gaze and comport their bodies in certain ways is not necessarily transposed to other spheres of social life. The least modern soul is thus a soul that cannot completely imprison the body, given the teeming variety of pedagogical regimes competing for sway. The body is not fully imprisoned by the modern soul. The least modern soul struggles to contain the various desires, inclinations, and motivations that stem from within while managing others that are encountered but remain to some degree are un-metabolizable.

In evading institutional forms of surveillance and punishment, the modern soul dilutes to what I call a least soul, opening up to other forms and traditions of self-training and redirection. As my interlocutors describe the predicament they face having to work within institutional protocols and procedures that are rarely implemented, they stress that their medical ethics continues to rely on Islamic understandings of self-formation, orientation, and training. Many of these physicians spoke of their upbringing (*tarbiya*), including a long-cultivated fear of deferred divine judgment (*taswif*), shaping their orientations toward medical-ethical practice. Others desired an external enforcement of the law. Taken together these differing approaches to ethics and law, inside and outside, body and soul are fruitfully explored with reference to Foucault and the work of Talal Asad.

Foucault's account of discipline is of an insidious and pervasive power. "Discipline makes individuals; it is the specific technique of a power that regards individuals both as objects and as instruments of its exercise."⁴⁸ It is a form of power and control of the body's movements and operations that "produces subjected and practiced bodies, 'docile bodies'."⁴⁹ In contrast (although practicing a Foucauldian method), Asad recognizes *disciplina*'s transformative and agentive capacity for medieval monastic practitioners. He defines *disciplina* "as a process at once transitive (the maintenance of proper order by the authorities inside and outside the monastery)

non-substantive soul promulgated by certain forms of power and referential knowledge are articulated through "scientific techniques and discourses and the moral claims of humanism."

⁴⁸ Ibid., 170.

⁴⁹ Ibid., 138.

and intransitive (the learning of proper conduct and the exercise of virtues by the monk).”⁵⁰ Although Asad argues that *disciplina* as a form of self-mastery is exhausted in the contemporary world, he examines its potentiality to form an agentive, obedient will in the medieval monastery. This agency was about the possibility to transform or mold one’s desire, even among other supervening desires, with a particular end in view. On the other hand, Foucault recognizes its fruition inside the monastery as instructing religious practitioners on how to obey God in order to achieve salvation, but does not explore the agency involved in this particular formation of a pious and obedient self. He views the physical training and exercise of and on the body as ways to regulate and calibrate the body according to a given force, in order to achieve certain ends.

Although my interlocutors did not speak of being trustworthy (bearing what is entrusted) through the idiom of self-mastery, the question of trust (*amana*) enfolds exchanges with others into the perpetual task of self-reformation toward perfection (*ihsan*). Discipline is not a one-stop shop for the techniques of the self, because those very techniques are always in and through the other as mediated by God. This question of the other and the willingness to engage the other produced a lot of anxiety, the contours of which I now turn to explore.

Part II

The Law: Is it Simply One’s Own?

In spite of all the discussions I had with physicians about how to become a good physician that emphasized the cultivation of piety and the refinement of character, many felt anxious about leaving the question of the good physician up to the discretion of personal piety. There was anxiety surrounding ensuring a health practitioner’s ethical practice and goodness in the absence of the enforcement of an external law. Among those who felt this were younger physicians that returned to Saudi Arabia from abroad, or those trained in Jordan, as well as Syrians in Jordan and Yemen.

After several months of shadowing Dr. Ilham in the clinic, I sat down with her to speak about her master’s thesis. She recalled when she first began to think about what drives her ethics:

During my residency in Canada, a patient came in, saw me in my hijab and said, “I don’t want a Muslim treating me.” The patient requested a different doctor in front of my supervisor attending. I said to her, “let me treat you and if I fail then you can say you don’t want a Muslim treating you.” I took a thorough history. When I was done, I noticed the patient was in pain and asked her if she needed anything. The patient then looked at the supervisor and said that I was a good doctor. In that moment, I knew I didn’t do it for her [the patient]. I did it for Islam. All she saw was my hijab. It did not bother me. I may have been the only hijabi doctor in the hospital. This is what I learned as a doctor: You are not Muslim, or Saudi, Christian, or American, but a doctor treating with *Amanah*.

For Dr. Ilham it was such unsettling encounter during her residency that shed light on what led her to think about her ethics. Other Muslim physicians training in the West also noted the discrepancy between protocols in the West aiming at ensuring patients’ rights, or as they saw it, protecting the physicians from the patient’s potential malpractice suit, and the stated purpose of such protocols to preserve ethical medical practice. Dr. Ilham’s desire was to both create a

⁵⁰ Talal Asad, *Genealogies of Religion: Discipline and Reasons of Power in Christianity and Islam* (Baltimore: The Johns Hopkins University Press, 2003), 159.

system of accountability that would be legally supported in the hospital, and have that system reflect Islamic ethics rather than the humanistic medical ethics of the West.

Upon returning to Saudi Arabia from Canada, Dr. Ilham recognized the disjuncture between the protocols adopted from Western institutions and the lack of implementation, for the protocols were avoided and evaded informally, through kin affinal relationships and internal networks. She set out to conduct her own qualitative research to produce new ethical guidelines rooted in Islamic ethical practices, but protocols that would be strictly enforced and not easily evaded. She went on to explain that one could not rely on physicians themselves to carry out the *amana*, the ethical task, because the style of education (*tarbiya*) has shifted.

We have lost our identity in our education system. They took away the courses on *din*. We have children that grew up that don't understand what is piety/reverence toward their parents (*birr al-walidaya*). They took away *adab*, humanities in Arabic and teaching the Arabic language and literature.

Beyond the sense of loss of a Muslim identity, cultivation and discipline, the question of ethics within the hospital was generational. Physicians who had recently returned to practice in Saudi after residency and their fellowship abroad demanded to update protocols and streamline practices across specialties. Many younger attending physicians I shadowed felt that senior physicians were unrestrained and did as they please. The senior faculty, on the other hand, felt their practices had yet to be greatly modified as they settled into their work. They felt that the young faculty have yet to experience their obstacles that inevitably awaited them. One obstetrics gynecologist noted that the younger faculty are misguided and lack wisdom that comes with years of practice. They did not understand that the law depended on social conditions.

You have physicians like me, who studied here, did our residency here and our PhD here. When I was first starting out, we had patients who came in and said, you choose for me, doctor. Even when I offered them various treatment and choices, they would rather I chose. But now the patient is also changing. He knows more. But you also have the younger generation of physicians. They studied here but then went abroad to the United States, Canada, Australia, Europe and other places. They brought the knowledge, the practice and culture of the place in which they were trained. Then they start to practice here just as they had been trained. However, over time, you see them change. They begin to understand that these are different patients. Their *tabi'a* (nature) is different. They get married earlier, they have many more kids, caesarean sections, and they develop different infections. We need our own research. Our own protocols.

Younger physicians like Dr. Ilham found the question of ethics inextricable from the question of research and knowledge. However, unlike the senior professors, Dr. Ilham argued that these physicians also utilized excuses pertaining to culture in order to justify their own ends. She explained that senior physicians marry their residents and medical students because it was within their customary right despite the power relations. Dr. Ilham also noted that physicians were rarely reprimanded for their errors and nepotism, as many would defer to God's judgment in the afterlife (*taswif*). According to her, then, the only difference between the ethics reinforced in the West and the ones in the Muslim world was that in the West their punishments are enforced in this world rather than the afterlife.

This question of reformation through discipline and punishment in the phenomenal world was not shared by other physicians. Other older physicians within the hospital had different thoughts about how a physician should receive criticism and punishment. After visiting a couple of misdiagnosed in-hospital patients, the infectious disease attending physician and I discussed the ways physicians should deal with their colleague's errors.

Professor Hakeem first noted that it is natural for physicians to be jealous and envious of one another, so that when they catch an error, they might tarnish the reputation of that physician to gain their patients. Quoting two hadiths from topical compilations on "good manners and etiquette" (*adab*),⁵¹ Professor Hakeem noted that the Prophet Muhammad instructed us not to "spy on one another," become jealous, and look for others' faults. He cited a hadith where the Prophet reprimanded his wife 'Aisha for pointing at Safiya's height mockingly; and another in which the Prophet warned that "if a [bad] word mixed with the sea, it would have rendered it undrinkable." The professor advised that instead of slandering each other, his colleagues should communicate with each other. Although Professor Hakeem is disappointed when his colleague misdiagnoses a patient, he suggested that physicians should reach out to physicians who make clinical errors and update them without correcting them, so as not to crush their pride. It is a prophetic example to teach another without calling attention to their flaws, in order to preserve their dignity. The point is to illuminate the error rather than debase the person who errs.

Securing the tradition in the life of the next generation is envisioned differently by Professor Hakeem and Dr. Ilham. The latter's commitment to reform medical professionalism within the hospital was grounded in both her desire for a more Islam-oriented ethics and seeking justice in this world. The resistance of the older generation, in practice and discourse, to the younger physicians' model of discipline and punish is also not simply a matter of conservatism with regard to maintaining the status quo or merely deferring justice to God. Their resistance is a question of practical wisdom, emphasizing the importance of proximity of the moral law to *fitra* and the difficult methods of dispensing the law in light of desire and in light of unknowledge (*al-ghayb*). As shown further below, this question also resonated with longstanding concerns of the ethics of psychoanalysis.

The Ethical and the Legal

What Dr. Ilham referred to as bioethical violations (such as recognizing a structure of power between teacher and student and the cultural or symbolic practices that evade it) had already emerged for me as a fieldwork question in Yemen in 2013. A bioethicist I was interviewing began to stress the necessity of bioethics as a legal apparatus that should preempt moves to take refuge in Islamic jurisprudence. Doctor Hader explained that bioethics as an institutional practice has only been attended to in the past ten years. He declared that the Yemeni constitution of 1991 (partially drafted by the US⁵²) was more prescriptive in forbidding euthanasia and abortion than local juridical opinions (*fatawa*), for muftis all over Yemen issued fatwas tailored to a person's specific situation. In some instances, these fatwas permitted abortion, which (in his eyes) allowed them to violate Muslim biomedical ethics. I could not find

⁵¹ Sunan Abi Dawud 4917. "Avoid suspicion, for suspicion is the most lying form of talk. Do not be inquisitive about one another, or spy on one another."

⁵² The Yemeni constitution was drawn up in 1991 after the war and unification between North Yemen and communist (Russian-backed) South Yemen. The US made the drafting of the constitution compulsory for Yemen to receive aid. See Abdulla Maktari and John McHugo, "The Constitution of the Republic of Yemen," *Arab Law Quarterly* (1992): 70-82.

anything pertaining to medicine or medical prescriptions in the Yemeni constitution, though it did declare shari‘a to be the law of the land. Even though I was perplexed at this intersection of medical ethics, what is of note here is how he bifurcated the law as a legal apparatus from the ethical decisions we make on a day-to-day basis. Doctor Hader’s preoccupation with bioethics as a question of what is legal (public), as opposed to the individualized fatwa (private), is similar to juxtapositions I found in the hospital in Jeddah, Saudi Arabia.

A younger colleague who also advocated for the streamlining of oversight similarly distinguished between the legal and ethical—though with somewhat different implications. Dr. Anwar, an oncologist, recalled his first bioethics course at the university medical school before traveling to Canada for residency and his fellowship in oncology. His professor introduced medical professionalism to the class:

In medical professionalism, you have doctor-doctor professionalism, doctor-patient relations, and a relation between you and yourself. If you see yourself in the mirror and you don’t like what you did, then, you have to look at your day.

I asked the oncologist what happened when a physician looked himself in the mirror. What was his judgment based on? What did the physician expect of himself? When the exceptional physician goes home and looks in the mirror reflecting on how he came up short, what is the basis for that judgment? Dr. Anwar responded by commenting on my framing of the exceptional physician’s consciousness.

The example of the exceptional doctor, I think the way you said it is in a negative way. I would rephrase: what could I have had done better? Is there something else I can do? There’s no ceiling to ambitions. When you reflect, you are asking, are you satisfied? Yes, I am satisfied. What is the impression, though? There’s no ceiling on what a human being can do.

Picking up on the way Dr. Anwar distinguishes between ambition or desire and satisfaction, I asked the oncologist what informed his philosophy of there being no inherent limit to human potentiality. He responded:

There’s definitely no ceiling to whatever you do. Imagine anything in your life you do right now compared to what you thought you would do, ten years ago. I never thought I would become a physician, but my ambition improved. I never thought I could become an administrative person, but my ambition moved up. There’s no ceiling for motivation. Yet there should always be a point where you think what you did is satisfying or unsatisfying. That is what I believe is the most important thing. Part of that is so that you don’t harm someone passively or actively. That ensures you did all that you can for a person. If you have [such conscience], that it is enough. Or sometimes you can get a negative message.

I received a text message while I was in Malaysia in January. I got a message from a patient’s relative that said: “On the Day of Judgment I will ask Allah to take away from you [due to] what you did to us. I am looking at my brother’s children who ask me where is their father. I said there’s one criminal person who did that to your father.” I was

looking at this message, the first time I received such a one. I remembered that patient very well, he would come without an appointment from Medina. I had given him all the options of chemotherapy treatments. Initially I planned to fire an angry message back to [that relative]. But then I wrote: “I hope your brother is in peace right now. God willing, I did not do anything to your brother that would make me worry about Judgment Day for what I did to your brother.” After receiving the message, I was really angry, but then thought, why should I be angry. I think I did the best for the person. If there is anything else... I was trying to think, not to blame myself, but to think if there was something else I could have done better for that person.”

I asked him to clarify the threat he received. The oncologist responded:

He is threatening toward Judgment Day, which for us is sometimes more than a legal threat. But in the end, I put things in pieces. You just take it in a positive way. Everything is done and over—but could there have been something better? Legally there was nothing, but ethically, I thought about whether there was anything else I could have done for that patient. But I did not find that part to apologize for.

When I asked Dr. Anwar what it would mean for God to take something away from him on Judgment Day, he explained that in the deceased patient’s brother was finding the physician culpable for a wrongful death and alluding to the law of talion (*qisas*). The oncologist said,

All the decisions I made, the treatments I came up with for the patient [his brother]—[he is implying] that God will do the same onto me. He thinks I treated his brother in a wrong way that made him die. Technically [he invoked] *qisas* (retribution, restorative justice). [This means] if you kill someone then you take their place. On Judgment Day, God will take away what I took away from them. [But] I took it in a positive way. When you give people your phone number, you expect these messages to come. Imagine how many other positive messages outweigh that one, it’s enough.

The problem of culpability in the hospital (see Chapter 4) led our discussion toward the question of God’s deferred punishment. This deferral, although veiled, was used by patients and their relatives as a threat much more than the threat of a legal suit. It is these threats and imprecations that drive the self-reckoning of the physician and the cultivation of his ethics, all in relation to an other through the mediation of the non-phenomenal Real. The oncologist continued:

Many patients do refer to God’s justice on Judgment Day. Yet, it is a law I am following. They need to understand that. Even in threatening me in this way, Allah can take my right from you [speaking of the threatening patient]. You don’t have the right to do that.

Dr. Anwar pointed to the unfolding of ethics as the question of a person’s decision or act toward the law. This is always a decision made in relation to another person’s desire and demand, mediated by God’s deferred judgment. Despite the patients’ demand of Dr. Anwar, to not follow the law would also be subject to God’s judgment. As such, a demand made between two people is a question of competing desires before the law, the ethical space between the two

people, and the judgment of the all-knowing God. What is tricky here is that Dr. Anwar's pronouncement—that he reserves the right to follow the law, even at the expense of defending the law against the possible oppression of another—could be taken for granted if his ultimate desire was the law itself. But his own taking-stock of his treatment toward patients and deliberate self-accounting tell a different story. Dr. Anwar did not simply seek the approval and pleasure of the hospital board of supervisors. Ultimately, the judgment of the all-knowing God loomed over him as well, as he continuously acknowledged his own limit to perceive the Good. Therefore, ethical decisions presented before Dr. Anwar required discernment of whether the bounds of the law can accommodate the demand of the other, without requiring his transgression of the law.

This distinction between the legal and the ethical should be understood alongside the way Dr. Anwar constructed the unmet ceiling of the Good. There lay so much space between the ethical and the legal—this is the very space that Dr. Ilham and others were attempting to close, even if in practice. Yet, they seem to demonstrate the very impossibility of closing that gap, which only expanded through both the patient's imprecations threatening God's judgment and the physicians' recourse to their ethical claims.

I wondered whether such threats were frightening for Dr. Anwar, to which he responded by rationalizing the situation. Even so, even if he doubted the basis for the patient's claim against him, Dr. Anwar weighed whether he was unjust. He clarified further:

If you deal with them in an unjust way, then Allah will take it [justice] away from us [on Judgment Day]. You have to ensure that no injustice befalls them. It is like injustice at court. However, on Judgment Day everything is different because nothing is hidden. It is the same court, but every evidence is ready to be supported for you or against you. You risk the erasure of your good deeds, your rank in heaven, whatever deed you did.

What is at stake in Dr. Anwar's self-reckoning is the necessity to remain distant from either party's partial claims to the Good (whether physician or patient), as a question of a hidden, eschatological demand (*al-ghayb*). This distance calls into question teleological approaches to the cultivation of ethics. That the Good is veiled, available only in its traces, led me to an engagement with how Das Ding is unknowable in Lacanian psychoanalysis. Dr. Anwar's question was not merely about the role of justice in the law, but about the eschatological divine justice and its knowability in this life.

Within the hospital, there is a bifurcation of law and ethics. More importantly, this bifurcation bears on the path of guidance to establishing justice and order on earth (*shari'a*) and its proper dispensation. Shari'a involves an understanding of creation (*takwin*) and responsibility (*taklif*), which is a question of understanding God's habits in the creation of nature as a way to appreciate the obligations set forth in the Qur'an. As a person comes to know the habits of God, understanding their patterns in nature, its physics, she comes to appreciate the patterns in law that govern human action.⁵³ As the study of physics continues to evolve, its central wisdom remains: the laws of nature continue to be in harmony with the laws of shari'a. This cosmology continues to be linked to a cosmogony.

In this chapter, and attempting to follow the physician's professional and ethical conundrums surrounding the law, in the hospital and in biomedicine in particular, I have linked the distinction between law and ethics (as seen within the hospital) to an anxiety over the demand for the divine trust (*amana*). By contrast, the literature on the anthropology of Islam has

⁵³ Murata and Chittick, *The Vision of Islam*, 63-68.

frequently attributed the separation of the ethical and the legal to the colonial and post-colonial compartmentalization of nation-states and their codifications and revisions of shari'a jurisprudence.⁵⁴ Although the Ottoman *tanzimat* attempted to introduce new court structures in Yemen, these reforms only applied this civil code in provincial sharia courts.⁵⁵ In Yemen, the authority of the jurist, especially as tied to tribal structures, persists even through the present conflict. For its part, in 1993 Saudi Arabia adopted from the Ottoman empire the office of a single Grand Mufti to issue fatwas that become applicable to all citizens.⁵⁶ On the other hand, Jordan integrated British law while under colonial rule and ratified its monarchical parliamentary constitution in 1952. Granted these varying degrees of legal systematization and reform, in each of these sites bioethics as a problem-space unearths the ethical as an uncontainable excess of the legal apparatus.

The conventional narrative regarding the loss of traditional ethics in the West posits that post-Enlightenment man (in contrast to Greek antique or monotheistic man) no longer looks to the cosmos for ethical wisdom. Jacques Lacan too points to the contemporary evacuation of the cosmos from modern western ethics—but only to demonstrate the limits of this narrative. Insofar as ethics has always involved the question of pleasure in the pursuit of the Good, it will always implicate humans in various ways. As seen in the next section, Lacan revisits the question of the Good in traditional ethics and how human desire and the law are already knotted in the path toward the Good. He thereby implies that the question of the ethical was always already in the human. It is through this exploration that I examine the younger physicians' desire for a reinforced legal apparatus—a desire that is undermined by their own ethical cultivation which *amana* demands.

Traditional Ethics and the Ethics of Psychoanalysis

In *Wisdom of the World*, Remi Brague follows the relationship between physics and ethics from the Greek to the contemporary period, to show whether the knowledge of the world still dispenses wisdom for moral guidance and action. Within Islam, and the monotheistic and Greek Traditions, a cosmology was always linked to a cosmogony, a story of origins. Brague demonstrates how the world produced ethical guiding models for the cultivation and reformation of the soul.⁵⁷ In knowing the world, a person comes to imitate it. From writings on the cosmos

⁵⁴ Saba Mahmood, *Religious Difference in a Secular Age: A Minority Report* (Princeton: Princeton University Press, 2015); Talal Asad, "Religion, Nation-state, Secularism," in *Nation and Religion: Perspectives on Europe and Asia* (1999), 178-196; Hussein Ali Agrama, *Questioning Secularism: Islam, Sovereignty, and the Rule of Law in Modern Egypt* (Chicago: University of Chicago Press, 2012).

⁵⁵ Brinkley Messick, *The Calligraphic State: Textual Domination and History in a Muslim Society* (Berkeley: University of California Press, 1996), 55. Messick also notes: "In 1975, a commission of shari'a jurists, composed of men who had trained either on the Shafi'i manuals of al-Nawawi and Abu Shuja' or on the Al-Azhar text of the Zaidi school, was created to participate in the drafting work connected with *taqnin*, the legislative restatement of *shari'a* materials in the Yemen Arab Republic.[45] Under Ministry of Justice auspices, this activity was defined as the "legislation of Islamic *shari'a* principles in the form (*shakl*) of modern codified laws appropriate to the spirit of the age and its requirements." [46] The republic had known no impositions or receptions of Western code law, and its legislative efforts were being initiated in a postcolonial era of questionings of Western values and reassertions of indigenous ones. The Muslim world climate was one of emergent fundamentalist movements and efforts to reintroduce the *shari'a*. As a guiding principle, the 1970 Permanent Constitution identified the *shari'a* as "the source of all laws" (Art. 3).[47] (68).

⁵⁶ Frank E. Vogel, *Islamic Law and the Legal System of Saudi: Studies of Saudi Arabia* (Leiden: Brill, 2000).

⁵⁷ The Epicurean atomist tradition was the exception, positing a physics of multiple worlds and so dissipating its possible wisdom.

and the celestial bodies, a psychology—a theory of the soul—resembling the movement of the heavens emerged within the Greek tradition and the subsequent Arabic philosophical and theological traditions. According to Lacan, the return of the stars to their places promised a corresponding kind of repetition for human beings. Through repetition a person would be able to return again and again to the ethical Good, aiming for her pleasure. However, Lacan argues, this Good is in actuality evil or Das Ding.

In *The Ethics of Psychoanalysis*, Lacan argued that the modern emergence of Freudian psychoanalysis marks the return of “a deep connection between our images and the world that surrounds us.”⁵⁸ It has caused the whole world to reenter us. That is, to put us back in its place, that is to say, in “our body, and nowhere else.” He writes: “For a long time even in scientific thinking, men seemed to inhabit cosmological projections. For a long time, a world soul existed, and thought could comfort itself with the idea that there was a deep connection between our image and the world that surround us.” Lacan argues that it is the very demand of Das Ding, the Thing or the Good, that sets into motion the demand for repetition, returns, and to the same place, as a “security of a return.”⁵⁹ Ethics is not simply generated to deliver the Thing, but the Thing demands a repetition that would guarantee its return. Ethics is not the guarantee of the Good, but of the evil Thing. According to Lacan, Freudian psychoanalysis’ focus on the Thing and the return of the world into us points to the reinjection of the soul, of energy, of desire in the contemporary. The task of psychoanalysis is to “restore the productive function of desire.”⁶⁰

While Brague objectifies the relationship between the good and its model (the law) as a simple one-to-one relationship, Lacan argues that traditional ethics centers the Good as the ultimate object of desire whereby the law becomes the path that promises its pursuit, guarantee, and return—and in so doing already makes the Good an obstacle in the path of desire. In traditional ethics, pleasure resulting from good work occurs by a person’s deferral of desire through sublimation rather than through actualization of the ideal good. The simple link between pleasure and the Good in traditional ethics does not admit the duplicity of pleasure itself: the pleasure of the Good at the cost of one’s desire and the desirous transgression of the Good for a painful pleasure. Lacan follows Freud in expounding the function of pleasure as a limit, regulating the distance between the subject and the Thing.⁶¹ The attainment of the Good results in unpleasure, which leads Lacan to repudiate the possession of the ideal good as the attainment of pleasure.⁶² Instead, a person seeks pleasure by moving from signifier to signifier in the form of a trace.⁶³

Although physics shifted during the European Enlightenment, Lacan continues, delinking cosmology from cosmogony and silencing the stars, Freudian ethics is not a humanist ethics. Lacan’s own re-reading of Kantian ethics in light of Newtonian physics decenters it from the

⁵⁸ Lacan, *Ethics of Psychoanalysis*, 92.

⁵⁹ Ibid., 75.

⁶⁰ Ibid., 3.

⁶¹ “The function of the pleasure principle is, in effect, to lead the subject from signifier to signifier, by generating as many signifiers as are required to maintain at as low a level as possible the tension that regulates the whole functioning of the psychic apparatus” (119).

⁶² Ibid., 230.

⁶³ Lacan argues “that the unconscious is structured as a function of the symbolic, that it is the return of a sign that the pleasure principle makes man seek out, that the pleasurable element in that which directs man in his behavior without his knowledge (namely, that which gives him pleasure, because it is a form of euphony), that that which one seeks and finds again is the trace rather than the trail—one has to appreciate the great importance of all of this in Freud’s thought” (ibid., 12).

Good of traditional ethics. He argues that Newtonian physics reintroduced the weight of the Thing (the Good, but as he ironically shows, in fact evil), and as a result heightened the importance of motion and energy in the course of this relation.⁶⁴ Although a Kantian triumph of pure reason would seem to entail a usurpation of the world as a site for knowledge and disclosure, it also introduced the laws of nature.⁶⁵ In the same way that nature is governed by fundamental laws of motion, so too now (following Newton) humans are governed. In Newtonian physics, a body moves according to the force that propels it forth. Unless a greater force intervenes, it tends to continue the movement according to the stable ground resisting change over time. To shift course, there needs to be a reorganization from within. In the tenth century Ibn Sina already considered the soul in terms of physics and motion (albeit not in a physical model then applied to human nature).⁶⁶ In the case at hand, Newtonian-Lacanian ethics envisions movement from within rather than through an imposed external force of the law: the very problem that would come to weigh so heavily on the physicians with whom I worked.

To understand the question of the force of law, its regulation of desire, and its relation to action, I turn to Lacan's writings on desire and the law in the *Ethics of Psychoanalysis*. Insofar as contemporary society exerts itself on a person's drive through the moral law, the individual redirects her excess libido through sublimation. For Lacan, the moral law is paradoxical. Through its very prohibition, it brings out a person's most intimate desires.⁶⁷ In Lacan's account, certain objects are pursued not by virtue of any intrinsic property, but by the mere fact that they are phantasmatically raised to the level of the Thing (Ding). Their sublime quality comes from their position within the symbolic structure of fantasy. Therefore, sublimation does not entail redirecting the drive to another object, as argued by Freud, but by shifting the position of the object within the symbolic structure of fantasy.⁶⁸

The lure of the Thing, conjoined by its power, force, and enigma ignites both the person's will to create from nothing (ex-nihilo), but also threaten her with death. For Lacan, the Thing seduces, flares, and drives a person towards it "by means of the law."⁶⁹ The person's drives can never be fully satisfied as they are also partial manifestations of desire. Therefore, the inaccessibility of the Thing and the unsatisfied nature of the drives make sublimation ultimately incomplete. Desire will continue to reemerge because the status of the Thing in the Real is ultimately unknowable. Sublimation itself regenerates; it gives rise to another signifier rather than resulting in repression.⁷⁰ As a consequence desire is permanently displaced and hence kept alive. The absence of sublimation results in repression in neurosis, foreclosure in psychosis, and disavowal in perversion.⁷¹ Although the law drives one's desire, Lacan warns that it might lead

⁶⁴ Lacan, *Ethics of Psychoanalysis*, 76.

⁶⁵ Ibid., 77.

⁶⁶ Robert Wisnovsky, *Avicenna's Metaphysics in Context* (Ithaca: Cornell University Press, 2018), 88.

⁶⁷ Lacan, *Ethics of Psychoanalysis*, 89.

⁶⁸ Ibid., 293.

⁶⁹ Ibid., 83: "Is the Law the Thing? Certainly not. Yet I can only know of the Thing by means of the Law. In effect, I would not have had the idea to covet it if the Law hadn't said: 'Thou shalt not covet it.' But the Thing finds a way by producing in me all kinds of covetousness thanks to the commandment, for without the Law the Thing is dead. But even without the Law, I was once alive. But when the commandment appeared, the Thing flared up, returned once again, I met my death. And for me, the commandment that was supposed to lead to life turned out to lead to death, for the Thing found a way and thanks to the commandment seduced me; through it I came to desire death."

⁷⁰ Ibid., 293.

⁷¹ Jacques Lacan, "Science and Truth," in *Écrits: The First Complete Edition in English*, trans. Bruce Fink (W.W. Norton & Company, 2006), 726-746.

to evil, asking what should be the ethical relation to the moral law rather than what is the ethical relation from the moral law.

In his writings on the ego, Lacan argues that no one is ignorant of the law, even if the law cannot be grasped in its entirety: “censorship is always related to whatever, in discourse is linked to the law, insofar as it is not understood.”⁷² He extends this to Islam by recalling the case of a Muslim man who complained of writer’s cramp. Through analysis, Lacan tied his symptom to both the fact that his father had been accused of being a thief and the Quranic injunction that a thief must have his hand cut off. Lacan argues that the emergence of the symptom is due to censorship “since the law is never completely made one’s own.”⁷³ Since the patient could not “stomach” why in Islam a thief’s hand is to be cut off, his “whole of his relation with his original milieu, everything solid, the judiciary, order, the basic coordinates of the world were barred.”⁷⁴ Lacan ties the cramp of the hand, representing the inability to write, to speak, to exchange, to the inaccessibility of a symbolic structure resulting from the inability to understand the law. Whereas Lacan argues that the nature of a person is that he will never master the law, I want to explore how Lacan also takes for granted the nature of the law in Islam, as it already prefigures this lack of mastery.⁷⁵ If we take Lacan literally, what might we discover regarding Dr. Anwar’s guilt and the status of the law in Islam?

First, we might discover that the corporal punishment for theft is found in a verse followed by mention of God’s mercy upon those who repent and reform after wrongdoing. Historically, this punishment was famously suspended by the third caliph, ‘Umar Ibn al-Khattab, in time of famine, suggesting a more complicated relationship between transgression and social conditions. Moreover, prescriptive and discretionary laws derived from the Quran are difficult to enforce and require a strict evidentiary threshold.⁷⁶ Examples from the Prophetic tradition tend to encourage restorative justice and redress of harm. In the case of retribution (*qisas*) invoked by Dr. Anwar (the law of talion), the family of the victim can choose to forgive, receive compensation, or enforce capital punishment. The dispensation of the law does not fall onto a subject from an abstract institution, but occurs on the ground among the parties involved.

The doubt that contributed to the symptom in Lacan’s case came not from the law of the Qur’an, but from what Lacan himself calls the inability of a person to master the law of discourse or to make the law one’s own. The Qur’an itself enjoins those who do not know to seek knowledge of the law from those who know, as well as forbidding those who do not know from following injunctions blindly.⁷⁷ This ability to occupy the position of the one who does not know

⁷² Jacques Lacan, *The Ego in Freud’s Theory and in the Technique of Psychoanalysis, 1954-1955*, vol. 2 (New York: WW Norton & Company, 1991), 127.

⁷³ Ibid., 130.

⁷⁴ Ibid., 129.

⁷⁵ “O you who believe! Ask not about things which, if made plain to you, may cause you trouble. But if you ask about them while the Quran is being revealed, they will be made plain to you. Allah has forgiven that, and Allah is Oft-Forgiving, Most Forbearing” (Q. 5:101). This verse forbade the believers from asking the Prophet about matters concerning which God had not ruled; splitting hairs and asking too many details might lead to things being prohibited, which would cause them hardship. It also forbade the companions from asking about things that were hidden from them which would upset them if they came to know them (e.g., the security of their lineage).

⁷⁶ *Shari’a* is designed in a way that it is difficult to enforce. Yet, the severity of the punishment is meant to reflect the abhorrence of the acts. *Shari’a* law is a totality of law. One cannot, in theory, enforce the penal law without taking into account the criminal’s condition, which might have predisposed him to such transgression.

⁷⁷ “Before you, also, the messengers We sent were but men, to whom We granted inspiration: If you do not know, ask of those who possess the Message” (Q. 16:43); “(O man), do not follow that of what you have no knowledge. Indeed! the hearing and the sight and the heart—of each of these it will be asked” (Q. 17:36).

is thus given its own possibility, something that Lacan himself believed the neurotic must accept in order to be guided by the analyst.

I use this example to explore the relationship of the law to desire in Islam with regard to psychoanalysis, which in this instance draws from Lacan's reading of the law in the Bible and Kantian ethics. Lacan argues that desire erupts by means of the law, and as such is not a means toward the law. Desire directs the person to a space beyond the law, the place of Das Ding. Lacan reads transgression as the crossing of a limit or threshold for biblical commandments whereby there is either sublimation, enjoyment of one's libido through transgression, or the repression of desire. The space "beyond the law" becomes the rediscovery of one's relationship to Das Ding.⁷⁸ For Lacan, the Thing flares up whenever the law is evoked. What Lacan also reads in Kant is the enjoyment of the law; by asserting the law as one's own, a person engages indirectly with Das Ding as a submission to the unknown, the Real.

In contrast, in Islam, it is within the space of law itself that a person continually engages with Das Ding. Yet desire is also a means to the law. Desire is here resulting from the reception of *amana*, the ability to have free will and the ability to discern with respect to desire. Equally important is the desire of the other, as a person must maintain and return the *amana* with respect to the unknowability of God's will and desire. The expression of God's law on earth will always produce a gap with respect to the needs produced by social conditions. As such, transgression in Islam with respect to *amana* is a question of discernment, discerning the signs of God; but it is also the unjust foreclosure of the space necessary for the expression of another person's desire, which is an endowment from God. In Islam, human desire is not seen as antithetical to the law; as Dr. Anwar states, one must not be unjust with the patient. It is through discernment that one can be mindful of implementing a law that does not crush another person or extinguish their desire, as in the famous precedent of 'Umar suspending the punishment for theft when social conditions demanded it. Therefore, guilt does not simply result from failing to meet the demand of society, superego, or ego-ideal, but it is also grounded in the Real, by lack or need itself. According to Lacan, guilt generated by religious prohibition usually locates the lack in the person. However, we see with Dr. Anwar that this does not occur here. Let us return to his evaluation of his treatment of the deceased patient.

Dr. Anwar did not believe that he was culpable for the patient's death. What compelled him to revisit the case was the fear of God's judgment in the hereafter. He stressed that what led him to account for his actions (*muhasaba*) was an ethical rather than a legal commitment. As a result, he often embarks on a form of ethical self-accounting due to the unknowability of God's desire and will. As we saw above, Brague's own exploration of the question of knowing the divine, the law, and the world in Islam ultimately refers to the realm of the unknown (*al-ghayb*).⁷⁹ As such, according to Brague, a person's relation to knowledge of the world, the laws

⁷⁸ Lacan, *Ethics of Psychoanalysis*, 84.

⁷⁹ Brague notes that in the Qur'an the discussion on the human's "harmonious form" goes hand in hand with the discussions on the signs that guide it, which are located both in the world and in the soul (*nafs*). Humans' perfected form grants them faculties, senses, and intelligence to decipher these signs, rendering the signification of the sign a tool for memory (*dhikr*) (*The Wisdom of the World*, 58-59). The inhabitants of the world are all connected through Allah and the connections are "through nature as divine goods"; "Allah created the heavens and the earth to establish the truth. Surely in this there is a sign for the true believers." The renewal of the earth too is a sign and site for the production of signs. The interwoven relationship between the creation of the earth and the heavens, the signs that they emanate, the signs that rest in the soul, and the physical composition of the human all reaffirms the implication of a coming into being with knowledge that initially began with Adam learning "the Names" of all things. Coming into being with knowledge thus transcends this world, temporally and spatially.

of nature, and the divine as a means to the ultimate object of desire is barred (or withdrawn into *al-ghayb*), but open to the search for signs.

Dr. Anwar even warns against the imposition of the law upon the patient. He argued that a physician must not be unjust to patients even if the law so advised. He was clear that following human law could result in the transgression of divine law, which is open to *al-ghayb*. As he concluded, he tried to examine whether he was just, a divine attribute that he extended to his patients so that God extends his justice on Judgment Day. Dr. Anwar's commitment to justice is also the key to bearing the divine trust (*amana*), so that it is returned as it was given.

Dr. Anwar acknowledged the limits of his treatment, the knowledge of the illness itself, and the patient's brother's knowledge. He referred to the clarity and transparency of the accounting on Judgment Day because then everything will be unveiled. What compelled him to ethically take stock of his actions is the anticipation of the eschatological disclosure of what is hidden in this world. His fear and displacement of blame away from himself comes from the distancing of what the greater good could have been. Instead of seeking the Good, what he sought is justice in the face of the knowledge he had at hand. Dr. Anwar's discussion of an ethical act as one being addressed to the Real rather than to societal expectations, some beneficial reward, or any worldly future is in line with Lacan's reading of ethics. Just as Lacan finds desire at the limit of the law, he also purports to inherit the Christian ideal of goodness for goodness's sake and no other. An ethical act must be carried for its own sake. The difference with Dr. Anwar's discussion of the ethical act is whether human law is just with respect to divine law. There appears to be a doubling of the law and no sense of clear transgression marked here except by the impossibility to know what God demands, which already presumed a lack.

This gap (space of the other) is not just simply a question of patients' demands intervening into the hiatus between law and ethics, but also of how that demand falls on oneself as a person with respect to his own desire. Dr. Anwar acknowledged the limit of his meeting patients' demand as an administrator bound by the legal apparatus. He spoke of the transgression upon his rights in the eyes of God when being called to transgress the law of the state. His desire was also at stake. He recognized his desire not to transgress the mundane law, but also to navigate that desire with respect to Divine law and Divine justice. The gap between a person's act, the other's demand, the beneficial Good, and God's justice is a question for every party involved. Here, the desire for God's justice in the afterlife allowed Dr. Anwar (as he put it) to put the pieces together in order to understand how to navigate his patient's demand, the demand of the law, and his desire. By conducting an ethical self-accounting, as he phrased it, he regenerated his desire for another journey with another patient. It is in this sense that I suggest Lacan's idea of incomplete sublimation has been misread by some as implying a repression of desire. The overpowering of the drive by the moral law does not allow for sublimation and results in either repression or neurosis. Incomplete sublimation is the function of the regeneration of desire rather than its repression.

By exploring how Dr. Anwar dealt with the fear of God, I have examined how he already presupposed lack as a question of *al-ghayb* and unknowledge. The physician's approach to self-accounting does not fit neatly into Lacan's three forms of sublimation. Dr. Anwar did not place the lack simply within himself (religious sublimation) or in the other (aesthetic sublimation), nor was it foreclosed (ethical/scientific sublimation). The question of unknowledge, rather, already presupposed a lack and prevented a foreclosure/deferral of the question of truth, as being a judgment of God in the afterlife.

Lacan does not follow Freud in positing the possibility of full sublimation. This is in fact on par with Islam, as we began the chapter on a meditation on *amana* as inscribing a lack within the person. Whereas Lacan situated the split of the subject—marked by a person’s self-distinction from the maternal body and the fuel for a desire for the mother which is barred, always producing a lack in sublimation⁸⁰—in Islam, lack results from the acceptance of the primordial covenant, the *amana*, the removal of the soul from the divine pool, and its entry into the fetus in the mother’s womb.⁸¹ The distinction between the split that occurs with respect to the mother in Lacan and with respect to the reception of the *amana* in Islam, is the visioning of the repetition of lack as potential and open to sublimation or inevitable wounding in the barring of desire. Therefore, a primordial cut could only lead us to understand that sublimation itself can never be complete.

Whereas desire is central for Lacan as a question of the law, I argue that in Islam, responsibility (*amana*) itself is central, implying a question of the force of the soul. To be proximate to God, is to be alive. Without desire, a person is not accountable or responsible for her actions (*mutakallif*), they not the generator of their act. Without the law a person is not alive, at least symbolically, as a person.⁸²

More importantly, the access to such self-accounting is opposed to the form of reformation that would occur through an enforcement of an external law, through an imposition of the moral law. Here, I want to echo the wisdom of Professor Hakeem regarding reformation and the habituation of the soul as necessary from within. Although Dr. Anwar and Dr. Ilham stress the necessity of the external law as the form of ethical engagement and introspection requiring forms of instructions which they believe are waning, the alternative is antithetical to the cultivation of ethics spelled out in Part I of this chapter. Habits are formed slowly, over time, through repetition, while the rousing of conscience is out of a self-accounting to God rather than a fear of human authority. Reformation, then, is simply a rehabilitation, a re-habitation. As Professor Hakeem stressed, the proper rectification of another’s person’s action is indirect, and thus does not involve debasement.

The Enigma of Desire

⁸⁰ Jacques Lacan, “The Mirror Stage as Formative of the I Function,” in *Écrits: The First Complete Edition in English*, trans. Bruce Fink (New York: WW Norton & Company, 2006), 75-82.

⁸¹ There are lots of commentaries on the Prophetic tradition on the soul’s recognition of other souls: “Spirits are like conscripted soldiers: those whom they recognize, they get along with, and those whom they do not recognize, they will not get along with” (recorded in *Sahih Bukhari*). In one citation: “Ibn Hajar, the noted medieval Shafi’ite Sunnī exegete, commenting on this specific *ḥadīth* notes: ‘It could be that what is being referred to is the beginning of creation in the realm of the unseen (*ḥāl al-ghayb*) when, it is reported, souls were created before bodies (*al-arwāḥ khuliqat qabl al-jasām*), and used to meet one another and express their pessimism about the future. When souls have entered bodies (come to the physical realm) they may recognize one another from the past, and may be on friendly terms or otherwise based on that past experience,’” in Bradley J. Cook, “Pre-Mortality in Mystical Islam and the Cosmic Journey of the Soul,” *Dialogue: A Journal of Mormon Thought* 50, no. 1 (2017): 31-56.

⁸² Jacques Lacan writes: “Is the Law the Thing? Certainly not. Yet I can only know of the Thing by means of the Law. In effect, I would not have had the idea to covet it if the Law hadn’t said: ‘Thou shalt not covet it.’ But the Thing finds a way by producing in me all kinds of covetousness thanks to the commandment, for without the Law the Thing is dead. But even without the Law, I was once alive. But when the commandment appeared, the Thing flared up, returned once again, I met my death. And for me, the commandment that was supposed to lead to life turned out to lead to death, for the Thing found a way and thanks to the commandment seduced me; through it I came to desire Death” (*Ethics of Psychoanalysis*, 83).

At the end of all my interviews, I often asked what I initially thought was a diversion from otherwise serious questions about ethics, expertise, and mistrust in medical practice. I asked, What made you want to be a doctor? While many of these doctors had physicians or prominent scholars in their families, their answers pointed to the role of contingency and the unexpected in how they turned to a science track in university (many of the southern Arabian and Levantine universities are modeled after the European system). There are a lot of assumptions about why one becomes a physician. Yet, several of the ones I spoke with did not mention their professional choice as motivated by pursuing a noble cause, for the sake of saving lives, curing people, and doing good. Many did not even speak generically of making a difference, for there were clearly many other ways than medicine to do so.

For the majority of the physicians I worked with and shadowed, medicine was not the first choice. Many had registered as engineers, mathematicians, and architects, but were later compelled toward medicine—taken over by some feeling, a projection, suggestions, and assumptions. It is as if they were called upon rather than found a calling. In the way they recounted their life histories, these physicians (much like prophets) did not choose their path. The path chose them.

Story 1

“I took my application to the registrar’s office at the university. At the time, one applied by paper. I told my parents I did not want to be a physician but an engineer. My parents saw how adamant I was and accepted my decision. I handed my paper application to the registrar. The registrar saw my high school grades and said, “Medicine, right?” I did not say anything in return. It felt odd. I had filled out engineering, but this intervention felt important. I did not respond. I felt that maybe this is *khayra* (the choice of God or fate denoting a better path). I went home and my mother was shocked that in the end I went into medicine, because I had made it such a big deal that I was going to choose engineering.”

Story 2

“Life is full of surprises. When I finished high school, I came to the university to apply to the school of mathematics. The first day of school, they weren’t accepting for that department, only for medicine. Because I had driven for an hour from Mecca, I decided to apply [that day regardless,] for medicine. After medical school, I applied for oncology. I decided to take the first post. Yet until now [despite these fortuitous circumstances], my passion remains math. Until now, I still think that I am exceptional in math. In math, you have unlimited time to work out a solution. In medicine, you have to come to a decision quickly, without the variables and the numbers.”

Chapter 4: Physicians, Magicians, and Prophets: Effectiveness of Medicine and Magic

The Throne Verse (Q. 2:255) refers to a Quranic passage that persons can recite daily to protect themselves from evil, whether it be that of people, creatures, or jinn. These verses are read upon oneself or for another person, such as children, parents, and loved ones in illness or in health. The verses provide protection for the reciter and recited upon by producing a barrier or fortification (hisar) and disarming the agency of potentially harmful beings by assigning the ultimate causality to God. They begin by attesting that God is the only God, the living, the self-subsisting, the eternal. By reminding the reciter of God's omnipresence and sovereignty over everything contained within heaven and earth, and God's knowledge of particularities, the verses and their enactment create a space for God's potential. God is not seized by sleep, knows what appears in front of and behind every creature, oversees all forms of causes and intercessions, and feels no fatigue in guarding and preserving them. The reciter or those recited upon are invited to reside within this space of refuge and submit to what may befall them or may not. Residing and submitting is a double movement that forces the powers of non-human beings to potentially wane, but also encompasses them within the jurisdiction of providential law, so that one may be saved in this life or be rewarded for their ordeal in the afterlife. These verses are meant to strengthen the recited upon and reciters' will in relation to God, but also warn them against the illusory power that may wield itself in relation to other beings, other humans' evil acts or intentions, and events where they may place their fear, desire, and hope in something other than the Lord of all worlds.

"The neighbor before the house," Aziza demanded.

The Magicians

The Quran mentions magicians in the story of the magicians who battled with Moses. Pharaoh has imprisoned Moses and Harun until they would fight with his court magicians. When that day arrived, the magicians threw their staffs and serpents emerged. Thereafter, Moses threw his staff and there emerged a serpent that devoured all the other serpents. The magicians were astounded. Herein lies the conundrum. Their magic cannot eliminate other magic by its own internal means: the initial magic must be undone through its own construction. The magicians are then said to have prostrated before Moses to his God because they believed that he had broken the laws of nature whereas they were merely enchanting the eyes of the public. They tricked and distorted people's perception of reality through an illusion, a mastery of the material conditions that was not false and was both affective and effective. However, Moses' act altered reality; it was a break in the laws of nature; it was a miracle. We have within this story the distinction between the internal structure of nature and its restructuring through an external power.

This story reveals that the status of the illusion is not a mere imitation of supernatural effect upon the order of nature---it is not a pseudo miracle or a belief. As the magicians occupy a position of the soothsayer, transformer, and manipulator of matter, they produce physical force. The illusion they produce is not simply a fabrication, but a refocusing of the senses by way of the gaze. This is about the gaze insofar as what the magician creates is within the realm of the imaginary, and conditional, as the symbolic is unseen, *alghayb*. The illusions which they produce have powerful effects. They are not mere representation.

Magicians do transgress the Divine however, by giving the illusion that they possess the unknown and unseen, *alghayb*, and thus total power over the external structuring of the symbolic. What is illusory is their arrogation of power and totality of the structure of nature, their representation as encompassing total power over nature. As it is inscribed in the concluding verses of the Throne, one must resist being caught in the gaze, or will, of the other and place their fear, desire, and hope, instead, in the Lord of the worlds.

Love, War, and Affinity in the Hospital

In my fieldwork in hospitals in Yemen, Saudi Arabia, and Jordan biomedical physicians were subject to their patients' and their families' hopes, desires, and evil in the form of revenge, threats of divine damnation, and physical assault in ways that other healers (Quranic and magical) were not. Patients in Yemen barged into their physicians' offices demanding they give them "medicine." A family physician I shadowed in a clinic in Sana'a in 2013 noted that many times when a physician cures one family member, the entire family considers him the family physician regardless of future bad outcomes. In Saudi Arabia, patients' families charged their physicians' clinical offices, and in front of other patients (and me) evoked the wrath of God upon them if their family members died. The family members would insist that the physicians must do everything and provide them with the biomedical care necessary for their patients' recovery. These reactions were seen as destructive by these physicians. Expressing to me their deep sense of fear of God and ultimate judgment, these physicians felt these reactions overestimated their power.

This overestimation of the physicians' power or culpability in bad outcomes represents a shift from earlier reliance on biomedical abroad. In Yemen, people often traveled abroad to seek medical treatments. In Saudi, many of the physicians were either foreigners or physicians educated and trained abroad, and still continue to be. In Saudi and Jordan, many of the physicians I worked with were trained in the US, Europe, or Australia. However, in the last decade and in all three sites, there has been a movement in biomedical facilitates and medical universities to reclaim the Islamic origins of biomedicine and the hospital as a medieval institution built to care for the ill. This movement has come with inheriting biomedicine's promise to cure, or at least, in the near future.

The institutionalization of biomedicine and expansion of high tech biotechnological medicine in urban infrastructures has both a colonial legacy and emerges from what my interlocutors refer to, and the many scholars working on counternarratives to the history of decline in Islamic historiography, as the historical flow of authority¹ between medical systems (Prophetic Medicine, Arabo-Greco medicine, Folk or Bedouin medicine) in the MENA region.² In my three fieldsites, biomedical facilities in Saudi and Yemen emerged in the 1950's and 1960's whereas they were established earlier in Jordan in 1920's. Yet, the figure of the physician, encapsulated in the *hakīm* (polymath), dates back centuries to the medieval period.

The physicians I worked with in Yemen, Saudi Arabia, and Jordan noted the initial state sponsored initiatives to educate and train physicians abroad and their correspondence with discourses of underdevelopment, producing expertise as a proximity to the West that intensified the difference between ethnomedicine and biomedicine. However, once physicians returned to

¹ Nahyan Fancy, *Science and Religion in Mamluk Egypt: Ibn al-Nafis, Pulmonary Transit and Bodily Resurrection* (London: Routledge, 2013).

² Jessica Newman, and Marcia C. Inhorn. "Medical Anthropology in the Middle East and North Africa." *A Companion to the Anthropology of the Middle East*, (2015), 205-232.

their home countries and encountered various obstacles, from the socio-political economic causes of illness, the limited capacities of facilities and desire for a bed in the hospital, recognition of God's agency,³ and the demands for *'afiya*, physicians struggled to negotiate their expertise within the patient-physician relationship. Many of my interlocutors cited various causes for the tenuous relation, many corresponding to earlier set of debates regarding contemporary science's objectification of nature and the body and philosophy, and the presence of alternative medicines. Physicians responded by focusing on their relationality to their patients, acknowledging the uncertainty that haunts diagnosis and prognosis by reintroducing *alghayb* (unknowledge, invisible) into the clinic rather than demonstrating their global biomedical expertise. As geopolitical and economic forces shifted in addition to patients' demands, so did the ways in which physicians laid claims to expertise.

In Yemen, physicians had very little equipment and resources and a shortage of hospitals and clinics, beds, and personnel. They faced competition from the burgeoning success of *ruqiya* (Quranic healing) centers that were in close proximity to every hospital. In Jordan, the influx of refugees, medical travelers hailing from all over the Arab world, and the dearth of local medical research placed people in cycles of consumption and repetition drawing focus away from biomedical knowledge production. In Saudi, technologically advanced hospitals that parallel those in the Americas led patients to demand the cure from physicians due to biomedicine's promise of the cure.

Unlike Jordan and Yemen, Saudi was not in a civil war nor flooded with refugees and migrants, it did not explicitly have competition from Quranic healing (*ruqya*) centers or an alternative medical facility. The hospital was far more technologically equipped and staffed. It possessed a cancer unit, infectious disease unit, and several operating rooms. Although it was not a level one trauma center, it was one of the best hospitals in the nation. Yet, altercations between physicians and patients, patients and their family, and families amongst themselves continued to occur.

Biomedicine's lack of lack, and the quandary of attempting to practice biomedicine amid deprivation and war and its failure to address lives and therapeutics that intimately tie together the spiritual, psychic, and physical (*'afiya*) produced a tenuous relationship between patient and physician. Biomedicine's promise to potentially cure alongside the imagined access to alternative medicines and magic, and demonic jinn through the use of *sihr* (magic, conjuring),⁴ led to cases where physicians became targets of destructive reactions often occurring in volatile moments of rage.

By inviting the patient to believe in their effectiveness and the efficacy of biomedicine and its prescriptions the physician contributed to the fantasy of a possible cure and implicated themselves in the treatment. Accordingly, there was a counter demand placed upon the physician to drive the cure. This invitation came with a price. In identifying the physician as the cure itself, the patient incorporated them in turn. As a result, physicians in all three fieldsites became entwined with the treatment and incorporated and devoured along with it.

³ Sherine Hamdy. *Our bodies belong to God: Organ transplants, Islam, and the struggle for human dignity in Egypt*, (University of California Press, 2012), 169-171.

⁴ *Sihr* is manipulation of the cosmos. The root *sihr* derives forms that encompass the meanings dawn, day break, lung, bewitch, curse, fascinate, conjure, and restriction of one's breathe. The word for curse or conjuring is also the word for hidden \ organs, such as the lung, the restriction of breath and the breaking of dawn, tomorrow, and the future.

Physicians focus on the patient-doctor relationship and desire for patients to believe in their expertise was met with an even more burdensome counter-demand, the demand to cure. This invitation to the patient to believe in the doctor's effectiveness belied the limitation that biomedicine itself claims, as it maintains an openness in its potentiality for the hope that the cure lies in the near future within its purview, what Donna Haraway considers an "illusion, a god trick" of contemporary science.⁵ This illusion, reminiscent of the illusion of the Egyptian magicians above, shrinks the space of uncertainty and unseen (*alghayb*), and relegates it to exceptional cases of misfires, mystery, and miracle.

In Yemen, when a surgeon walked out of the Operating Room and headed to the waiting room to update the family and break the bad news to them that their family member had died on the operating table, he could not have foreseen the deadly consequence lying ahead. Nurses working at the hospital that day, did not anticipate the scene they recalled to me. As the physician leaned over to report the death of their family member, the patient's son reached for his dagger in mere seconds, and stabbed the surgeon, who fell instantaneously while everyone stood by in utter shock. That marked the day of a ban of possession of daggers in public spaces, a time after the Arab Spring protests that did not lead to any ban of any weapon amidst social and political unrest. Months later, when a physician refused to perform a surgery on a dying patient without prior payment, a family member stabbed him in the middle of the Emergency Room waiting area. In Jordan, similar cases of violent consequences occurred in Amman. A bereaved father of a deceased patient asked around for the address of the physician who hauled his daughter into the operating room after being admitted in the hospital and where she subsequently died on the operating table due to unforeseeable complications. The father found the physician culpable for her death. The father went to the physician's home and upon the physician's opening of his home's front door, he stabbed him to death. Although these stories present the consequences and destructive forces that follow on patients' deaths or cure, they are nonetheless stories about love.

The Prophet, the Magician, and the Incorporation

I was sitting outside of the operating room watching the attending physician insert dye into a patient's vein in order to trace a potential blood clot in her brain when I met a neurology resident, Dr. Naseem, who was similarly interested in the problem of culpability and the relation of medicine and magic and astrology. Dr. Naseem was curious about my research and felt he could help clarify a few things: he had conducted rotations all over Saudi in the course of his residency and knew about the interworking of many hospitals. I began to explain that one component of my research was regarding physician-patient relationships. Dr. Naseem told me that he had once held misconceptions about the cause of distrust in the therapeutic relationship. Trust was not established through reconciling knowledge amidst power differentiation, he argued. Rather, he and other physicians have found that trust is built through invitation and receptivity. This receptivity, however, is not without its pitfalls, as it had to be coordinated and managed. There is a necessary discernment of potentially unhealthy attachment, which at times resulted in patients desiring physicians as not just healers, but lovers.

Dr. Naseem had witnessed assaults in all the hospitals he worked in across all the provinces. Whether poor or rich, educated or not, personal altercations occurred between

⁵ Donna Haraway, *Simians, cyborgs and women: the reinvention of nature*, (London: Free Association Books, 1991), 188-189

physicians and patients, family members and physicians, and family members amongst themselves. It always puzzled him as to how to navigate or mitigate the tensions that seem to escalate within the therapeutic space. I was very familiar with these instances as throughout my time in the hospital, several times a week, in the various wards and floors, I was alarmed when the page overhead was “code strong man.” Code strong man meant that there is a situation that required security or even the hospital police, as a physical assault was involved (whether between patient and physicians, physicians and family members or family members amongst themselves). The times that I did show up to the rooms, the situation had usually deescalated or resolved. In many of these situations, the argument was about blame and responsibility for bad outcomes or death.

How could these physicians seem culpable at all? For physicians, the promise of biomedicine and effectiveness of Quranic healing and magic arrogates a power to them, the Imam, and magicians that did not exist. Their own role in healing as instruments of God, proclaimed by the Prophetic tradition, positioned God as the ultimate cause. Somehow, their claims of efficacy by virtue of practicing biomedicine and invitation to participate in its project together with their association with the state as employees of a public infrastructure made them culpable for individual and collective *sahha* (health) and *afiya* (physical, spiritual, and psychic well-being), but also for the evils of the exploitative and monetizing mechanisms of biomedicine.

Dr. Naseem began to discuss what I consider an affinity that binds patients and physicians that had little to do with actual medical practice or effectiveness of specific treatments. Much of that effectiveness depended on the relationality cultivated between the physician and the patient. He spoke of the importance of welcoming patients into the office, sharing your phone number with them, and following up. This very insight came to him not as a result of his own biomedical practice, but from the experience he had accompanying his father during a surgery. This new perspective as a companion in an unofficial capacity shifted his orientation toward his patients from an otherwise distant, unaffectionate demeanor he carried from when he first began practicing biomedicine as an intern. After that, he bought a separate phone with a number just designated for his patients and he began to notice a drastic change in not only his patients’ experience in the clinic but their receptivity to treatment. However, this also placed him in challenging situations wherein patients began to exhibit signs of severe attachment to him or even profess their love. This affinity was not just unidirectional, he mentioned. He had witnessed physicians falling in love with their patients as well.

Dr. Naseem did not understand this receptivity of patients as only a result of his own efforts or the quality of his care and concern, but importantly as shaped by the encounter within the clinical space. Since certain people are drawn to some more than others because of their elemental compositions and their compatibility, physicians have to decipher ways to build on and discern these existing factors in order to overcome them when needed. This affinity was not merely psycho-social, but physiological and had physical effects. It was not merely affective, but effective. A patient’s receptivity to treatment depended on the receptivity of their respective physician and his treatment.

In this chapter, I attempt to trace some of the conditions that made physicians culpable, interpellated, and subject to revenge in a way that a magician, the Imam, or the folk healer are not. I argue that this culpability is tied to the logic of evidence-based biomedicine as prognostic and potentially unveiling. This ‘promise to cure’ evacuates the unseen and unknowledge (*alghayb*) from within the hospital, mirroring prohibited practices of prognostication through use of demonic jinn in *sihr*. A certain objectification of science, the logic of biomedical knowledge

as always potentially knowable totalizing and contained led to a foreclosure of uncertainty and the possible unknowability. Against this backdrop, physicians desire for patients to affirm their expertise and invitation to believe in their biomedical efficacy produced patients' demand for a cure. In turn, patients' demands, judgment, reactions, and threat of divine damnation led physicians in each of my three fieldsites to recognize the risk and danger of incorporation or expulsion that was raised by their claim to know the patient, their illness, and prescription. They involved people across class, education levels, and geographic regions.

I encountered physicians' attempts to manage patients' receptivity and aversion early on, during the first weeks at the hospital. I shadowed the nephrology team with one of the most beloved nephrologists among the residents and medical students. The shortage in interns and residents during the month of Ramadan 2017 (May 2017) led to a series of events regarding the uncertainty of the illness and the problem of prognosis. After rounding on 8 male inpatients in the male medical-ward and 5 in the female-medical ward, we arrived at a female patient whose kidneys were functioning at 30% and who had refused the surgery necessary to insert a fistula in order to connect an artery to a vein for long-term dialysis treatment in an out-patient clinic. The 50-year-old Palestinian woman (Aziza) and refugee did not give the student a chance to finish presenting the case. They were speaking in English, but she broke in in Arabic. She began to voice her grievances with the nephrologist's interns and residents, complaining of being pricked and prodded in order for them to prepare for the vascular surgery to insert the fistula. The patient demanded that the nephrologist discharge her. The attendant explained that she cannot discharge her until she was able to have a vascular surgery.

The patient then pointed to her neck (a symbolic gesture that signals the pathway to life or death), and grunted "My life is on your conscience." Through this gesture, Aziza claimed that not only was her life in the nephrologist's hands, but that she was also culpable for her death. Medically, the neck has arteries that carry blood from heart to the body and veins that carry oxygen-poor blood from the body back to the heart. In the prophetic teaching (*hadīth*), God is described as closer to humans than the jugular vein. Hence, noting that God is closer to your heart than the oxygenated blood supply that maintains its beat. When anyone points to this vein, they usually are attempting to raise the fear of God in the accused, a plea to their conscience.

Aziza continued to speak to the nephrologist: "The surgeon didn't know what he was doing. He closed my vein. I could have died in his hands." The nephrologist interjected and refused this designation of the surgeon as life taker and giver. He pronounced the supplication that there is no power except Gods and asked the patient to give prayers to the prophet, as a reminder to be mindful of one's behavior and decorum in relation to the prophetic exemplar. The nephrologist then explained that she had sent Aziza to the best surgeon in the hospital in order to insert her AV fistula in preparation for long-term dialysis. The nephrologist addressed the patient as *qalbi*, my heart/love, and reminded her that life was in the hands of God and that she was doing everything to address her renal failure through the evidence she had at hand. The nephrologist pleaded that dialysis was the only way for Aziza to avoid renal failure and death and stressed the grave path that lied ahead as nothing will return her kidneys to their full function. This surgery was the only way to ensure her long-term dialysis. She also reminded Aziza that unless she believed in her treatment and it would not work. Furthermore, if she did not allow the vascular surgeon to perform the surgery in order to insert the AV fistula, she could not discharge her. The nephrologists argued that the vascular surgeon's failure to perform the surgery was not because of his incompetence, but that she (Aziza) was not receptive and that he would fail again unless she was open to him. The nephrologist stressed that her ability to treat

Aziza with dialysis depended on the latter's belief in the former's treatment. Aziza then agreed to the surgery and asked the nephrologist to educate her students and other physicians to be kind and merciful. The nephrologist promised she would ask them to be gentle, supplicated for her 'afiya ('may there be well-being ahead of you'), and moved us along to another patient.

The other patient we saw was a young woman suffering from disparate symptoms, one being kidney malfunction, who the team could not diagnose. They had run tests for a week. The physician reassured the young woman that they were doing everything they could and needed to conduct more tests. The patient was overwhelmed by the physician's uncertainty and refused to allow more tests, confused as to how previous tests could not have furnished a diagnosis in order to be treated. The physician leaned in and said that she could not treat her without first diagnosing her and the tests were necessary evidence to inform the treatment. She told the patient she was not a magician that can magically cure her without getting to the root of the cause. She stressed that was like the prophet (*rasūl*) who came with evidence (*bayān*) to show us the truth. The patient agreed to the new tests and we concluded rounds for the day.

As we walked back to the nurses' station, I asked the nephrologist if the figure of life giver and taker troubled her. I also asked her why she recruited the figure of the magician to assuage the patient. The nephrologist emphatically stressed that it was terrifying to be made into a god. She stressed that a patient needed to believe in the process of investigation and the direction of the cure, but also in her role as a mere divine instrument. Being caught in this way was nerve wracking as the judgment she feared was not necessarily that of the patient, but of God. Patients needed to be reminded of who is the true cause of their well-being for their own ability to recover. It was as if the physician was managing the patient's reception of their illness, as ordeal and trial (*ibtilā'*), and its passage as emanating from God, as much as their reception of the diagnosis and prognosis.

The figure of the instrument of God that the nephrologist invokes comes from the *hadīth* where Abraham asks God of the role of the physician in the cure. God told Abraham that the physician was a *sabab*, an instrument/reason, "a man whose hands I [God] send and cause the cure," authorizing the position of the physician relation to God's decree.⁶ This invocation also presupposes an occasionalism,⁷ a theory of causality within the Sunni tradition, particularly the 'asharite school, that attempts to reconcile human will and freedom to act with predestination, and God's will and intervention in the world.⁸ The role of the instrument within this elaboration

⁶ Al-Jauziya, I. I. Q. *Healing with the Medicine of the Prophet (PBUH)*. (Darussalam Publishers, 1990), 29

⁷ I limit my engagement of the discussions on *Qada* and *Qadr* with respect to the tradition. *Qada* and *Qadr* is not simply an assertion about time or destiny, but about the limitation in knowledge and power in understanding the unfolding of personal, communal, natural events and in relation to one's acts.

⁸ Jane Idelman Smith and Yvonne Yazbeck Haddad state, "theology struggled at length over the issue of *taqdīr*. Those who held to the necessity of human free will as a guarantee of divine justice were called *Qadariya*, of whom *Mu'tazili* were the best-known exponents. The discussions in the early community were political as well as theological; the Umayyads, entrenched in power, not surprisingly supported the idea that events are predestined by God, while the Shī'a, who did not have political power, supported *Mu'tazili* opposition to the doctrine. The *Mu'tazili* affirmation of human free will expressed a concern not only for testifying to God's justice, but also for avoiding the conclusion that He is in any way associated with acts of disobedience or kufr. The compromise put forward by the school of the *al-Ash'arī* is a rather complex piece of intellectual argumentation propounded in an attempt to safeguard the assurance of both divine omnipotence and human responsibility. This formula suggests that while God is creator of human acts, man himself acquires or appropriates them, expressed by the term *kasb*. Human acts are predestined by God from all eternity; they are placed into the human heart in the course of time, making those who receive them fully responsible for them," *The Islamic Understanding of Death and Resurrection* (Oxford University Press, 2002), 22.

of divine predestination and divine power (*qada wa qadr*), is to assert a non-fatalistic view, but also an assertion of *tawhīd* (oneness of God's divinity). The belief in God's oneness (*tawhīd*)⁹ is the first principle of faith in Islam.

To claim a share in divinity is to attribute partnership or the power to cause to some force other than God: this is transgressing by attributing partnership to God (*shirk*).¹⁰ This complex theological and philosophical elaboration of freedom and God's will and knowledge is often distilled into an aphoristic Prophetic saying tie your camel and trust in Allah, meaning act then rely on God.¹¹ When a person acts, to fulfill something measured out, one must prepare. *Shirk* in the hospital for my interlocutors emerged in the attribution of the power to cure to the doctor, but also in the belief that the pill itself, in its movement through one's body is the object that has realigned its functions or muted the pain of its autocratic regeneration.

Physicians viewed both their medical practice and supplications as a divine instrument. The way supplication works in tandem with the treatment, is what al-Ghazālī considers part of predestination itself. al-Ghazālī writes:

supplication is a cause [*sabab*] for the revocation of the affliction and the procurement of mercy, just as a shield is a cause for the deflection of an arrow and water is a cause for the growth of a plant on the ground. Just as the shield selects the arrow and the two work against each other, so supplication and affliction work against each other.¹²

al-Ghazālī argues; "He who decrees good does so through a cause and He who decrees Evil decrees a cause for His rejections [of good]."¹³ Humans can strive toward a goal through the many causes available, but they also possess the free will to deploy others for evil ends. God's will, *Qadr*, does not entail an absence of human will. In the same way that physicians see their role as an instrument of the divine as decree by the prophetic tradition, they view their supplications as another instrument. These instruments do not succeed or fail based on the biomedical heuristics of diagnosis and treatment efficacy.

Physicians claimed that both faith and a lack of faith on the part of the patient leads to the over-determination of their power to cure, and can leave them culpable. When physicians fail or succeed, they hope the patient will understand, when negligence was not involved, that it was ordained by God. Physicians do not want to share in God's divinity nor act as self-sufficient.¹⁴ The predicament of the physician's culpability unfolds around a set of various interpretations of predestination and free will, but also the lure of the illusion of the biomedical dream-work.

⁹ "Worship God, and do not associate any others with Him. (Quran, 4:36). Do not associate others with God; to associate others is a mighty wrong." (31:13). "Say [O Muhammad!]: Surely God is one god. Surely I am free of the others you associate." (6:19) "Say: I have only been commanded to worship God, and not to associate anything with Him." (13:36).

¹⁰ Sachiko Murata, and William C. Chittick. *The vision of Islam*, (New York: Paragon House, 1994), 61.

¹¹ "O Messenger of Allah, should I tie my camel and trust in Allah, or should I leave her untied and trust in Allah?" The Prophet, peace and blessings be upon him, said, "Tie her and trust in Allah." Sunan al-Tirmidhī 2517.

¹² Muḥammad ibn Muḥammad Abū Ḥāmid al-Ghazālī. *Invocations & Supplications: Itāb Al-adhkar Wa'l-da'awat: Book IX of the Revival of the Religious Sciences*, (Islamic Texts Society, 1990), 90

¹³ Ibid, 90

¹⁴ According to Fazlur Rahman 'higher causation are not duplicate nor in addition to natural causation. "It works within it, or rather is identical with it," as humans are finite and dependent upon God. In the Quran God is infinite and absolute and any claim of self-sufficiency or independence is a claim to "infinitude and a share in divinity. *Major Themes of the Qur'an*, (University of Chicago Press, 2009), 67.

Within this shifting landscape and in light of the patients' demands to be cured, biomedical practice began to resemble prohibited prognostic practices, some forms of magic.

Similar to Aziza, other patients often found physicians culpable in spite of the latter's malpractice protections in Islamic law. In Islamic law, guilt or culpability in medicine is restricted to intent to harm, gross criminal negligence, and transgression. In Islamic *fiqh* on medical malpractice¹⁵, physicians are not liable in cases where complications or death arise without transgression, incompetence, or negligence. Incompetence, transgression, and negligence in medical malpractice is understood as not performing according to the accepted authorized methods of the culture and custom of its time. This is different from general prescription in Islamic law where a person found guilty of accidental death, such as running someone over with a car, is prescribed to fast two consecutive months or pay a *fidya* (befitting amount to the family). The judgment for guilt of gross criminal negligence is akin to the punishment for an intent to kill, which is *qisas*, (punishment corresponding to the crime); people's murder of physicians reflected this judgment of *qisas* rather than accidental death.

Uncertainty—whether regarding the cause of the illness and its response to treatment, the presence and success of Quranic healing and miraculous recoveries, or unpredictability in patient prognosis—raised the question of the relation between the physician and the patient, and the physician and his soul (which I discuss in chapter 2). This relation was figured as one that could promote a drive to cure and be cured, solidify enmeshment on the model of the family, or even generate destructive reactions. In scenes such as the two above, any epistemological questions of efficacy and claims made upon the effectiveness of the treatment, or cause of cure in biomedicine was displaced by biomedical physicians as a question of relation and openness to the patient in what I am calling a radical field of physics of relationalities—a physics of affinity.

Physics of Affinity

This field of affinity is not about faith in a physician's ability to cure. When I say affinity, I mean to call to mind forms of inclusion and exclusion, power of repulsion and attraction, the act of incorporation, and the vocabulary of kinship in affinal relationships. The physics of affinity is to delineate a spatio-temporal field that is occupied by people, spells, rituals, texts, the gaze, and non-human beings, such as bodies of nature through which God's powers are channeled, including jinn which can be demonic or non-demonic. These cosmological forces influence the very dynamics of the body's internal structure as we will see with astrological knowledge. The physics capture the structuring of the field where events occurring within these interacting forces at times cross between this world and another world occupied by non-human beings. I understand physics as it is elaborated in the Arabic and Islamic philosophical tradition as *tabi'at* (nature). Physics is the study of natural bodies in so far as they are undergoing change in motion.¹⁶ Within the field of affinity, there are barriers that include, exclude, block, break, and knot and tie persons (souls) to one another and jinn across two worlds, which are coordinated by affinity. Through this physics, a force flows, an affinity, which entails orientations between

¹⁵ Much of Islamic law on medicine dates back to Imam *al-Shafi'* and Ibn al-Qayyim in the 14th century: Mohammad Ali Bhat, "Ethics, Medical Malpractices and Islamic Solution," in *International Journal of Innovative Studies in Sociology and Humanities*, 3, no.10 (October 2018), 5.

¹⁶ In the case of the study of the soul in medieval Islamic philosophy, it is the body's first perfection as a force and motion that moves the body toward a perpetual state of becoming. Therefore, the encounter of souls affect other bodies.

persons, persons and jinn, jinn and jinn, and they and God. Through these forces and channeling of God's power it displays the affinity at play.

When I returned to speak to Aziza days later, she pointed to what I am calling the physics of affinity. She was excited that I was Yemeni and gave me her condolences for what was happening there. She was still upset that she was not discharged to spend Ramadan with her family. We spoke about the prior visit and why she was still somewhat repulsed by the physicians who she saw as smart, but who possessed no *akhlaq* (sharia-oriented virtues). "Once they see all the patients, they lose all feelings and senses. Even if they had the treatment, I will not accept it or receive it. One doctor was smart, but had no *akhlaq tayyibah* (tender characteristics). The Prophet says that a smile is charity." Aziza then said that a physician's character is important for his craft, and that this is the reason physicians are called *malakat al rahma* or Angels of Mercy. Even though they want to learn, they continue to put themselves above everyone else. Said Aziza:

We are not cocktails, everyone's illness is within a spectrum. I want sweet talk. I want them to make me feel that they feel what I feel and that they are the patient and not me. The Prophet (Muhammed) said ask about your neighbor before your prospective house.

The cocktail here serves as a refusal of the treatment of patients as hollow vessels, the experiment subject, which serves as a container for a recipe, measured mixtures and ingredients, that produces uniform outcomes. Aziza went on to explain that she feels that her body rejects biomedicine and feels her kidneys reject dialysis. She had been sick ever since she was a little girl. She believed it was *sihr* (magic) and the evil eye. She has always been sick and has accepted it. Nothing had worked. Her own mom had also been ill, but died even though she was on dialysis. "Dialysis killed my mother," Aziza argued.

In a critique of what it would mean to care or love one another in the hospital, Aziza utilized the metaphor of the neighbor as one you come to know. She drew on the prophetic teaching that prescribes knowing your neighbor rather than the recognizably Christian injunction to love your neighbor. Aziza pointed to what it would mean to cohabitate not by focusing on one's domestic sphere (a house, an abode, or the body) but rather by the relationalities within that field. This co-presence is about knowing the other. To know your neighbor, is not simply to love them, but to know them so as to anticipate and respect their desires and boundaries, opening up the question of love to one grounded in knowledge. In this way, I understood her to gesture to the idea that knowledge and discernment about the neighbor entail a recognition of the effects relationality can cause. This gesture was also to recognize and respect the neighbor's desire as much as you recognize, and demand their recognition of your own. This desire extends beyond both parties' own interest. It is in relation to God's knowledge and commandment to cultivate a virtuous public space where desires are negotiated rather than avoided in fear of aggression, panic, and incivility. This focus on relationality rather than internal or self-modification also marked a field of the physics of affinity as a question of attraction and repulsion, incorporation and expulsion. As Aziza pointed to with the hadith, the physics of affinity is about knowledge of the neighbor, of the patient, of *al-ghayb* (unknown or unknowledge).

When I was wrapping up my interview with Aziza, a patient in a bed adjacent to Aziza yelled out, "Yes, *akhlaq* are important." Aziza then instructed me to also interview her. The woman, Sarah, was Saudi, and was one of seven patients in this shared room; she agreed to the interview. Sarah explained that she came to the hospital due to kidney failure and that she was

meant to begin dialysis. But, she was not convinced. When I asked her how she came to choose her physician, as characteristics were important to her, the patient said that the physician was a member of her extended family, a famous southern Saudi tribe, and *'asabiyah* was important. I asked her why *'asabiyah* was important to her in terms of effectiveness of treatment. The patient then began to explain that being able to anticipate someone's actions and character is key. *'Asabiyah* was important as it was formative and binding, it anticipated ethical virtuous action. Confused as to how a 14th century term, coined by Ibn Khaldun as "group feeling,"---but also what comes from the root meaning nerve---found its way into our conversation in 2017, I asked the patient if she could speak more to the importance of *'asabiyah* in efficacy and care. The patient was curt and said pointedly, "I know this physician, and his character, because he is family. The physician will explain everything to me and will give me the best care. I could get my kidney function back and I will try by chewing Arabic gum," a claim that often drove all the nephrologists in the hospital mad. In turn, the nephrologist ordered the educational nurse to give the family an informational session on dialysis and kidney failure. Although they attended the informational session, Sarah would only say that everything is in God's hands.

Sarah then concluded our interview and said the information that she provided me was more than enough. Strangely enough, she was right. To know a physician was to anticipate their care and ability to discern and respond to your demand, whether for care or its withdrawal. Rather than incorporating a stranger into their family unit to entrust, someone whose characteristics and virtue-ethics were unverified, the patient opted to only be examined by her family member.

There were many patients and families, similar to Sarah, that spoke of their physicians as a family member. Patients often entered this clinic and hospital weak, as described by their family members. The patient's family would not only discuss the patient's symptoms but also the way the illness had affected all of their lives and ways they attempted to share it and distribute it so that the patient can regain some strength to treat it. As I argue in chapter 3 of this dissertation, the illness implicates everyone recruited in its alleviation. Therefore, the illness became distributed among the family, physician included, in order to prevent panic around the illness overtaking the patient. I argue here that physicians are recruited as a member of the family of the sick through a process of incorporation. This incorporation takes the form of a psychic identification. The physician becomes the embodiment of an ideal, a person of knowledge with cultivated ethico-religious ethics that enabled a discernment of a potential knowledge as the *instrument of the divine* and *angels of mercy*.

In these scenes, physicians become the subject that is supposed to know: patients and families demand from physicians a knowledge of their state of ill health and its treatment. What is negotiated within that space often is the question of potential knowledge and the physician's ability to cause an effect in the patient: the physician's discernment is implicated as an instrument and guide of the cure.

At the outset, one may begin to think that these patients desire magic from the physician and these biomedical facilities in the face of a potential loss. However, this is a counter-desire; the demand of the patient is a response to a prior demand, namely the physician's demand for recognition of his expertise. The prior demand is itself a reconfiguration of the field of affinity that once included *alghayb*, a necessary symbolic instantiation of a gap that already exists between self and other and knowledge and totality.

Magic

Magic has been a central topic since early anthropological studies. Across various trajectories of such work, it has been given the form of false science prior to religion,¹⁷ mystical or pre-logic,¹⁸ esoteric logic,¹⁹ and transferential energy, of a cosmological nature, for bodily and self-transformation.²⁰ Many often overlook earlier anthropological studies on magic because those theories seemed to focus on where magic lands, whether it be outside or inside the individual, in nature or the mystical realm, or in collective or individual psychology.

Unlike his contemporaries, Marcel Mauss did not view magic as prior to religion or any ritual rite. Mauss describes three forms of practices: traditional, religious, and magical. Traditional practices are legal actions, techniques, and religious rituals, external forces that establish contractual relations between persons. Religious practices are public, authorized, and institutional while magical rites are unauthorized, secret, and illicit practices conducted in forbidding terrain such as forests and deserts. Both magical and religious rites, however, possess communal efficacy. Where other scholars had claimed religion as conciliatory, and thus distinct from magic insofar as the latter represented an improper arrogation of power outside the frame of intercession, Mauss argued that magicians prayed to and served spirits as well.

In a similar critique of other scholars of magic, Mauss points out that they often blurred the line between technique and rites, as other forms of arts and crafts were often indistinguishable from magical acts. However, he argues that where technical practices show over time that a particular cause will create a corresponding effect, magic does not rely on such a demonstration. Mauss does not view magic as false or unreliable, but rather as an attempt to transcend mechanical effectiveness as a probable, unauthorized, abnormal act within ‘a totality of social customs.’ Magic has a different form of effectiveness that is not “mechanical effectiveness.”²¹ Even medicine contains that very effectiveness. Mauss argues that medicine imbues ritual movements and gestures such as incisions and potions with “symbolic, sympathetic, homeopathic, and antipathetic actions” bound “by religious and magical taboos, prayers, incantations, and astrological predictions.”²² Here, the practice of a science is not without some magic.

Lévi-Strauss similarly displaces the question of causality that distinguishes science from magic in early anthropological texts and instead thinks through the relation to the totality of knowledge and power. In *Myth and Meaning*, Lévi-Strauss views mythical thinking as a totalized form of apprehending the world. He considers practitioners who work within a mythical world as disinterested thinkers; this is called *la pensee sauvage*. They “proceed by intellectual means, exactly as a philosopher, or even to some extent a scientist, can and would do.”²³

The bricoleur/disinterested thinkers are different than scientists or engineers, insofar as they attempt to understand everything, in the shortest time possible, and without explanation, an illusionary apprehension of the universe.²⁴ On the other hand, a scientist, attempting to explain a

¹⁷ James G. Frazer, *The golden bough*, (Palgrave Macmillan, London, 1990).

¹⁸ Lucien Lévy-Bruhl and Lilian Ada Clare. *Primitive mentality*. George Allen & Unwin Ltd., 1923.

¹⁹ Edward E. Evans-Pritchard, *Witchcraft, oracles and magic among the Azande*. (London: Oxford, 1937).

²⁰ Jeanne Favret-Saada, *Deadly words: Witchcraft in the Bocage*, (New York: Cambridge University Press 1980), Claude Lévi-Strauss, *The sorcerer and his magic*, (1963).

²¹ Mauss, Marcel. *A general theory of magic*, 20

²² Ibid, 19-20

²³ Claude Lévi-Strauss, *The Savage mind*, (University of Chicago Press, 1966), 16

²⁴ Ibid, 14-16

problem, conducts a temporally fixed inquiry into the intricacy of the workings of a problem that generates more questions than answers. Science attempts to explain everything.

Drawing on both Mauss and Lévi-Strauss, my ethnography attempts to displace the question of efficacy as a criterion for a classification between science and magic, magic and religion, and religion and science, not as a sleight of hand or not real, but by pointing to a power and its channels.

To further understand the structure of the subject's relationship to truth as cause, I turn to Jacques Lacan's distinction between the subject of science, magic, and religion. Here, truth is understood as divided from knowledge, as subjectivity is marked by a relationship to not-knowing. The claims to and rejection and repression of truth defines the function of knowledge. Following Lévi-Strauss' observation of the Shaman's work, in magic, knowledge is veiled and its efficient causality defines its truth. Whereas in magic truth appears in action, in science objective knowledge foreclose the truth as a cause. Lacan states: "science does not want to know anything about the truth as cause."²⁵ What science forgets and what psychoanalysis and Marxism put into work is truth, to go where knowledge cannot lead. For Lacan, Marxism like psychoanalysis takes seriously subjective truth. He states, "an economic science inspired by Capital does not necessarily lead to its utilization as a revolutionary power, and history seems to require help from something other than a predicative dialectic."²⁶ Unlike science, Marxism, like psychoanalysis, "does not forget the circuitous path by which it came into being."²⁷ As I will explore at the end of the chapter through my reading of Marx's parallelism of the sorcerer and the modern bourgeois, revolution or truth requires innovation or a relation to the netherworld or *alghayb*, something beyond 'a predicative dialectic' or 'subsistence of the subject of a not-knowing.' This foreclosing nature of science is not inherent, as Lacan views psychoanalysis as a potential new science that avoids this foreclosure and follows other epistemologies, such as Canguilhem's, that maintains a relationship to truth as cause. Religion, on the other hand, represses the truth as cause, as traditions expansion over time and space requires the reproduction of the archive. Although Lacan argues that the religious person "leaves the responsibility of the cause to God," barring "his own access to the truth," the religious person who puts into play the truth as cause' does not exhibit the mechanisms from obsessive neurosis.²⁸ I will demonstrate how some physicians' reintroduction of *alghayb* into the clinic and redirection of the patient's desire to God is not akin to placing 'the cause of his desire in God's hands,' but instead is an injunction precisely to remember the truth as cause. The physician does not relinquish power completely, claiming that science doesn't exist. Instead they remind the patient to seek through science something beyond it.

Alghayb

Knowledge is at the heart of the question of affinity. Patients' demand to physicians for '*afiya*, articulated in the field of affinity, is about knowing the physician and what the physician knows. Therefore, the ability of the physician to know the patient and what ailed him opened up the question of uncertainty and unknowledge both at the heart of the illness and in the heart of the physician. In these sites, lie what is theologically understood as the unseen (*al-ghayb*). In the

²⁵ Lacan, Jacques, and Bruce Fink. "Science and Truth." *Ecrits: The first complete edition in English*. WW (Norton & Company), 2006, 742.

²⁶ Ibid, 738.

²⁷ Lacan, Jacques, and Bruce Fink. "Science and Truth," 738.

²⁸ Ibid, 741.

relation between the physician and the patient and the physician and God's knowledge patients call for the discernment to potentially unseal the unseen and to remain open to its vastness. The unseen, *alghayb*, is a theological term denoting the omnipresence of God and God's atemporal knowledge, because God stands outside of time and space. Physicians often told patients that they will do their best with the knowledge at hand, but that all knowledge belonged to God (*Allahu a'lam*, God's knowledge is ultimate). Physicians were not only salvaged, but haunted by *alghayb*.

Alghayb is a powerful source of potentiality, healing, and protection, but also potentially deadly and dangerous. It refers to a knowledge, a realm, partiality, the future, God's knowledge, and God's absent-presence. It is not simply visual or a division between essence and existence. My interlocutors speak of *alghayb* as unknowledge, absent-presence, potential knowledge, uncertainty, God's will and knowledge, but also God's miracle that cannot be subject to scientific inquiry. The potentiality of their own will that encounters that of God's, in the same way a physician is an instrument of God, all depended on a relation to *alghayb*, the zone of non-fatalistic determination from which possibility or destruction may arise. Physicians positioned themselves with respect to *alghayb* in terms of the production of new research and the limits to predictability of treatment outcome. They also used *alghayb* as a buffer between the determinacy demanded by the patient and the uncertainty of illness and prognosis.

Although many physicians across all three fieldsites were staunch empiricists, they were also clear that there are two forms of knowledge: *'ilm al-tabi'a* (knowledge of nature) and *'ilm al-ghayb* (knowledge of the unseen). Trained in the knowledge of nature, physicians say they will always be limited in knowledge. For my interlocutors, *'ilm al-ghayb* can both be known or deferred to the afterlife. All potential knowledge was *alghayb*. *Alghayb* is decipherable and potentially known as a will of God, becoming known through its effects, like knowledge of cures waiting to be uncovered as noted in the Prophetic tradition. When my interlocutors spoke about the science involved in biomedical practice, they spoke of it as uncovering nature rather than as discovery: as was God's signs deciphered and not knowledge made out of nothing. It is not concealed knowledge as it is potentially knowable under various conditions, leading some to argue that knowledge is only derived by *kashf*,²⁹ but it also the limitless knowledge of God. A physician may learn something with time by honing their senses and cultivating discernment or *hads* (intuition by way of empiricism).³⁰ This gap was not a dyad as it involved the absent third.

In recognition of the constitutive nature of *alghayb* (unknown) and the other, there was an attempt to leap into a potential truth (course of treatment) or illusory unsealing of total knowledge. Uncertainty of the totality of knowledge regarding illness and diagnosis, prognosis and efficacy, inner logic of events, and people's bodily acts and reactions all raised the question of unknowledge in the clinic. The potential knowability of *alghayb*, the potential to unseal the unseen, opened up the capacity of discernment as a potential method for knowing.

In desiring *'afiya* and the cure, patients demanded that physicians produce an effect. The other can cause something in you as a function of knowledge. Physicians then countered this demand by attempting to guide the cure without foreclosing the future or at least performing *alghayb*. It is in this way that affinity and the relationship between physician and patient serve as

²⁹ Frank Griffel, "Al-Ghazālī's Unspeakable Doctrine of the Soul: Unveiling the Esoteric Psychology and Eschatology of the *Iḥyā'*," (2004): 108-111.

³⁰ I take up the question of cultivation and discernment in physician's biomedical practice in other parts of my dissertation. *Hads* is a concept invoked by my interlocutors and can be traced back to Ibn Sīnā's theory of the soul. See Jon McGinnis, *Avicenna* (Oxford University Press, 2010), 94.

the backdrop for the demand and counter-demand that revolves around the doctor's knowledge of a cure. It is in this field that the effectiveness of a cure is recognized and disputed.

This is an expansive method of prognosis and operates with knowledge with respect to its partiality. My argument here is that this respect for *alghayb* is an attempt to avoid incorporation by assigning the cure to God. As patients and their families seek to avoid loss by conjuring the image of a positive future, the physician exercises discernment in producing knowledge about what remains unseen. In this scenario, the physician recognizes the finitude of human knowledge while the family disregards the elusive nature of the illness.

The physicians claimed that their work was a work toward *alghayb*. They do not though, seek access to *alghayb*. Instead, they assert that any act of knowing, any transition from the realm of *alghayb*, such as prognosis is ultimately caused by God. Though one does not have direct access to *alghayb*, there are mediums and practices that move towards *alghayb*.³¹ While it is important to note the dimension of *alghayb* that might be ultimately invisible or unknowable, we cannot delimit *alghayb* to simply intermediary realms, prophecy, dreams, magic, angels, veiling, and partiality.³² Equally important is the dimension of *alghayb* that unfolds in time or is unsealed through scientific inquiry. *Alghayb* is not simply a noumenal realm that is tucked away from the phenomenal, even if respecting its opacity is critical to the submission to God or if miracles are not subject to scientific inquiry.³³ The drive to read the signs and to seek knowledge is also about the potential relationality to *alghayb*. Otherwise, no human can act on knowledge if everything is uncertain, unknown, or indeterminate. Knowledge entails a relation to unknowledge.

The performances of total knowledge and totality collapsed operating within a field of affinity and the openness to *alghayb*. Physicians were constantly performing *alghayb*, as the nephrologist who called herself a prophet with evidence, by referencing a finite limited knowledge. Other physicians, such as the oncologists, cited the research behind treatments they recommended (mostly conducted abroad), but then said that this was all they were able to offer an opinion on (*ifti* from *fatwa* or juridical opinion). Some physicians often utilized terms such as *bab al amanah* (the door of the trust of God) to reassure the patient that they were as honest as possible with the limited knowledge present before them in evidence-based medicine. In this way, they drew closer to the patient, but also created space between them by invoking the ultimate knowledge of God as *alghayb*, a present-absent unknowledge. Physicians actively resisted incorporation by the patient's desire or into the family to waylay loss and instead redirected this desire to God as cause.

This redirection of the patient's desire to God as ultimate source of knowledge occurred by deferring the cure to God. When patients would often ask physicians whether a treatment might cure them, the physician would respond by linking the treatment to the evidence at hand, and deferring to God's knowledge as greater (*Allahu a'lam*) and beyond them. In response, many times physicians confirmed their unknowledge and affirmed their commitment to do everything that was within their power while entrusting in God's plan (*tawakkul*). This very unknowledge surrounding the physicians' practice and their patients' demands, placed them in a precarious

³¹ Stefania Pandolfo, *Knot of the Soul*, 261.

³² Nils Bubandt, Mikkel Rytter, and Christian Suhr. "A second look at invisibility: Al-Ghayb, Islam, ethnography." *Contemporary Islam* 13, no. 1 (2019): 1-16.

³³ My engagement with my interlocutor's relation to *alghayb* is not to be confused with early modernist argument that miracles could be explained scientifically thereby subjecting *alghayb* to a rationalism that aims to reduce God's will and power to a natural empiricism.

position in relation to magicians and the assumed promise of biomedicine to cure. As a result, they attempted to redirect the patient to God and *alghayb*.

For some physicians' and patients' knowledge is enhanced by both attraction to or repulsion from God³⁴ as expressed by Sarah's desire for a virtuous family member. Yet for all, it was always about the field of the physics of affinity itself being open to the other. As knowledge is integral to both efficacy and power, to know your potential --what attracts, repels, manipulates -- is also to know your potential action and reaction, your future. The physician in knowing the other, is powerful. So, a prognostic practice, any attempt to produce or predict a particular effect is a form of power established through a totality of knowledge: by effecting a closure.

Theologically, this is both an unsealing and foreclosure of the potentialities of God's channels.

The opposite is true: if no relationality to *alghayb* exists then the field of affinity can collapse. If the physician purports to possess total knowledge of the illness then they will be incorporated alongside their treatment, as Aziza had almost done. The physician is then subject to a demand to cure and found culpable, as the cure depended on a totality of knowledge that they did not possess. In attributing the cure to Physicians, patients asked them to foreclose the future through definite prognosis. This was the function of knowledge within affinity and its potential collapse. The collapse of affinity is also collapse of the zone of *alghayb*. The collapse of *alghayb* necessitated the murder of the physician.

The Neurologist: Astrology and Affinity

In the hospital, people utilized Arabic humoral medical terminology to speak about what I am calling affinity. In meetings with patients they would make reference to someone's fire attributes or phlegmatic demeanor. As someone who practiced astrology, after much study of its use in the Medieval Arabic tradition, I often utilized it as well as part of my intellectual repertoire. Interns and medical students would recommend others with good temperaments, based on the nature of their blood: light (agreeable), heavy (stubborn), hot (easily angered), and cold (insensitive). This was in addition to their medical knowledge. Residents would suggest not to attempt to shadow physicians who were *nafsiya*, a neologism, meaning to be consumed with one's passions or self/soul. In spite of the remnants of Arabic humoral medicine, many would both discuss astrology and also discount it as it was also a taboo in the collective imaginary. In almost all of our conversations around astrology, I often made the necessary preface of my usage of astrology as a form of classificatory description of traits and habits rather than a path or guide from which to arrange my life decisions or foreclose my potentiality. This usually assuaged the general anxiety that both my interlocutors and I had around a notion and usage of astrology as a system of classification that encloses the potentiality of souls and futures.

In the same way, the physicians had to manage the field of affinity within the clinical space, avoiding incorporation by their patients and their families, I had to also manage it with my own relations to hospital staff, physicians, residents, and medical students. Important factors and social interactions for discernment about others within the clinic were also important outside of the clinical space. This was both at the level of social interaction and the kin network. People wanted to place me in terms of geography, lineage, personality, and profession. It was not simply whether they can account for my trustworthiness or a surveillance of my performance of ethical acts, but bore on my potential dispositions and discernment. People wanted to anticipate ways to relate to me. This field of affinity was a mirror of the field of affinity within the clinical space.

³⁴ Chapter 3 has a longer discussion on habituation or innate capacity of physicians. Some argue that a physician is good due to their intuition, which is a provision from God regardless of their piety.

Judging and knowing about the other, and they me, was not about what they do and assumptions they have.

As I followed the attending physicians, their residents, and medical students during rounds, two questions were constantly repeated. They would ask me and others about the region of our birth in Saudi and comment on our dress and demeanor. More often, those who overheard my California-accented English assumed that I was a Saudi student who returned home from studying abroad to conduct research. Others who heard my own Arabic dialect were perplexed as to whether I was from Jazan or Najran, two cities on the Yemen/Saudi border, or other Gulf countries. They could not quite pin it down. With the exception of a couple of Northern Yemenis who had rotations in the hospital and physicians of Ḥaḍramī, southern Yemenis, ancestry, very few ever guessed that I was of Yemeni descent or discussed theirs with discretion. Northern Yemenis were usually merchants and laborers, as one had to be a Saudi citizen in order to attend public universities. Many could not fathom that there was a Yemeni-American community in the US. The only wealthy and educated Yemenis they knew were Ḥaḍramīs, who became Saudi citizens early on and have a distinct Arabic dialect apart from Northerners.

I had discovered that Saudi was filled with Ḥaḍramīs, Yemeni laborers, and Yemeni traders, which further complicated my localizability. This hospital was also unique among other Saudi governmental hospitals in that it was filled with many Yemeni, Palestinian, and Syrian refugees and migrants who did not possess governmental insurance and could not afford private hospitals. Who I was and where I was from was fluid and was determined by the field and other bodies within it and their extensions outside of it rather than as something intrinsic about myself, where I am from and what I have accumulated along the way. In spite of the ongoing conflict and the crisis in the region, I was able to build affinity.

Ḥaḍramīs were integrated into Saudi society, intermarrying with other *Hijazis* with many acquiring citizenships as early as the 1920's. Many were prominent physicians, ministers, Imams, and entrepreneurs. Many physicians in the hospital were Ḥaḍramī Saudis, as they have a long history as seafarers, tradesmen, and Muslim scholars some were amongst the wealthiest families in Jeddah. They are referred to as Hijazis as many of them settled in the Hijaz, the area between Madina (reached all the way to Palestine during the Ottoman Empire) to the Saudi-Yemen border, and gained citizenship during the unification of Saudi Arabia from the 1900's-1930's. For the Hijazis, my cosmopolitanism as a Yemeni and American, reflected their own. Many of their own families traveling from Turkey, Syria, Palestine, Bosnia, India, Indonesia, and southern Yemen remained after their pilgrimage to Mecca.

As for Saudi Bedouins, to my surprise, my tribal lineage made me legible through an imagined shared ancestry. Ibb, a province in central Yemen where my family is from, contains some of the most prominent southern tribes and Qahtani roots, relating to old classification of an imagined affinal relation, Qahtan (Pure Arabs) and Adnan (Arabized Arabs). Bedouin Saudis consider Hijazis *tarsh bahr*, the vomit of the sea, and this question of difference is extenuated by access to resources, social networks, and social capital, essentially a route to and from expertise. As imaginary as this shared ancestry might be, it had palpable effects, whereby Bedouin Saudis shared their sympathy for the plight of the Ibb tribes from the resurgence of the Houthi rebels and takeover of the Capital Sana'a and welcomed me as a host rather than an intruder. Ibb was also a region of neutrality in the conflict that was ongoing at the time (2015) between the Houthis and the allied Arab countries. Although my embodiment of Arabness (*'urbah*), was often placed in doubt as I grew up in America, its very presence as a thing to be evaluated and measured was a form of access and witness to my trustworthiness and value of honor, making it

possible to maintain ties and to enter into exchange with. This affinity, operating as it did along multiple registers, was critical to my access to a multinational and cosmopolitan space, which was also spatialized by citizenship.

The second question was usually regarding my character and dress, which often was tied to region. Hijazi interns and residents often joked with each other about the untraceability of their lineage or their purchase of Saudi citizenship while Bedouin Saudis joked about their close ties to the Saudi government, as many did not have this imagined access. Hijazis are imagined to be more relaxed with respect to their manner of dress and temperament, embracing western fashion trends and ideals. Meccans are known to be rough and stubborn and rigid in their customs while nearby tribes are considered by Hijazis as backward and obstinate. People from Madina, similar to their portrayal during the Prophet's time, are considered to be very kind hearted, pious, modest (in dress and manners), and soft spoken. Ḥaḍramī, are stereotyped as scholarly, hardworking, but frugal and modest as many belonged to the *ba'alawi* Sufi order.

Everyone wore a white coat. Medical students, medical interns, residents, and female physicians. Male attending physicians, on the other hand, wore the traditional white robe and *'iqal* and *ghutra* or *keffiyah* (a black cord, worn doubled, used to keep a *ghutra* in place), becoming indistinguishable from Imams, businessmen, and administrators. Women wore slacks or skirts underneath their white coats while very few wore an abaya (long black robe) as I did. The physicians also encouraged me to wear a white coat, arguing that patients would not take me seriously or speak to me otherwise, as it was difficult enough for them to garner their attention.

Though these are stereotypes, people would enact them in order to remind each other of their past and in order to reform or affirm a reputation they should uphold. Therefore, when people heard I was from Ibb, they extolled virtues of the people of Ibb as kind, generous, honorable, pious, hospitable, and affinal. In addition to behavior, mood, and orientation to others was a surprising attunement to one's appearance: in a place that many often imagine as a land of turbans and burqas, most everyone sported the latest fashions underneath their white coats, slim jeans, loafers, while their ID badges hung from Louis Vuitton, Coach, or Gucci lanyards. I, on the other hand, was often teased for not wearing make-up and wearing last season's dull abayas. That was what I could barely afford on a graduate student salary, as other abayas could be as high as \$1,000.

As a university hospital and also a hospital that is open to the public during visiting hours, from 5 to 9 pm, patients and their families encountered various individuals on any given day who varied in dress. Without my coat, they argued, I was indistinguishable from these visitors. I would relay to physicians and residents the voluntary condition of participating in my research and how a white coat exerted influence and power that would otherwise coerce patients and violate the Internal Review Board ethics. In return, they shared their skepticism of my ability to recruit patients without a white coat, sharing their own struggles to recruit participants for their own research, as it was difficult enough to convince patients of their treatment's efficacy and the importance of their participation in evidence-based research. Other interns and residents suggested that I bring tea and snacks and convene a communal sit-down that would allow me to build rapport with patients in shared rooms. Yet, managing my relationships with hospital staff were just as if not more precarious than it was with my interlocutors.

The bulk of my fieldwork depended on negotiating relationships with medical personnel, physicians, the Interval Review Board, and obtaining the good graces of the guards (especially in the ICU, which had restricted access). This should not have come as a surprise to me, as I had a fair amount of experience living and traveling in the southern Arabian countries, but it did. It

would be through my lineage, and ability to converse with others about others through my knowledge of astrology, social theory, and psychoanalysis that I negotiated working relationships. As physicians thought about the field of affinity often, having an anthropologist around to discuss habits, proclivities, and logics of practice was of value. This is opposed to the typical narrative wherein the anthropologist gains access by virtue of a power that imbues them, by virtue of the anointment of a western university, especially when conducting fieldwork in institutional settings. At some point, people started calling me the hospital therapist.

My interlocutors often reminded me that I am Arab and Muslim and that I do know what I should be doing, how I should be acting, and what they may believe. This reminder was both for my edification but also placed in doubt my reliability as a source of witnessing, my potential proclivities, for us both in order to manage affinity. They were not asking whether I was teachable as a new member of a group or community in order to be incorporated, but the question instead was whether I understood how to manage the attraction and repulsion in interaction, my own relation to *alghayb*. Were my actions and reactions predictable? Did I have the ability to discern? What was repeatable and what was not? The question of trust was raised through signs and the readings of my disposition and connection by way of my lineage. It was against this background, of the social potential of knowledge of the other in my fieldwork, that astrology became a form of inference and prognostic method.

When I mentioned to Dr. Naseem my use of astrology as a guide to navigate these relations and avoid being captured in the same way as the physicians, he also expressed his own fascination with astrology, but limited his interaction with it as it was derived from the same mathematical science of *sihr*.

There's another form of calculating someone's attributes that people consider *sihr* (magic). You would take your name and your mother's name, then they will figure out if you are fire element or another element. There isn't anyone who practices it, but people talk about it. For example, my sister named her son after our grandfather. My sister is also named after our grandfather's mother. My father told me that my sister's son has the same attributes of our grandfather.

I said, "yes, naming practices, *sumya*, taking on the attributes of the namesake is very prevalent in Yemen too."
Dr. Naseem continued:

This is more prominent when the two mothers' names resemble (in addition to the son). I read this in my father's old books. There's some of these books called *Khawatir* and *Kashkut*. When I asked my father, he said that there is mathematics to these practices, that the letters transform into numbers. *Sihr* is conducted utilizing these same mathematical operations. If you read into these practices, you will enter into other worlds and other realms.

The close association between *sihr* and astrology through their methods alarmed me. It unearthed a deep-seated doubt within me regarding my own usage of astrology with my interlocutors: had my use of it to classify, understand, and read as a discursive tool to foster affinity unconsciously been misguided? Unlike astrology, *sihr* is an engagement with and intention to manipulate the order of things through cosmological sciences, astrology being one,

and by also deploying non-human beings, namely the jinn. Dr. Naseem sensed my ambivalence toward astrology, fueled by scholarly debates against it and its repression among lay people in Islam. Yet, people's continued engagement, even fragmented and distant, with remnants of astrology and numerology points to its insistence of a past to be heard. Both the moving away from prognostic practices and also the hyper-rationalist relation to knowledge of the self contribute to its dismissal as pseudo-science. My own concerns lay with blameworthy practices within the tradition as an essential corrective to fluidity of the self, the lack of submission to *alghayb*, and unproductive enclosure of the field of affinity. Living in Yemen, we often had astrologers come to our homes to decipher our astrological signs and Chinese calendar, a practice at once predictive and diagnostic. In hindsight, my mother often dismissed it as a form of indulgence of a particular period in the life of our family, our very own “*jahiliya*” (pre-Islamic/time of ignorance). What is missing from the collective consciousness was that astrology and magic were sciences in medieval Islamic knowledge production, grouped under physics and mathematics.

In Islam, magic and astrology are not in excess of the natural law or a concretization of a social or psychological influence emanating from an assumed supernatural force. The realities of the ‘*ayn* (evil eye), *sihr* (spells/conjuring), *tanjim* (astrology), and *sha’wadha* (quackery) are confirmed in prophetic teachings, narrations, the Quran, and the exegetical traditions. This is in addition to their classification in the Islamic philosophical tradition as subdisciplines of physics. *Tanjim* comes from the word *najm* which means origin, celestial body, star, divination, or fortune-telling. It is from the reading of the position of the stars during one’s birth, and charting thereafter, that one can extrapolate one’s attributes, character, and life trajectory. *Sha’wadha* means trickery, fraud, and deception through ineffectual means, whose practice is essentially a form of naivete. *Sihr* is manipulation of the cosmos. The root *sihr* derives forms that encompass the meanings dawn, day-break, lung, bewitch, curse, fascinate, conjure, and restriction of one’s breath. The word for curse or conjuring is also the word for hidden organs, such as the lung, the restriction of breath and the breaking of dawn, tomorrow, and the future.

Sihr and *tanjim*, *ayn*³⁵, and *sha’wadha*,³⁶ whether predictive of a future or seeking to bring it about or revoke it, take the form of a prognosis, the knowledge before the event, before the action, and behavior of a being. These four prognostic practices serve as a constellation for a flotilla of intimacies between perception and incorporation, action and intention, and God and his channels. It is an illusory enclosure of the future through an unsealing of fate that makes present a future unknown. Yet *Sihr* and *tanjim* are not a complete enclosure of the future, but the creation of effects made visible through the channels of the *jinn* disguised as a disclosure of what is assumed to be all of God’s knowledge, an illusion at best.

In *sihr*, the magician devises and orchestrates this unsealing, applying his will to natural forces by enlisting jinn to what they perceive as an overt perversion of the channels of God. However, when deployed by a magician, the Jinn persist as mere mediators. In the chapter on the jinn in the Quran³⁷, the jinn mock humans for leading themselves astray through their own will to effect change even if it was by way of following the Jinn’s suggestion, arguing that all Jinn

³⁵ In the case of evil eye, the Prophet stated that the gaze of the one who envies and wishes to strip the blessing from the gazed upon is preceded by the jinn, so one is prescribed to invoke God’s bounty utilizing the invocation *mashaAllah* (whatever God wills).

³⁶ The illusion created by the those who practice *sha’wadha* (who are also herbalists) is similar to *sihr* in attempting to bring about a particular future desired by the patient except he does not utilize the jinn and is a public and accessible figure. Many believe his practices are more akin to as placebo effect.

³⁷ (Quran, 72).

not only fear God but do not deny God's powers as the source of all power. Within the magician/patient encounter, what the magician discovers or discloses about the person seeking knowledge on how to bring about a particular future is his past and present. The magician through the assistance of the *jinn* and magic, comes to read the signs about the life of the patient. However, he does not know their future, but can merely convince them that they can deliver it.

Sihr and *tanjim*, even in enlisting natural forces to enclose a future do not transgress the power of God, or channels, according to the Quran. *Sihr* is a powerful force that brings forth an event from the future and restricts the expansion and potential of the soul. As a source of power, *sihr* does not just claim causality in the present, but in the future. Its temporality structures the life of a being according to a particular fixed restricted future rather than being open to the potentiality of the soul and God's fate. *Sihr* is a practice of prognostication but one that not only offers gnosis, knowing, but also acts on the future by restricting it.

This question of prognosis, of soothsaying, has led to much debate in the tradition regarding the permissibility of practices like *sihr*, astrology, healing with medallions, and the reading of palms: the potential to enclose one's fate by disclosing it, the certainty in the unsealing of the unknown. The manipulation of natural forces by demonic beings through the breaking the veil that these practices entail forecloses an openness to a future. In taking some other form of power as my aid in this world, I have altered my present by hastening a particular future, setting it in stone and as a result risk foreclosing the possibility to relate to God as the ultimate cause and intercessor through prayer and supplication. My supplications and prayers to God would otherwise maintain an openness of my fate and to the future, as supplications are said to wrestle with fate in the heavens to (re)determine the course of one's life.³⁸ In turn, my own hasty decision to alter my present by choosing a particular future erases futures that are beyond my own foresight and understanding of the best course of action in my present world, the afterlife, and the states of my body and soul. It is both this arrogation of the powers of God and non-openness and intolerance to the unseen (*alghayb*) and to unknowledge of the future and afterlife that prohibits these prognostic practices. The moment when you interface with magicians, who possesses only knowledge of the past through the assistance of the *jinn*, you allow their soul to occupy your will by accepting the future they present before you.

Therefore, both *sihr* and these practices become suspect only in their illusory aspects mentioned above. But, *sihr* is not denounced as an illusion: it has real effects. Rather, it is disavowed as a closure of the trajectory of a cause and an effect (the magician's will and the future enclosed). The magician's explicit and undue arrogation of the power to enclose knowledge of the future, his misunderstanding of fate itself, is the source of both the illusion and the reason it is prohibited. The recruitment of impersonal forces is not what prohibits magical or religious rites. Instead, it is those prognostic practices that aim at self-sufficiency, a share in divinity, or restrict the future that transgress.

Emphasizing that the same mathematical operations of astrology and numerology are used in *sihr*, Dr. Naseem argued that it was more than simply a secondary rationalization for a physical manifestation. If the celestial bodies and the placement of the planets affect a human's composition or temperament---through the air that we breath and the earth that grows our food to the moisture, water, or lack thereof (as in the dryness of fire) present---then we are continually affected by the cosmos. According to the Sheikh in Saudi I worked with, when one is born, the quality of the air and soil which impacts the very nutrients that one consumes informs their temperament, elemental combination, and the resulting proclivities. In his own PhD training,

³⁸ al-Ghazālī. *Invocations & Supplications*, 90.

understanding astrology had been important to begin to build a repertoire as to how to decipher different people's temperaments, receptivity, and lacks in order to better serve them and their communities. Therefore, the spells cast were actually mathematical operations that put into effect the very cosmological forces that manipulate one's own material, physical, psychic acts by apprehending unknown or unseen knowledge.

This proximity of *sihr* to astrology unnerved me and challenged the way I viewed magic as some exceptional zone of engagement. In retrospect, the multiple registers according to which I had to navigate relationships, difficult as it may have been, their affinal components, and the risks involved (including my own faith, my relation to God, uncertainty, and the gap between me and the other) with my usage of astrology, was about affinity. Was astrology my own way of filling a lack, an uncertainty of my own desire for incorporation into the hospital, or my desire for receptivity?

Dr. Naseem and I laughed at how our own compatibility may very well be due to the affinity of our own astrological signs, which are mutually receptive to one another. His wife and I had the same astrological sign. She was hard working, often misunderstood, perceptive, and vents a lot. These were common features we shared. Dr. Naseem and I joked about how the more you generalized about someone's sign rather than looking at the entirety of their chart or even have a disregard for their potentiality to overcome some proclivities of their sign, the less capacity, room, fluidity you grant the other. Not all Cancers nest in their homes and not all Geminis are two-faced, regardless of how fans felt about Angelina Jolie's divorce from Brad Pitt. Yet, our own encounter and his willingness as an interlocutor may have been astrologically fated.

Dr. Naseem and I discussed what it meant to mark such generalization and conclusions. To my surprise, many of my interlocutors argued that my own disposition did not completely fit the typification of my sun sign (one component of one's astrological chart). For them, I did not exhibit the typical asocial, suspicious, reluctant, and intimidating demeanor. However, these generalizations were the very assumptions that could collapse the physics of affinity as they delimited what an interaction with someone with my sun sign could entail. Both the enclosure of the knowledge of others and the world in order to produce an effect and anticipate affinity existed within the frame of affinity.

Dr. Naseem assured me that I was not dabbling in magic, reading people's fortune, nor deluding people in order to lure them to participate in my social world by discussing their moods based on their moon sign and the predictability of compatibility of their Venus³⁹ planetary sign and their betrothed. As many may denounce the use of astrology as a form of a secondary cause in the popular imaginary, Dr. Naseem assured me that my usage of astrology to predict potential affinity was not blameworthy, prognostic, or illusory. Dr. Naseem noted that Magicians themselves transgress by deploying jinn and crossing a barrier:

You are far from these practices. You pray and fast, so you have a barrier that distances you from *shayāṭīn* (demonic jinn) and these realms, so you don't see them or their realm. But once you break the barrier, you open a door to the other realm. When an aspiring *sahr* (magician) wants to break the door (to the other realm) in order to practice magic, he makes a great transgression. He may write Quranic verses with period blood or rip pages of the Quran and throw them into the bathroom. In this way, he becomes outside of the fold of Islam. He gives a sacrifice to *shayāṭīn* and gains access. To further this access, the

³⁹ Although a person's sun sign discloses one's potential disposition in a general sense, Venus represents the ways one experiences love and pleasure.

sahr enters into modes of seclusion by going to caves, which are known for encounters with other forms of being. The *sahr* does this out of idiocy. The *shayāṭīn* will benefit from him. Yes, they will be at his service, but he just made the *shayāṭīn*'s work easier. By exiting out of the fold of Islam and faith (*dayanah*), they forfeit the protection of God. When you pray, you have protection from angels (*Hafadha*). They lose that protection. They lose God by virtue of becoming a *sahr* and will become those who will draw other people to transgress. If they do not [lead people astray], what will stop the *shayāṭīn* from murdering him?

Many cases of *sihr* are transgressive and denounced due to its erosion of another's agency. Many Islamic scholars go to the extent to warn against utilizing such practices in any form to produce an effect, whether to control another human, one's body, or one's soul or to predict events. *Sihr* is meant to produce an opening for possession of a jinn and an enclosure of a future. The pitfall of *sihr* is the manipulation of others for one's advantage. When magicians want to produce an effect upon the person's soul or body, they must possess a trace of someone or have them ingest something. By placing a knot around the material trace of the targeted person, in the form of a lock of hair, blood, or garment or have them ingest the potion, they bind a jinn to that trace. They knot the jinn to their soul. To learn about a person's past, magicians also utilize jinn to gather information by deploying them to speak to the person's *Qarin*⁴⁰ (spiritual double), which is theologically understood as an ensouled companion (a non-human essence that is not a jinn), that a person disciplines or be disciplined by and led astray away from the path to God.

Through the magician's intervention, you place your soul in the will of another, place another under the will of the jinn, and attribute any effects there in to a primary cause other than God. In denouncing such acts, scholars do not claim that the magician or the jinn exceed or are other to God's channels of power for all action. They do not deny that magic and jinn have real effects. As such, these scholars prohibited their use and deployment rather than claim they are false or refer to them as forms of placebo effects. This is opposed to opinions on prognostic practices, which are said to foreclose God's powers. These prognostic practices do not simply rely on jinn, and their influence on the soul and will of another, but also on the readings of other signs generated through the science of astrology. The focus on communal societal structures and the mediation of self and other was a general question of a field and the physics within it---the motions and movements of bodies---and the forces of attraction and repulsion and the powers channeling them. It cannot simply be theorized as a necessary incubator of establishing boundaries due to the potential evil of the neighbor.⁴¹

In the Quran, it is narrated that God has created the *jinn* and the human to worship him. *Jinn* are presumed to be the beings that God created before Adam that were wrathful upon the earth, which is recounted in the dialogue between the Angels and God in the chapter on the cow (Surat al-Baqarah). God created a veil between humans and jinn in order to protect us. A lot of stories about the jinn come from the prophet Suleiman, the only prophet that we know of to have been given the privilege of conversing and interacting with the jinn. In the chapter on the cow, it is stated that Suleiman (Solomon) did not deny God (*kafar*), but that the *shaytin* (demonic jinn) taught men magic and in doing so disbelieved by sharing these practices that pervert the channels of God.

⁴⁰ The spiritual double, *Qarin*, is mentioned in the following versus: Quran 50:23, 4:38, 43:36, 37:51

⁴¹ Jeanne Favret-Saada. *Deadly words: Witchcraft in the Bocage*, (New York: Cambridge University Press), 1980.

and [they] follow [instead] that which the evil ones used to practice during Solomon's reign - for it was not Solomon who denied the truth, but those evil ones denied it by teaching people sorcery -; and [they follow] that which has come down through the two angels in Babylon, Hurut and Marut-although these two never taught it to anyone without first declaring, We are but a temptation to evil: do not, then, deny [God's] truth! And they learn from these two how to create discord between a man and his wife; but whereas they can harm none thereby save by God's leave, they acquire a knowledge that only harms themselves and does not benefit them - although they know; indeed, that he who acquires this [knowledge] shall have no share in the good of the life to come. For, vile indeed is that [art] for which they have sold their own selves---had they but known it. ⁴²

According to these verses, magic was sent as temptation to evil, which is illusory in its benefit and temporally truncating within an Islamic eschatology. The Jinn that turned demonic have done so in service of Iblis, who requested from God the ability to test the people of Adam by way of their heart, so that he can prove their fallibility to his being. As an angel made of smokeless fire, he was far superior to Adam's clay. The *jinn*, which share his likeness, are often deployed by him. Yet, not all jinn are demonic *jinn* (*shaytin*). The distinction between *shaytin* and *jinn* reveals that some *jinn* are believers and Muslims, pray amongst us in disguise, but can never reveal themselves nor are we meant to encounter them in this world as a question of safety and limits. Both humans and jinn have limits in this world under the channels of God and the prescribed realms. The transgression of the boundary, movement from one realm into the other by either jinn or humans, although still an illusion that it occurs without God's will, garners the displeasure of and distance from God as protector and pardoner. Many *jinn* stories attest to these presumed myths.

Dr. Naseem has always believed in magic, in jinn, and their potential evil, but it was not until his neurology residency that he encountered various manifestations in the hospital, crystalizing the reality of his limitations.

I once saw a patient who had more than one surgery for tumors. On her second visit, the patient was in the ICU and I was paged to go see her. When I arrived at the ICU, she told me that there was a woman reciting Quran three beds down from her and requested that I tell that woman to stop reciting. I then went to the woman (another patient) reciting Quran and asked if she could stop reciting Quran. The woman reciting Quran said that she could not as she was afraid to since she felt that the patient who wants her to stop reciting is possessed with something. When she stopped reciting Quran, my patient calmed down. As I walked back to my patient, I began to recite *Ayat al Kursi* quietly to myself, as I also became afraid. The patient saw me reciting to myself and told me to stop reciting as well. I was more afraid then. My patient then frankly told me that before entering the OR, that she saw a jinn that told her that the tumor will return. Later on, her husband told me that his wife went to a sheikh where the sheikh confirmed the *sihr* and that was why her tumor returned. This was the third time of its return. I believe that *sihr* had been knotted.

⁴² (Quran 2:102) Translation by Mohammed Asad.

For this ICU patient and Aziza, what is a physician to do? Where would they send them? I asked Dr. Naseem what is the role of the physician in relation to the illness brought about by *sihr*? Dr. Naseem responded with a caveat. His awareness of the potential presence of magic led him to recommend to patients that they need both treatments: the biomedical and Quranic. He often suggested to his patients to bring their sheikh during visiting hour and to recite Quran on themselves for protection.

Even if this is magic or evil eye, you need to believe that what happened to you might not be changed. This is an ordeal from God. It is not 100% certain that it was magic or evil eye. Even if it was magic, this is an ordeal from God (*ibtila*). You have to have faith that it is an ordeal and that God will test you and he is testing you. Because you are in a test and if you want to pass it then you have to have faith and supplicate for the cure from God. The physician and sheikh are not the ones who will cure you.

In the end, Dr. Naseem knows that the only way to unknot a *sihr* is by unknotting it through its spell. The magician is the only one who can unknot it and even then the jinn can turn on him. Nonetheless, Dr. Naseem suggested that people should learn the science of magicians in order to reverse the knot rather than cast this knowledge as idolatry. Although physicians dealing with the effects of these practices attempt to treat the physiological manifestations and Quranic healers attempt to exorcise the jinn, much of spells must be unknotted by undoing the spell. Though other forms of therapeutic power can affect the body, magically cured illnesses should be addressed also at the level of magical efficacy. He acknowledges that this is a limit to him as a physician. He cannot unknot magic. It is this very inability that often raises questions of physicians' own expertise of illnesses, particularly in those cases where the illness took the form of jinn possession. The fact that magic exists, that its science remains pervasive, and an ongoing practice demands an engagement from within the Islamic tradition rather than being buried. Dr. Naseem's provocation is not an easy one.

Even though much of Dr. Naseem's knowledge about the *jinn* or *shayatin* came from his father and grandfather, he also read some of the books his family owned. He recounted how his father and elders in their community attested to abandoned places in the desert where magicians sought other magicians to be instructed in their magic. *Sihr* and its science was produced by numerical operations that resemble those that examine the elemental compositions of humans and reflect their cosmological underpinning. This very knowledge is available but required a particular type of training and mastery of one's soul and strength of faith in God.

I was able to gloss some of these magic books, but could not fully read them because to read them is to recite and to recite is to bring them into being. By reading and in reciting these magical texts it incarnates forces and beings, enacting a speech act. This led me to restrict the amount of time I spent examining these texts. These texts included old drawings of jinn, mathematical and cosmological diagrams, spells, recipes to communicate with and call jinn, and formulas in non-Arabic script. To my dismay, the supplications included the glorification of God through his names/attributes/power, as well as appropriations of more familiar supplications derived from *hadiths* and Quran for ends that involve the manipulation of people's will.

Magicians manipulate supplications, invocations of God for remembrance and praise as signs of gratitude and humility, which gives reciters consciousness and brings their daily life as a need for further blessings in this life and the thereafter. Instead, these manipulated invocations become spells, as they unbind the supplication from its source of power and redirecting it,

bending other people's will and conjuring the jinn as a channel of power. This has led to the banning of these texts: without proper training in jurisprudence and theology (and strength of soul), it would be dangerous to interface with them. Therefore, these texts and practices do not fall within the Islamic sciences, but rather are prohibited. They place one in risk and danger of exiting the fold of Islam and entering realms one may not necessarily be equipped to navigate. They make humans susceptible to the potential evil of demonic jinn whose reality is affirmed though their agency is still attributed to the Divine. For Dr. Naseem, both physicians and Imams are only instruments of God, not the cause of the cure.

If you go to a sheikh and say he is the source of the cure then you made him like the Pope in the Vatican. He is not our God. This sheikh has bad deeds and you do not know and you don't need to know about the physician either. But you have to know one thing, and that is your orientation toward them. You could also be your own sheikh as you know your own deeds. You recite Quran on yourself, you perform remembrance of God (dhikr), you recite the chapter of *Yasin*, and supplicate. There's a story, my father told me. That there's someone always living off charity. One man, a sage, told this man whether he wants him to give him charity or teach him something. The man told the sage to teach him something. He taught him one saying. Verses from *almuzamil*, "the lord of the west and the east, no God but he, take him as a *wakil* (an agent).

Anyone who arrogates to himself the power of cure has deluded themselves into thinking he or she is the true cause and cure of illnesses, which belie the real causality of all things and recognition of God's channels of power. Since physicians and Quranic healers are mere instruments, Dr. Naseem argues, they are dealing with the symptom rather than the knot itself, the origin.

Physicians' difficulties with the designation of life giver and taker and the uncertainties around the cause of illness often turn into theological quandaries. They understand themselves as mere instruments of God and oppose themselves to the magician in two ways. On the one hand, physicians believe that they are instruments of God. On the other, Muslim physicians deferred all causality to God, both regarding the illness and the cure, the knowledge of the cure is *ghayb*, veiled. In this deferral, they opposed themselves to the figure of the magician. It was not on the basis of epistemological arguments that positioned an irrational magic against rational and empirical science that physicians criticized magicians. They do not deny the effective power of magic: the magician very well could be a cause of an illness through conjuring (*sihr*). Though the magician also gives the illusion that they possess the power to conjure the cure as a matter of their immediate willful power. However, magic in Islam is still susceptible to the will of God. This arrogation of causality, contrary to the physicians', is a claim to channel, or transgress, the power of God. Physicians repudiated this aspect of the magician's claim to causality, but not at the level of the epistemological status of their work or their effects-----rather, at the level of theology.

As mentioned above, the nephrologist's insistence that she was a prophet incapable of performing miracles rather than a magician had two implications: 1) a rationalist reading of the status of prophets⁴³ as one who does not produce miracles and 2) the distinction of a physician's capability from the magician's illusion of power. The rationalist reading of the epistemological status of the prophet as the messenger of truth configures it as distinct from the category of

43 Fazlur Rahman, *Prophecy in Islam*, Routledge, 2013

miracle was necessary to perform the space of *alghayb*, to manage affinity. A miracle then, would be an act of God that was given to previous prophets rather than the manipulation of natural forces. The magician gives the illusion of mastery over nature, though they inherently cannot supersede divine forces nor defy the boundaries between heaven and earth, created by God, except through God's will.

The Illusion

The magician's illusion is effective in that it encloses everyone in the totality of their knowledge of the illusory netherworld they construct, the containment of a vision of a world. The magician has a recipe that aligns with a physics, grounded in a particular cosmology, knotting, incising, and concocting potions (not very different from a physician) that attempts to draw the targeted person's focus and gaze to the effectiveness of his magic thereby producing the conditions possible for transforming their physics, their physical composition. The bewitched or patient is entangled in their attraction to or repulsion from the effectiveness of the magician or physician and as a result, they participate in the illusion by choosing the version of the future that the magicians conjures. Illusion as it is presented here parallels the way illusion is presented in the *Communist Manifesto*. The illusion for Marx and Engels is a vision of the world that has real material effects. In the same way that magic forecloses the potentiality of the channels of God, capital forecloses the potentiality of the netherworld, which is why the proletariat must win a world rather than possess the means of production.

In the *Communist Manifesto*, Marx and Engels illuminate the illusory nature of magic, a means of production, and the illusory totalizing power of the sorcerer.⁴⁴ According to Marx and Engels, the sorcerer is not a sorcerer as we understand them in our world/society as one who controls paranormal activity. They are a transformer, a manipulator of their society, a conjurer of 'a world.' In applying their spells, which have a developed procedure that require certain tools, they disclose a method detailing the proper employment of that procedure in the production of certain effects. As a result, sorcerers produce change, transform, manipulate, or pacify "stuff" in the world: their procedures have material effects because of the relation to a totality of power of the illusory netherworld that they project.

Like the sorcerer's proclaimed property relation to the netherworld, a parallel illusion of total power they do not possess, the Modern Bourgeois (MB) set up free competition through magnified means of production and of exchange contingent upon certain property relations, relations of production, and instrumentations.⁴⁵ This is a world contingent upon the effects of capital. The MB possess the means of production that makes their action effective only insofar as they project an illusion of a totalizing power that makes their actions effective.⁴⁶ It is only an illusory power over capital and the nether world. The MB cannot be the localization of that power and as such capital and its production exceeds them as a historical fact, inevitably open to both the overhaul of the means of production by the proletariat and the unpossessable nether world.⁴⁷ While capital calls forth the forces of the nether world, increasing it and attempting to curb its force through the MB's modes of production, the nether world can never be fully possessed. However, the MB project an illusion of totality and try to preserve that illusion by making present a particular future that forecloses other potentialities in the same way as sorcerer

⁴⁴ Karl Marx and Friedrich Engels. *The communist manifesto*, (Penguin, 2002), 41

⁴⁵ Ibid, 41.

⁴⁶ Ibid, 40.

⁴⁷ Ibid, 40-42

presents an inevitable future by foreclosing all others. It is not a coincidence that Marx parallels the illusory power of the sorcerer to the MB, as a projection of a totalizing power and knowledge over the netherworld and conditions of possibilities within it. In the same way that magic forecloses the potentiality of the channels of God, capital forecloses the potentialities of the nether world, which is why the proletariat must win a world rather than possess the means of production in order for the future to remain open.

Therefore, what Marx considers the netherworld, I view as *al-ghayb* through Moses' miracle. The miracle can extinguish the illusion of the magician, as in the example of Moses' altercation, as it is of another order, outside of time and space. It points to other structuring forces within the physics of affinity that interrupts the illusion of totality. By pointing us to what secures a vision of a world that produces effectiveness, the illusion of totality within relations, it reopens the field of the physics of affinity by reintroducing *al-ghayb*. The management of the field of affinity secures the vision of that world that produces effectiveness. The miracle interrupts the mechanisms that attempt to totalize knowledge and its potentiality and possible effects. As Derrida remarks, in mourning a lost object, a lost world, Marx "is out to get the specter."⁴⁸ He argues that Marx "draws a diagnosis and prognosis" that refuses a magical recovery of the lost world for the sake of a revolution or return prior to capitalism, an instantaneous recovery of a loss, in the form of imitation and death by way of identification (the future of the revolution) which is parallel to attributing the cure to the physicians.⁴⁹ Therefore, revolution is only possible through the decryption of the MB's magic and an openness of the future just as healing depends on the openness to *al-ghayb*.

Both the physician's and magician's knowledges are finite and temporal, but they are also temporally truncating: they focus on current events and immediate consequences. Though their prognostications may presence a future, the long-term effects, and the many potentialities, are outside their purview and within the domain of God. The fact that patients take up their treatments, enter their dream-work, and participate in its illusion is what anchors their effectiveness within the field of affinity. It is this very affinity that the physician then attempts to counteract, that they must work to counteract, in this moment when the promise of biomedicine's illusory effectiveness is unavoidably present within the clinic.

When a patient enters the office, the physician affirms that they will conduct all the investigations and provide a recommendation, which is based on evidence conducted by other leading figures for the treatment of others like them. This invitation to believe in the production of effectiveness is received by the patient who at times accepts it or may ask the physician for their number to remain in touch. When physicians become incorporated and fail to redirect the desire to God, the treatment fails, and altercations ensue, because the patient has been enclosed within the illusory world of the effectiveness of the doctor and their knowledge. However, when physicians remained in touch, to both ensure the patient continued the treatment plan and understood its limits, they coordinated the field of affinity, attraction and repulsion. They were not completely incorporated and the patient was not enclosed within their prognosis. The world of biomedicine, and its effectiveness, takes the physician as its magician who mediates it by casting spells, refining its tools, and deploying its methods. Evidence-based medicine revolves around the production of concoctions for clinical trials that represent the effectiveness of successful treatment or physical transformations. The expansion of evidence-based medicine

⁴⁸ Jacques Derrida, *Specters of Marx: The state of the debt, the work of mourning and the new international*, (Routledge, 2012,) 128.

⁴⁹ Ibid, 128, 144.

across space and time, and many times its failure to encompass its own temporal shortcomings has led medicine to continually need to revolutionize itself, to become even more personal, more magical.

Just as the collapse of the field of affinity leads patients to devour or incorporate the physician as a family member, when the incorporated physician fails to deliver the cure, it is only by the extremity of murder that the physician can be expelled. We may want to think that the magician can also be found culpable and may face judgment in this world, but then again, even if one goes looking for the magician, he wouldn't be found at home.

Chapter 5: Illness as Passage: The Absent Patient

I devoured the water of the sea
until my unquenched thirst left me as debris
I dipped a finger into the tides
wand in depths of cries
The sea says,
I found company for my floating body
shifting course blindly, heads up gladly
like a curse cast onto its curse
blood running fast first and arms moving slow last
“Refuge” by Ashwak Hauter¹

“Health is a crown only the ill can see” – Imam Shafi‘i

The Illness as Passage

The field of medical anthropology has long examined the illness in opposition to disease,² the subjective experience of medical realities. From the earliest time of the discipline, medical anthropologists focused on the illness as a problem space. Their reading of the illness as a subjective elaboration of physical ailments, or imbalance of one’s body, positioned against the biomedical representation of the ailment, the disease, and the semantic configuration³ of certain physiological expressions of one’s physiological impairments. The lure of the illness for everyone around it and its interweaving narrative speaks to the ways the illness knots us all in its uncertainty, infinity, and incoherence. It belongs to no one but itself.

The illness did not present itself in the hospital as a singular, atomistic experience, nor as physical expressions of psychic or spiritual malaise. To relate to it, physicians within the hospital spoke of the illness as an imbalance of an individual’s norm that was read according to a spectrum—rather than by way of one concrete, congealed state, which might vary from person to person—and that involved other factors beyond physical ailments.⁴ When physicians saw or visited patients’ they told them: *‘qudamak al ‘afiya,* “May *‘afiya* be ahead of you.” Here, the illness was not the opposite of physical, psychological, and spiritual wellbeing (*‘afiya*). In the hospital, *‘afiya* was used to speak of patients’ passage through an illness. Their movement away from the illness included a holistic transformation of the body, soul, and psyche rather than the recovery of health which is represented by the Arabic word *saha* (physical health). Even *saha* is not the opposite of illness, but one aspect of *‘afiya*. In this chapter, I explore the illness as a passage, where its treatment exceeded *saha*. Just as the unfolding relation of illness to *‘afiya* in the contemporary hospital returns us to the ways the illness was a site of understanding the body-soul-spirit nexus in the medieval tradition, Imam al-Shafi’s aphorism (quoted above) returns one to the ways ‘vision’ and ‘imagining’ was thought in Islamic medieval medicine. Imam al-Shafi cites the illness as a vision, as an exemplar, where the crown is secured only in the reflection of

¹ Oatmeal Magazine, No. 12, May 2017

² Kleinman, A., 1988. The illness narratives: suffering. *Healing, and the Human Condition*.

³ Good, Byron. “The Heart of What’s the Matter” *Culture, Medicine and Psychiatry* 1:25-58, 1977.

⁴ This conception of health was an old definition that was shared by medieval physicians such as Ibn Sīnā. See, McGinnis, J., 2010. *Avicenna*. Oxford University Press, Pp 227-244.

the other's lack: the illness crowns the healthy. A person does not give themselves health, but health is conferred upon them.

'*Afiya*, in particular, is one part of a two-part supplication that everyone makes to God for "pardon and physical/psychological/spiritual wellness."⁵ Hence the request for pardon for one's impious and unjust acts, those sparked by the ephemeral passions, is both a request for purification and predisposition to repeat of transgressions against one's self/soul (*nafs*). Ultimately, the predisposition to repeat transgressive acts harms one's body and constrict one's soul. If '*afiya* is ultimately from God, then the request for '*afiya* is one made to God; therefore, its absence is also to be addressed to God. The loss of '*afiya* is thus viewed by some patients as an ordeal, divine trial, or "*ibtila*," but also a '*ibrah*'⁶ (passage).

Many patients spoke of *ibtila* as that which was necessary to accept as part of a divine decree. Within the Quran, there is a revision of the pre-Islamic Arab fatalism that saw life end at death. Instead the course of human life and death is in the Quran as a passage to an afterlife.⁷ Pre-Islamic Arabs understood fate as the work of time, as the dominance of impersonal forces that drive one's life on an inevitable course, which no hope or action can alter.⁸ The Quran, in contrast shifted the meaning that one could extract from temporal calamities, both individual and communal; calamity might be viewed as exemplar of judgment—both in this world and the ultimate judgment in the afterlife.

Ibtila comes from the trilateral root b-l-a, which means to try, plague, and afflict. There are multiple root stems that form sets of associated meanings, including: to take notice of, to mind, and to heed as well as to decay, to render worn out, to wrack—just as a dress you wear too many times, rends and tears. The various stems of b-l-a show the correspondence between decay and an attunement to the shift in one's condition. Patients throughout the hospital that spoke of their illness as *ibtila*, also spoke of their bodies' affliction as wearing out a past, a past of body-self/soul, a past of collective indiscretions—socio-economic, political, or spiritual—and a readiness for a future body-self/soul. They often admitted to the possibility of such an affliction preventing a more severe fate or preparing them for the decaying conditions whether humanly devised or divinely ordained. The ordeal was also understood by some patients as purifying of past deeds, where they strayed from the divine, while for others it was a sign, heeding, warning, and accounting for either the ill individual or the collective. The illness as an atemporal conditioning of the body-soul accounts for a past, suspension of a present, and openness to a potential future. Thus, the ordeal was not indexed simply as a *spiritual 'combover', meant to cover over* material and worldly struggle, misfortunate, or violence, but as a passage, as *ibrah*. As a passage, *ibtila* undoes the temporality of present world (*dunya*) through recourse to an afterlife and the concomitant judgment of the divine. I argue that articulation of illness as a

⁵ "It was narrated that Ibn 'Umar said: 'The Messenger of Allah (saas) never abandoned these supplications: (O Allah, I ask You for forgiveness and well-being in this world and in the Hereafter.'" (Sunan Ibn Majah 3871, English translation: Vol.5, Book 34, Hadith 3871).

⁶ '*Ibrah* means a passage to serve as an opening and a 'bridge,' but also a transgression of border, as the exemplar is the condition by which a lesson is imparted in the very elision of its transmission. See: Mahdi, Muhsin. *Ibn Khaldun's Philosophy of History: A study in the Philosophic foundation of the science of culture*. Routledge, 2015.

⁷ Jane I. Smith, and Yvonne Yazbeck Haddad, *The Islamic understanding of death and resurrection*, (Oxford University Press, 2002).

⁸ The Quran replaced "the pessimistic world view of a people who felt themselves under the sway of an impersonal force leading inevitably and only to personal death came the conception that life has a purpose, that the events of human history, both individual and communal, are in the hands of a just and merciful God, and the death is not the end but the passage into a new and eternal existence." Smith and Haddad, *The Islamic understanding of death and resurrection*, 3

passage redirects the former to the question of God's knowledge and divine time, and so as a form of human unknowledge.

Within the field of divine time and unknowledge, the removal of *'afiya* from one's possession is not simply a test to stimulate an increase in piety or station, nor is it simply seen by all as a form of tribulation, but a redirection of one's soul to God, witnessed by both family and community. It is an address that calls everyone around it to bear witness to its reality. This redirection to God, as an expression of the potentiality to draw near or away from God, was an address to everyone witnessing the effects of the illness. In the scene of the hospital, the illness as passage did not serve simply to return the patient to God as a space of purification or vindication, but produced a wave that generated new paths on the struggle of soul. This movement on? a path is not ultimate, teleological, or utilitarian. Rather, it is the movement of the soul that cycles between piety and impiety, strength and weakness, and *'afiya* and illness. It is an exemplar that one's fate is for an Other and from an Other. In the scene of the hospital, the illness illuminated a vision of the human's finitude and fragility and consequently a register of *'afiya* illegible within the biomedical index of health.

Writing about the knowledge that illness affords a person in his *Alchemy of Happiness*, Imam Abu-Hamid al-Ghazzali distinguishes first and secondary causes of illness.⁹ The first cause is attributed to *alghayb* (the unseen and unknowledge of God). al-Ghazzali presents illness as speech and a cord of love, by which God draws to himself his chosen individuals, citing the Prophet's speech, "sickness themselves are my [God's] servants and are attached to my Chosen."¹⁰ Visiting the ill is an obligation as it is a form of encountering God; the prophetic tradition details that to visit the ill is to visit God because he is with the ill.¹¹ Illness is insight into knowledge of God, insight into God's unknowledge. Determining secondary causes of illnesses through various sciences, a person might gain further wisdom relative to their respective instruments of examination. Al-Ghazzali notes that in cases of depression, a physicist explains it as a dryness of the brain due to hot weather, the physician calls it melancholy and prescribes something, while the astrologer attributes it to convection of planets. With each science, further insight is achieved into the nature of things, and likewise into the state of the ill person.

The reflection of the health of the soul in the vision of the ill, according to Ibn Sīnā, occurs because during an illness the senses weaken and allow the soul to divert from its practical management of the body. During illness the body's imbalanced temperament weakens the soul,

⁹ al-Ghazzali, Abu Hamid Muhammad, Elton D. Daniel, and Claud Field. *The alchemy of Happiness*. Routledge, 2015.

¹⁰ al-Ghazzali, 38

¹¹ "On the authority of Abu Hurayrah (may Allah be pleased with him), who said that the Prophet Muhammed said: Allah (mighty and sublime be He) will say on the Day of Resurrection: O son of Adam, I fell ill and you visited Me not. He will say: O Lord, and how should I visit You when You are the Lord of the worlds? He will say: Did you not know that My servant So-and-so had fallen ill and you visited him not? Did you not know that had you visited him you would have found Me with him? O son of Adam, I asked you for food and you fed Me not. He will say: O Lord, and how should I feed You when You are the Lord of the worlds? He will say: Did you not know that My servant So-and-so asked you for food and you fed him not? Did you not know that had you fed him you would surely have found that (the reward for doing so) with Me? O son of Adam, I asked you to give Me to drink and you gave Me not to drink. He will say: O Lord, how should I give You to drink when You are the Lord of the worlds? He will say: My servant So-and-so asked you to give him to drink and you gave him not to drink. Had you given him to drink you would have surely found that with Me." (40 Hadith Qudsi, Hadith 18)

ceasing the activity of the soul's theoretical intellect.¹² It is the soul that puts the imagination to work in order to process sensible and non-sensible data into images. When the imagination is set free from the soul's management, the former projects images back to the latter. The soul experiences these images as real. For Ibn Sīnā, illness works in the same way that emotional states divert the soul from hunger, fear, and anger.¹³ Ibn Sīnā's discussion of the illness unfolds within a body-soul dualism that he posits after uniting Aristotle's philosophy with Galen's anatomy.¹⁴

This particular dualistic framework is one of many iterations of body and soul within the Islamic tradition. They range from atomistic philosophies of body and soul to peripatetic notions of a body-soul-spirit tripartite. Yet these theories do not point the theoretical question of the nature of the soul as a starting point to better understand the illness as passage. Rather, the illness and its various expressions give rise to, and continue to show, the polysemy of the soul in its contemporary instantiations; illness makes us think about the soul.

Thus, the circulation of the illness within the hospital, between the patients, their care givers, their physicians, and their institutions indexed ways that the object of *'afiya* exceeded the patient, but encompassed everyone within the web of the illness. *'Afiya* involved the alleviation of symptoms shared between the patient and their relatives, as well as alleviation from collective tribulations.

In this chapter, I explore the work of the illness as it relates to the patient, their soul, and those implicated within it. I argue that the work of the illness illuminates the problem of the field of the soul. As the patient's treatment is dependent on other souls around them, I examine the tension that arises within the singular experience of the patient vis-à-vis the collective as passage. The circulation of the illness within an enclosed space, such as the hospital, made possible and visible both the work of the illness as a passage, as well as the affective forms of witnessing and redress of the oppression residing outside the hospital.

Inasmuch as physicians, families, and Imams are each included in the prescribed treatment plan, I argue that the object of care, namely *'afiya* (psychological, physical, and spiritual wellness), implicates everyone in the alleviation of the illness. The illness here in sum is not an individual atomized experience but concerns a network of people; it is a symptom that opens to the experience of the divine. The hospital as a heterotopic space is made possible through the work of the illness in the latter's implication of the collective in the former's alleviation.

The Hospital

Hospitals do not (cannot) contain illness. This site has deep pedigree. The hospital is one of the greatest achievements of medieval Islam, alongside Ibn Sīnā's *Canon of Medicine*. The hospital as an institution emerged in the ninth-century in the Iraq-Iran region and served as a

¹² Ibn Sīnā, *Avicenna's Psychology*, 53. According to Ibn Sīnā the practical intellect manages the body and the theoretical intellect turns to higher causes and principles. The theoretical intellect for Ibn Sīnā is the source of knowledge and understanding, the faculty that receives universal forms. It is at the top of the hierarchy among the powers: the theoretical intellect rules the practical intellect, and the practical intellect rules the internal senses (37-38).

¹³ Ibn Sīnā, *Avicenna's Psychology*, ed. Fazlur Rahman, (New York: Oxford University Press, 1952), 53.

¹⁴ Jon McGinnis, *Avicenna* (New York: Oxford University Press, 2010), 227-229.

charitable institution for the physically and mentally ill, the disabled, travelers, the poor, and the elderly who lacked care.¹⁵ It provided both free care and basic income to those in need.

I do not intend to romanticize the potential space produced within the hospital, eliding the violence contained and repeated within it. The exclusions, the violence, and the disparity that occur outside the hospital repeat within its walls; the thrust of the illness and the violence of structural racism and inequality blister within it. The hospital does not succeed in containing illness. Yet, as a space of communal possibility, despair, corruption, and hope, the hospital emerged as one of the few spaces in each of my three fieldsites (Sana'a, Jordan, Jeddah) where a critical engagement with political, economic, and social realities unfolded. Whether I was in cafes, restaurants, afternoon tea gatherings, funerals, or weddings, there was an unspoken rule to withhold criticism of the state, public institutions, and courts. One's personal opinions were not simply an autonomous enactment but placed everyone at risk of state repression. If one happens to mention their disapproval of the state, someone would always ask, "do you want to be taken behind the sun?" The act of speaking out against the state publicly was understood as a risk of not simply social isolation but of disappearing into the night without a trace.

Within the hospital, while disciplinary and institutional apparatuses were upheld, they were also contested and even dismantled; everyone spoke. Among each other, patients and their families debated the rise of cancer amongst youth, the reduction in governmental assistance to both residents and non-residents, and the possible toxicity of western goods. Patients, families, and medical staff exchanged knowledge about new state residency regulations and the impending 2018 taxes that would reshape the economy. Within the hospital, novel discourses regarding the pervasive structural inequalities within the society were possible.

Many hospitals in my fieldsites were guarded during working hours. However, the prophetic injunction to visit the sick and maintain family ties often proved too overwhelming to regulate. As such, the hospitals maintained unregulated visiting hours beginning at 5p.m, when the guards would stand down. Families, relatives, and neighbors were then allowed to roam the corridors freely (with the exception of the ER, ICU, and infectious disease units), without the need to register by name with the hospital staff. Visitors carried picnic baskets, thermostats, and gift baskets, and, using the elevators unsupervised, would take rotating shifts in accompanying patients.

Visiting hours are special. The hospital comes alive; the prayer rooms downstairs are flooded with family members. It is the only time one finds families, hospital staff, and physicians praying side by side. In surgical and medical wards, family members of one patient encounter the family of another, supplicating and seeking God's mercy for one another. Neighborhoods emerge through the bridging of various rooms by the movement of bodies in and out. Children run through the halls of the ward while others play on the grass in front of the main entrance.

The illness's demand upon, and distribution among, the family was recognized by the physicians I interviewed. Many of them argued that the success of treatment was contingent upon the amount of broader support that a patient received. This orientation toward the illness was an affirmation of the condition of its passage, in that it necessarily passed through everyone,

¹⁵ Ahmad Raghab notes that there is inconclusive evidence to prove that Harun al-Rashid built the first documented hospital in Iraq. The nature of the hospital as a charitable institution was multiple in its function and purpose, but by the tenth century it was understood as a singular institution that distinguished itself from other charitable institutions by focused on health and disease. See Ragab, Ahmed, *The medieval Islamic hospital: Medicine, religion, and charity* (Cambridge University Press, 2015), 4-7.

including the physicians. The illness was anything but the atomized experience of an individual. It was never merely localizable within the patient, who was never the only one to speak of the pain and suffering that the illness had produced. The patient never fully contained the illness's history. Patients could not fully bear witness to the past of the illness, nor to its present expressions. This work of the illness points to more than an analytic binary of individual expression and collective reckoning. Instead, the illness forces one to wrestle with the attention it constantly demanded within the hospital.

As noted in the introduction, patients and their families demanded that physicians address their well-being (*'afiya*) through an engagement that went beyond attending to the physical body of the sick. Physicians, in response, placed themselves in a position to receive this demand, specifically when they saw themselves as limited in their ability to cure as they were merely instruments of God. The physicians reminded themselves and their patients that ultimately the cure is from God. In seeking well-being (*'afiya*), physicians become implicated alongside the family. The family, community, and other healers were thus each strands in the broader net of the patient-doctor relationship.

When patients visit the hospital and the clinic, they do not arrive alone. They were accompanied by many of their family members. This included children, spouses, parents, aunts, uncles, siblings, or even cousins. As many as ten people and at least three would be in the diagnostic room; rarely did anyone arrive alone. Many a time, the family members would enter into the room before their ill relation, place their hands on the table, and negotiate with the physician the form and extent of the disclosure of the illness to the patient. The family members were often stern about what may be disclosed or withheld, being oriented to the patient's perceived state of mind and emotional capacity. As an interventional neurologist that trained in Canada noted: "In North America, patients protect their loved ones from the information surrounding their illness. Here [in Jeddah], the family protects the patient from their illness. The patient themselves say 'talk to my family. I trust them and you.'" The family in this example oriented their activity around securing the patient's physical, psychic, and psychological wellbeing (*'afiya*). The oncologists and nephrologists were especially discerning with respect to actions of patients' families. Dr. Anwar, an oncologist, stressed to me that the family is integral to the the treatment of the patient.

If you get the family on the same page, it is easy. My whole treatment adventure with patient is easier. As a medical student, you think that the physician is the only person who can help the patient. But when you become a physician. You realize that you are the least person helping the patient. The social worker helps the patient, the nurse helps the patient, you are the least person helping the patient. Despite the fact that the patient looks to you for help. He gets more help from the nurses, from everyone in addition to you. The question is, how you can put the pieces together and how you make the patient feel at the center.

In both the clinic and the hospital, patients rarely spoke about their symptoms because much of the time their families withheld diagnostic information from them. Between themselves family members recalled the timeline of the patient's illness and its temporal expressions and progressions (in the rhythms of treatment or pain, for example). Much of the anxiety around disclosure was intensified in specific hospital units and clinic: oncology, neurology, gynecology, and infectious disease. These medical subspecialties—dealing with death, psychic life, and

reproductive life—interpellated more than just the body of the patient, but the life world of everyone around the patient and their social-political and economic realities. In order to hold the weight of the illness, the family or support system would often withhold information from the patient, specifically how the illness has transformed others around them, or how the management of their illness produced symptoms in the patient's care givers. Once in the infectious disease clinic, when an ill daughter left the room, her mother turned to the physician, complaining of her own pain and grief stemming from her daughter's tuberculosis. The mother spent the next fifteen minutes confessing to the physician the toll that the illness had taken on her. The body, as the site of the patient's illness, did not contain it. It circulated between both people as well as between souls, spaces, and temporalities.

In response to patients' demand for *'afiya*, as it extended to the patient's needs, physicians were also called to address the proliferating oppression residing outside the doors of the hospital. Some physicians provided medical care to non-residents (migrants and refugees) by using pseudonyms and concealing¹⁶ their identities. Others physicians leveraged state laws¹⁷ that enable medical care for non-citizens as a preventive measure for public health safety.¹⁷ This demand came in the form of patients' supplications pleading for assistance and exceptions from hospital staff, the presence of abandoned bodies of refugees and migrants in the emergency room, and pressure for favors from family friends and neighbors. Simultaneously, the hospital was also a space of despair and repetition in the denial of care for non-residents and refugees and the exclusion of pharmaceutical provisions for non-citizens. For every physician acting as pious as the prophet in the hospital, there was another physician, acting as an accreditation protocol officer, spewing the superior ethics of the streamlined criteria of the global, biomedical ethical procedure.

The Fall of the Father

I met 'Adil and his family during my first week of shadowing one of the Clinical Teaching Unit (CTU) teams. A nephrology resident whom I had interviewed was leading one of the CTU teams and requested that his attending physician allow me join them during their rounds. The resident, I later learned, had seen me continuously wandering the female and the male wards, sitting in the café alone, or in the computer lounge writing, waiting for another interlocutor to host me. Sympathizing with my frequent isolation from an otherwise tightknit community, he hosted me on his rounds.

The CTU teams were not a specialty unit, but handled patients who came with an array of issues: the teams simply handed off the patients to the necessary sub-specialty units. The attending physicians from various subfields would rotate supervision of the CTU teams. On my first day shadowing one of the teams, we did rounds on several patients in the male medical ward. After rounds, I usually returned to the patients and would introduce myself as an independent graduate student researcher. That day, I returned to the first patient we saw, a father of nine whom I call 'Adil. His family requested that I keep them company since my presence pleased their father

¹⁶ Healthcare benefits in Saudi Arabia are available in government hospitals to all citizens and non-citizens with residency visas. Due to rumors of corruptions and bribery of hospital staff, physicians now have the sole authority to open case files for all patients.

¹⁷ Physicians lobbied the government to recognize certain transmittable disease, including HIV and AIDs. They made HIV retroviral drugs accessible and free for all citizens while they privately fundraised for non-residents. They also demanded that therapies for other infectious disease are made available to everyone, including refugees, migrants, and non-citizens.

‘Adil was brought to the hospital the day before the Eid al-Fitr holiday (the festival at the end of Ramadan) on June 24th, 2017. He died exactly two months later on August 24th, 2017. His sons had brought him to the hospital after he had developed persistent edema in his legs and thighs following a fall. ‘Adil was diabetic and his kidneys were failing. He had heart complications. The medical team started him on antibiotics in addition to anticoagulants, so that he would not develop blood clots. Yet, his INR (International Normalized Ratio) levels began to rise. They stopped the anticoagulants so that he would not bleed out. During rounds the residents began to worry about the infection on his foot and they were also concerned about the array of detrimental effects that further medications might have on his already failing organs. The team was at a loss as to what kind of care they could provide, given the severity of his symptoms. The foot infection compounded with his nephrological symptoms began to put a strain on his heart.

When I met ‘Adil, he had already begun to receive dialysis against his will, as he often lapsed in and out of consciousness. He had refused dialysis the years leading up to the failure in both of his kidneys. With the permission of his family, the nephrology team sedated him, as he resisted at first, and began to dialyze his kidneys, which prolonged his stay in the hospital. When I would ask ‘Adil if he had sought care before his current hospital stay, he would initially speak about the time he was disrespected by physicians in the clinic but soon lapse into various other memories of his youth: when he was able bodied, working in construction before he opened a small shop in his neighborhood near his home, and before that, when he was a soldier. The only history, in various moments, that he wanted to speak of was the one that displaced him from the hospital. As ‘Adil fell asleep, his eldest son described a typical scene where his father rushed them out of the clinic, dismissing the physician’s prognosis and treatment.

Although ‘Adil suffered from a heart condition, failing kidneys, and a slew of other complications, he was brought to the hospital due to a fall that injured his foot. When I spoke with the family and ‘Adil about his aversion to biomedical care, he emphasized that one only finds themselves in the hospital after falling. His wife and eldest son described his reticence to dialyze his kidneys and to treat his heart condition as indicating a general aversion toward all biomedical care.

When I asked ‘Adil why he wanted to leave the hospital, he explained that he wanted to be surrounded by his family. He emphasized the importance of his daily ritual; walking around the neighborhood in the morning and tending to his small shop around the corner, after which he would find himself steps away from his neighborhood mosque. In the afternoon, he would enjoy his grandchildren running around him and the company of his children, wife, and mother. His aversion to the hospital was not necessarily rooted in a fatalist response to his physiological complications, but in the fear of being restrained to and constricted by a movement between two beds—the home’s and the hospital’s.

When I first met ‘Adil and his sons, I introduced myself as a researcher who had accompanied the attending physician during their rounds. They were all perplexed by my questions and by my form of inquiry, which was distinct from the usual visiting medical student researchers (who would typically disseminate surveys that did not involve much engagement with the patient). They began to examine my Arabic accent as it was familiar to them, if it remained oddly unfamiliar. One son said that I was Tunisian based on my usage of the letter *qaf* as opposed to *jeem* in certain words. The other guessed Kuwaiti due to my cadence. The father then began to recite verses from what I thought was a poem due to the rhyming couplets in every other line. The poem sounded familiar, something I had heard of before.

‘Adil sang the first stanza, repeating the first line, “My heart’s fuse is burned”:

Oh people, my heart’s fuse is burned,
short-circuited my body,
even my appetite is lost,
from my passions’ toil

فيوز القلب محروقة * في جسمي ضربني ماس
حتى الأكل ما اذوقه * من أفعال الهوى يا ناس¹⁸

Astonished at their father’s engagement with me, ‘Adil’s sons pointed out the rarity of his singing in their presence, and subsequently teased their father. They asked him to sing some more, as it elated him and strengthened his breathe. He then turned to me and affirmed that he knew I was Yemeni from my accent. While he had never traveled to Yemen, he had heard of the lushes green terraces of the Ibb province, which he could only imagine must mirror those of Indonesia and Malaysia, where he had often visited. Malaysia and Indonesia were places where he had often escaped the arid weather of Saudi along with his friends. It was also an escape from the banality of the home and from the enclosed domestic sphere.

‘Adil’s accounting of the effects of his passions on his heart, desire, and body brought to the fore his ambivalence towards the acts that had contributed to his rotting organs. This assessment, that the strength of his heart reflected his piety, responsibility, and nearness to God, reflected ‘Adil relation to his faith and fate. More importantly, the poem he recited is an address, a warning, and a cautionary tale to ‘the people’ (*al-nās*), which as a noun means either ‘people’ or ‘creatures’; both humans and jinn (smokeless fire beings). As a verb, (*nāsa*) means to dangle, oscillate, or wobble. The word for people in Arabic is an articulation of oscillation and as memory is seen a function of the soul both dangle and memory paint the soul as an oscillating figure. The “oh people” is a warning that sets into relief both the effect of the ephemeral passions (*hawā*) on the external and internal senses, and the relationship of the passions to the discernment of the heart, which acts as the coordinator and limit of one’s actions and the one’s imagination.

Hawā (passion) derives from a trilateral root (h-w-ā) that implies ‘air,’ ‘heaven,’ and ‘sky,’ as well as ‘longing’ and fleeting or ephemeral desire. *Dhawq*, which translates to ‘taste,’ is both a sensorial experience, at the level of the external senses, and the processing of the knowledge that arises from sensory data at the level of the imagination. For ‘Adil to sing the song that links the flooding of the heart by the passions to the inability to taste or experience a satiating desire such as food illustrated the function of the heart as the impressionable recipient of sensory data. The breaking of the threshold and limit of the heart, the malfunction of its fuse, is tied to the imaginal reception of sensory data. Here, the heart tastes. It overfills. It discerns. It desires. It knows. It experiences. It is also consumed. The heart is the seat of knowledge.¹⁹

In the poem, the heart, which is connected to the body as an organ through its fuse, functions as a filter of the passions, preventing their overflow and meltdown of the entire system. In the very localizing of a fuse, the heart makes possible a limit that signals the breaking of a threshold. The heart was not of the passions, but works to ignite the passions, desire, and the intactness of its fuse. Therefore, the burning of the fuse leads to the malfunction of the heart as

¹⁸ I would like to thank Fady Joudah for his contribution to the translation of this poem/song. According to Joudah, the couplet (seen in the Arabic) in classical Arabic poetry was a dialogue between the I and the soul.

¹⁹ This is also evoked in Al-Ghazālī, *Marvels of the Heart*, xx.

filter, heightening the external senses, and short-circuiting the body. The intensification of the external senses dulls the input of sensory data, the latter of which provides the potentiality for the experience of pleasure (*dhawq*) or, in the case of the poem, the ability to receive and process the impression of the satiation of an appetite.

Both the heart's presence as an internal sense and its absence as the coordinator and the receiver of external senses is modulated by the excess of desire and the overdrive of the senses. By speaking of a fuse of the heart, the poem points to the limit of the heart in serving as a channel for a current or drive. The heart facilitates the works of the passions but it is also susceptible to their effects by the very presence of a fuse, a limit that signals the break of a threshold. A fuse melts in the event of the emittance of an excessive electric current, which surpasses a threshold. Likewise, the satiation of passions (*dhawq*), which include both physical and spiritual pleasure, go hand in hand, as the object of care and wellbeing, '*Afiyah* is the balance of physical, psychological, and spiritual well-being. Both the drive for nearness and distance from the divine encounters a limit, due to the threshold: a current cannot flow unconditionally and endlessly. Both piety and impiety are punctuated, conditional states. Thus, piety is not a complete renunciation of the body nor its complete envelopment. This balance requires the preservation and satiation of the passions inasmuch as the drive for the passions, which includes the preservation of the body, is also the drive for nearness to the divine.

Likewise, 'Adil acknowledged the exposure of his heart to excessive currents, the result of the gradual imprinting of the works of his passions, which had blown the fuse of the heart. The overflow of the body's currents was due to the excessive burning that remained fueled, melting the device and detector of excessive consumptions (i.e., the heart). Once the excess currents shocked his body, contaminating the filter, the heart fell, aimless and undirected. This excessive satiation of one's passions leads to the neglect of a person's own desiring abode. As 'Adil repeated the first stanza, immobile from the waist down, he placed his arms on his stomach and acknowledged a past that was at once his own and beyond him. 'Adil accounted for the past of his drive.

Coming in and out consciousness, 'Adil often lapsed into various temporalities. One moment he was frightened at the idea that his sons would travel abroad and remain there. Another moment, he was returning from one of his indefinite trips to Indonesia, Egypt, or Malaysia, and to which he would invite me and the attending nursing student on the next excursion. The next trip, he promised was for the whole family, as much time had escaped him without their company. I and the nursing student were also invited to that family trip. We were desired as companions and daughters.

During many of my visits to 'Adil's room, he recounted to me his many galivanting trips with his buddies. With these recollections, he lamented the lost time with his family and the loss of his brother to the West. This often provoked the fear that some of his children might also want to travel and remain abroad. Unlike his brother who traveled to acquire medical training, 'Adil returned home each and every time. Traveling was always simply a momentary stay that enabled a return home. Journeys that enabled sedentary life. Transgressions that enabled containment and repetition.

'Adil's brother, on the other hand, who traveled to Canada to train as a physician, never returned. 'Adil hoped that his brother would visit, especially during this time of illness. He would remind me every time I visited that his brother was on his way. He even joked that his brother requested that he sought medical care in Canada and that he would take care of him. It was always a joke as treatment was not sought in Jeddah either. 'Adil acknowledge both his

brother's care, but also the reduction of that care to the physiological working of his body. There was no care that required his departure from his family. I had not realized until after the funeral that his brother did not visit because he renounced his Saudi citizenship and became a Canadian citizen, which required him to obtain a visa to visit his family. 'Adil's brother never made it to the funeral.

The days leading up to his Intensive Care Unit (ICU) stay, one of 'Adil's sons expressed his deep regret for not having become a doctor, as he noted the importance of learning and knowledge. Another son asked me to advise his youngest sister as well as their nieces and nephews against the overconsumption of fast foods. Likewise, I was often asked whether I would marry a non-Arab or whether had I maintained the etiquettes of tribal hospitality in accepting an invitation (ensuring the cycles of obligation necessary to enter into an exchange). These conversations, in addition to others, concerned what it meant to live a healthy life, to renew a love of one's self and others, to relate to one's family and one's Arab identity, and to host others. Conversations regarding/in the presence of? 'Adil had deeply reoriented many of our thoughts and concerns. His illness brought to the surface issues that his families faced about the way they would continue to lead their lives. On one of the days leading up to his death, 'Adil remained deeply concerned for the challenges awaiting his family. As his condition worsened, he went into septic shock, and was sent to the ICU. In the ICU, he got worse and could barely muster the energy to maintain any dialogue with family members.

When I visited 'Adil in the ICU, and asked him why he seemed so anxious, he shared a Bedouin proverb with me, one that exemplified his concern for the state of his family following his death: "When the camel falls, the knives multiply." 'Adil lamented the impending events that would follow his passage. At first, I thought the camel was an echo of 'Adil's potential death and in the figure of the camel, the cutting up and devouring of his authority. In this scene, the image of knives multiplying depicted both the ensuing desire of the inheritor to devour and accumulate, as well as the vulnerable position it would place his entire family in upon his death. His worries about migration, over-consumption, and the passions were equally exacerbated by what he felt his prolonged absences may have fertilized.

A year after his death, I learned from one of his sons with whom I remained in contact, that 'Adil's father had passed away in similar conditions to his son. 'Adil's father had fallen ill, like his son, in his late 60's, and was taken to Egypt to be treated for a lung condition. His father died in a hospital in Egypt, away from his family, and had left behind his estate to be managed by his sons and daughters. As the eldest, 'Adil took on the *amāna* (divine trust), and, according to his wife, managed both his father's affairs and his estate. In his father's absence and his illness that eclipsed the witnessing of his father's passage, 'Adil took charge and managed to band his family together. His resistance to seeking medical care—which came with the precarity of potentially seeking medical care elsewhere, away from his family and home—culminated in a resolve to receiving the impending event of the slow dissolution of his organs. This event was intensified by the punctuated satiations of his desires, jolted by the excessive electric currents spawned by the works of his passions, and exemplified through the punctuated travel escapes; the promise of a return home may have kept the fear of transmitting a silent inheritance. As the illness circulated through the family, its rupture may have emerged from an open wound.²⁰

²⁰ The parallels in the fate of 'Adil and his father, as well as 'Adil's illness, leads me to consider the resonance of this case with Abraham and Torok's work on the inheritance of silences from the dead and their illnesses. Patients who haunted by the dead and the presence of a phantom, such 'Adil's father "indicates the effects, on the descendants, of something that had inflicted narcissistic injury or even catastrophe to the parent" (174). In some

In this light, it is uncertain if the camel proposed in the proverb was ‘Adil or his own father, as the legacy being transmitted was necessarily one that preceded him. In the former case, ‘Adil found himself surrounded by others who unsheathed their knives that had existed in concealment. His father’s passage illuminated some, as he took on the position of overseeing his affairs and estate, an exposure to everyday transactions and dealings (*mu’amalāt*) that displayed people’s characters. In the latter case, ‘Adil took hold of the falling camel. He contained the falling of his father’s body, his legacy, ensuring the replication of the family and allowing his body to extend the time of the fall, staving off both the sharpened knives from reaching the body and the body from reaching the ground. Serving as host to the effects of the interruption, time had taught ‘Adil that which may have been interrupted by his father’s sudden death, and the absence of a declaration of his last will that may have distributed the responsibilities among the family rather than localize them in ‘Adil. In turn, ‘Adil had attempted to reproduce the family as his father might have envisioned it, in the face of a transmitted silence, but in a way that may have effaced ‘Adil’s in his needs and desires.

To further complicate the anxieties brought out in the proverbial myth of camel, what might also be at stake is not so much the fall of the camel to the ground, but the uncertainty surrounding the knives’ proximity to his inheritance. There are many versions of this proverb enunciated through the Arab world. In Egypt, the camel transforms into a cow, but the proverb remains the same. Commentary on the proverb stresses its warning against veiled and masked predators who await the toppling of the camel to the ground. They are a reflection of the potential lack of cohesion, cultivation, and circulation of the law within the community or family.²¹ The multiplying knives’ undisclosed presence acknowledges a potential threat. As the knives gathered around the camel, still concealed and sharpened over time, they await the camel’s descent. As the camel falls, the masks fall off and the knives are drawn. The ground itself exists as the potential for a fall. The ground prefigures the fall; the fall necessitates the ground. Yet, it is not the presence of the ground that enacts the cut of the knife, but a turn away from the cultivation of the divine law within the family amidst a passage.

‘Adil’s illness centered around a question of his relation to others, and the divine. He was never concerned about death or the uncertainty of the afterlife or the short span of his life, as he understood his ‘*afiya* as grounded in God. Prior to raising this concern of his absence after his death, ‘Adil rarely addressed the state of his health. He often used his index finger to point to the sky, stating that his life and his ‘*afiya* were in God’s hands. He responded to everyone’s

cases, some patients only resolution is to “use their own body in a quasi-hysterical fashion, thereby avoiding fantasy,” (163). They designate these psychosomatic illnesses as self-to-self affliction, (such as ulcers, colitis, asthma); a return of the dead by way of pain and illness. This illness is an “internal conversion,” which the authors oppose to hysterical conversion (164). Internal conversion is a ‘peripherization,’ the dead’s grief over having lost the subject and the lodging of the melancholic crypt within the body. Abraham and Torok consider this to be the “periphery of the psychic apparatus.” Hysterical symptoms, on the other hand, aim to exorcise a state of being (164). For Abraham and Torok, the illness or internal conversion “functions as the subject’s own internal substitute for the impossible endocryptic fantasy of empathy with the love object” (164). The symptoms themselves are “secondary consequences of these shifts and are in no way expressive of them” (164). *The shell and the kernel: Renewals of psychoanalysis*. Vol. 1. (University of Chicago Press, 1994), 164.

²¹ See, “If the Camel Fell, the Knives Multiplied,” last Modified September 27, 2009, <https://www.albayan.ae/our-homes/2009-12-27-1.506543>. Other commentaries on the proverb stress that those surrounding a person in a particular station were often seen in a good light, as one was unable to discriminate between exterior masks and true masks of those gazing. As one was in a position of a particular social standing, the surrounding others present themselves as adoring sycophants, acknowledging your standing through praise and admiration and yet looking to climb up on the camel’s back.

reassuring sentiments by thanking the grace of God. Rarely did ‘Adil object to the physical and paralyzing struggle of his condition or speak of his pain. This was not simply a resignation, but a recognition of the fate of the works of his passions. It was not about an uncertain future, but a relation to a present state. Yet it was uncertain what troubled Abdullah. His uncertainty about his family’s replication shifted between a concern for his family’s ‘*afiya* as a question of a redirection to God and whether his many absences produced a lack of circulation and cultivation of the law.

‘Adil accepted his illness as an ordained *ibtila* (ordeal), and reminded the visitors and imams who came to console him and to supplicate for him that everything is from God. As the temporality of his illness extended to the time of his hospital stay, the ordeal—his assumption of his trust, and his containment and replication of the family—had been traveling alongside ‘Adil since his loss of his father. In the moment that the temporality of the ordeal was shrinking, ‘Adil was plagued by how this passage proliferated for those surrounding him. It was not the rotting of his organs and the withering of his stature that worried him, but the containment of the passage’s destruction in its distribution across his family. ‘Adil cautioned against the rage of the devouring mouth in his passage, where the open mouth²² was the knives multiplying.

‘Adil’s reflection on his past travels—passages that, through the poem he recited, had left imprints upon his soul and body—often segued into his lament regarding his impending passage. This included the family he would leave behind, and the uncertainty surrounding his family’s cohesion. It paralleled the ways that in Islamic eschatology, life itself is a passage. According to the Prophet’s teachings, a traveler must carry a light load in order to make their way through *al-dunya* or lower world, and pass through *al-barzakh* or the limit between this life and the hereafter. The traveler’s movement involves several intentional activities including pilgrimage and seeking knowledge, sanctuary, and refuge. The man who killed 200 people was advised by a sage to walk to a new land where his soul may transform in order to turn away from his current passion. Movement was portrayed as a passage, of the body, and of the soul. As ‘Adil reflected upon his impending passage to the grave and to the afterlife, he ruminated upon other passages that had prepared him or inhibited his preparation for this passage.

After experiencing two cardiac arrests in the ICU, ‘Adil miraculously delivered an oral last will and testament. *Wisāya* comes from the triliteral root *w-ṣ-y*, which means will, bequest, ordinance, and commandment. ‘Adil’s insistence that his family continually accompany him at his bedside produced the space that enabled him to pass on a will (*wisāya*). As the first cardiac arrest had disabled him from talking, ‘Adil miraculously spoke for the last time and implored his wife, sons, daughters, brothers, and sisters to care for each other. ‘Adil *waṣṣā*, meaning he advised, entrusted, ordained, prescribed, and enjoined his family to remain together, to prevent their division by intruders, and to manage and to divide the estate and inheritance equitably among them. The *wisāya* was a warning and caution against the devouring, raging mouth. By delivering his last will in speech and in the presence of the entire family, ‘Adil entrusted the entire family with the *amānah* (divine trust) to be just in their replication of the family’s structure. This *amānah* to carry out the *wisāya* concerned both his nuclear family and his own siblings, so that his children extended it to their extended family. A *wisāya* which takes into

²² In *Group Psychology and the Analysis of the Ego*, Sigmund Freud writes: “identification, in fact, is ambivalent from the very first; it can turn into an expression of tenderness as easily into a wish for someone’s removal. It behaves like a derivative of the first, oral phase of the organization of the libido, in which the object that we long for and prize is assimilated by eating and is in that way annihilated as such.” Freud, Sigmund, *Group Psychology and the Analysis of the Ego*, (WW Norton & Company, 1975), 47.

account that what is to be inherited is not simply a gift, but also a debt. The form of an *amānah* conferred a responsibility and accountability upon the family and its stature. In the Quran this trust is that which God offered the heavens, the earth, the mountains, but only humans bore it, and it was not one lightly received. It is a trust that has the potential to wound. *Amānah, here, was also the possibility of a human will, its wound and transgression.* ‘Adil was warning his family against the abandonment of the *amānah* and the transmission of the potential wound. In the words of psychoanalysts Nicolas Abraham and Maria Torok; in unsuccessful mourning, what haunts the living are not the dead but the “gaps left within us by the secret of others.”²³

Whether Adel’s sons successfully upheld the *amānah* and kept the knives at bay, or anticipated the transmission of the wound, is irrelevant. Both the circulation of the illness and *wisāya* were forms of affective witnessing that do not depend on their effectiveness. It was not so much the prevention of the illness? The wound? passage, but in the successful acknowledgment of the necessity of the distribution of the *amānah*. In gathering his family, ‘Adil left the fate of the replication of the family to everyone by his bedside. This does not preclude any of his sons taking up the task and enveloping the psychic wound. As mentioned, the attunement to the health of the family and the necessity of its limits as well as the resistance to overconsumption, began to shift around ‘Adil’s illness. Most importantly, the attunement was distributed within the family rather than located in any one family member.

Upon death, every Muslim is required to leave a will of testament to ensure a continuity of pious acts, as a ‘form of subject formation.’²⁴ In a famous prophetic hadith,²⁵ a Muslim’s pious works terminate at their death except through three channels: ongoing charity, beneficial knowledge, and the prayers of his progeny. For ‘Adil, it was this vision that may have presented a gap for him when his father passed away abroad. It was his children’s reproduction of the family and the accumulation of pious acts beyond his death that concerned him. This practice of extending an *amānah* and ensuring a just distribution of responsibility and accountability might have been unavailable to him at the time of his father’s passage. The *amānah* was not distributed then, nor did ‘Adil have the opportunity to refuse it.

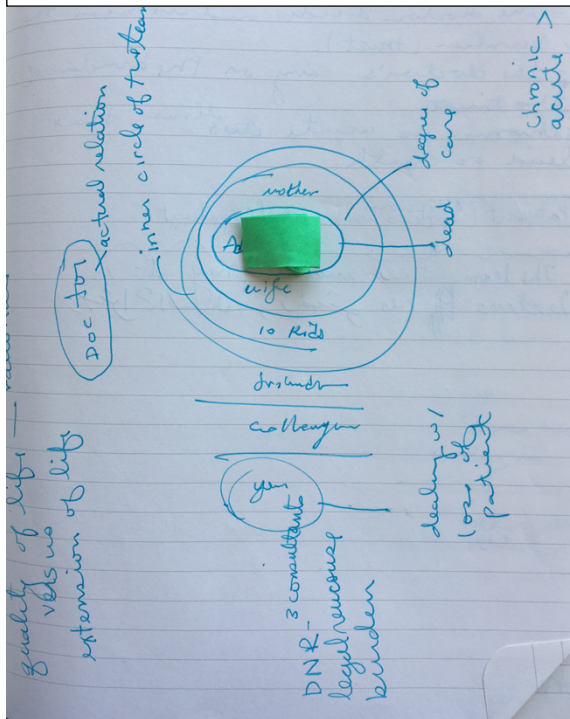
Days after his third cardiac arrest, ‘Adil passed away on the night of August 24. I had visited him hours before his passage, speaking with one of the nurses, who disclosed that the physicians had signed a DNR (do not resuscitate). Confused by the policy, I asked the nurse to explain how it came about that three physicians decided when to put a DNR in place. The nurse explained that the physicians had explained to the family that continuing to revive ‘Adil would place him in much duress, one that his body could endure, but that his soul may not be able to bear. I later confirmed with the ICU director regarding the DNR. He explained that there’s a *fatwa* (Islamic juridical opinion) printed on the back of the DNR that explicitly states that if three physicians evaluate and conclude that reviving a patient whose heart stopped several times before resulted in the torture of a patient, then they had the authority to sign a DNR. This authority transcended that of North American accredited protocols, which invariably left it to the patient or the medical proxy to decide.

²³ Abraham describes the as an entombment of the dead in Abraham and Torok, *The Shell and the Kernel*, 171

²⁴ Beshara B. Doumani, 2017, *Family life in the Ottoman Mediterranean: a social history*. Cambridge University Press, 59, 102, 139, 228, 296. Although there are rules of division detailed throughout the Quran, many people utilize endowments (*waqf*) in order to customize devolution of property, structure disbursement of the endower’s vision, and reproduction of the family, its piety, which is tied to accumulating reward in the afterlife.

²⁵ When a human being dies, all of his deeds are terminated except for three types: an ongoing charity (*sadaqah*), a knowledge (of Islam) from which others benefit, and a righteous child who makes *du'a*, supplicates, for him." (Sahih Muslim)

A medical intern drew this in my fieldnote book to explain the degree of care, in relation to family, physicians, and community.



There were also stories that circulated in the hospital regarding physicians signing DNRs against the family's wish. One particular story was of a physician who refused to resuscitate a Syrian refugee that arrived at the Emergency Room nearly dead. The physician refused to resuscitate him after he coded several times because he insisted that it would place an incredible strain on the patient, one that would only revive a lifeless body. When the physicians attempted to explain to the patient's wife that the extreme measures would have made her husband's soul suffer, the wife of the deceased wailed and supplicated to God against the ER physician for his eternal damnation. In response to the wife's supplication to God, the physician vowed to never follow the fatwa. He shared with his medical residents his fear of God's judgment, which had led him to question whether he made the proper ethical decision. From that day on, the physician refused to follow the fatwa, requiring other physicians' intervention to sign a DNR. The fatwa, according to the ICU director, was

necessary, as the patient's well-being—a question of their body's toll inscribed upon the soul—was prioritized over the family's grief and over their potential loss. The ICU director described certain medical interventions—compressions, defibrillation, and intubation—as forms of suffering when the patient had more than three cardiac arrests and had not shown any signs of stable heart and brain activities. The physicians intervention in the form of a DNR points to the rights of the soul over the body and those clinging onto the life of the person through the revival of that body.

As an index of the symptom of the soul, fuse presented itself in the poem as the filter of the heart and the propellant of the limbs toward constructive and destructive action, illustrates not only the way the illness is an index of physiological symptoms. It is a site of the aftermath of war and dispossession and readdress to the divine.

Whereas 'Adil's containment of the illness and its distribution across his family was a question of the work of his passions, the next patient I encountered contained the illness in a different way, one that promised a space of discussion around tracing the illness across familial networks and within an unheard collective. The illness for 'Adil was the fertilization of the constant uprooting of a ground, memory, as well as a usurpation and corrosion of power and just distribution. For the next patient, the weight of the illness was lifted through the organization of a cancer awareness campaign, the invitation of the public to participate in its prevention, and the recognition of those afflicted.

As presented in this chapter, the object of care in these hospitals and clinics was not the body or the patient but rather *'afiya*. Thus everyone, including the divine, the soul, and the spirit

is involved in the patient's recovery. The illness unraveled the polysemic nature of the soul and its knot/complex (*'uqdah*), which tied everyone in their various relationalities.

The psychological-moral knot, *'uqda*, is a reminiscence of the memory of a past, but also a tie that produces families (as marriage is itself a knotting of ties). It is this form of knotting that one can understand active in the knots that bind everyone in the presence and conjure of the illness. The knotting of affective ties, of families, and of one's relation to one's passions and desires (one that must be anchored in God), is a struggle of the cyclical return and its pull of the anchor. The knotting of souls by the illness issues from the unrealized selves and the collective that is further intensified in the uncontained blistering wound of inherited silences and the refusal of both the other and collective.

The following scene within the hospital presented a similar yet different way that the illness was contained, shared, and was made to account for 'Adil's deteriorating body as well as the rise in cancer in youth as ordeal/trial—*ibtala*. The illness knotted. It was not an atomized experience, but a wound of singular experiences that were emblems of the injustice, curse, and betrayal pervading, haunting the hospital, the city, and the region as a form of witnessing for an unconscious or collective unheard.

***'Ibrah* (Exemplar): The Enigma of the Illness The Rise of the Martyr**

My heart hurts. I stepped out of the diagnostics room of the radiology/or/and/oncology clinic. The patient was very young, a woman in her twenties. I thought she was in her late teens until she said that she had graduated college. She was very pale, frail, and petite in stature. Her father sat on the opposite side of the table across from the physician and me. When she began to speak, I was very surprised by her knowledge and deep awareness of her symptoms as well as the diagnosis. She spoke about the effect of the new pangs where her mastectomy lain. She spoke about the speed in which her symptoms took place. 'It goes from one to ten,' she stressed, calmly. Her father sat across from her, concerned, and seemed to mind that I was in the room, but his daughter spoke before he could say anything and reaffirmed in English that she did not mind that I was in the room. She spoke very assertively and knowledgeably in English. The first patient to do so. Unlike all the other patients, she utilized English medical terminology and noted that she had received treatment in the US. The doctor was taken aback whenever the patient would speak in English. She usually spoke about the patient's case, diagnosis, and anything related to it in Arabic as most of her patient only spoke Arabic. She often listened to her patient in Arabic and wrote in English while continued to speak in Arabic. When the patient's father would chime in, the patient reminded him that she was accurate.

When asked for her family's history, she spoke about her brother's case of cancer authoritatively, stating that it was not hereditary, but rather an issue of delayed diagnosis. She stressed that his potential illness was masked by the aspirin he was taking. She said that her brother had been cancer free for four years before passing away four months ago. Dr. Arwa said, "I heard about your brother." I found that to be strange. How did the doctor hear about one specific case from the many patients that come into the clinic for radiation?

The patient sat there describing all the procedures that she had undergone; all the CT scans and pet scans, what they picked up, what they did not, what she recognized and understood by inspecting her own body and informing the doctors. While she went on, I sat there thinking about the many times I had thought about having children and being healthy enough to have

children and how I had to have children. My mind wondered to all the times that I thought about what it would mean to delay having children and the ways that a woman's reproductive organs become potential cancer sites, and how much of it is always stressed as having physical, temporal, and psychic qualifications and conditions. I sat there thinking, 'did I unconsciously make myself late for today's clinic because I had known that the radiology oncologist's specialty was ob-gyn?' In that moment, the patient's impossibilities felt very familiar in a radically different lens, as she was faced with the question of her body's physiological deterioration. However, she seemed to have a handle on the accounting of her illness and there was something about the way she bore the illness that felt very light. I was the one who received it with such heaviness.

The doctor then proceeded to do a physical examination. Dr. Arwa was one of the few who asked me to leave the room while she physically examined the patient. I left the room and found myself waiting longer than the previous patient. It occurred to me that this patient's examination went longer than usual.

When I left the room, I felt a reprieve. The young woman was a few years younger than me and seemed to have an advanced type of end-carcinoma. I uttered a supplication under my breath while I witnessed her state—a supplication for when witnessing an affliction that you have been spared and being grateful for your own state. She spoke about her symptoms and her surgery with such detail that I felt that I must have a weak heart, which is how people describe those that cannot witness things and not be affected. Doctors are known to have strong hearts. My mom always said my heart was weak, but my brother who became a doctor had a strong heart. The strength of the heart was what enabled him to withstand the witnessing of difficult scenes. But this particular case was difficult. I had only had coffee and dates and my body felt cold and I probably had low blood pressure. I felt my iron-deficient body become colder than ever before. I had fainted in a hospital before when I saw a hand sliced in half, but I thought I was past that now.

Dr. Ilham saw I was in the hallway, came up to me, and said it was difficult sometimes to encounter some of these cases. "We see so much around here," she reminds me and herself. She had a clear view from the diagnosis room where she was meeting a patient while her door was open. She saw that a young child had just passed me by in the hallway while I was waiting, sitting in a bed, in fetal position, tugging on a blanket. She goes on to reassure me, "I myself am usually a very happy person, there is very little that bothers me *alhamdulillah*. However, I go through depression after seeing certain cases." She then instructs me "We have to grieve too." In that moment, I thought to myself, what is it we are grieving and why? People often die in the hospital, so what are we grieving?

Dr. Ilham continues to tell me that she often called her friend who is a psychiatrist to speak to her about difficult cases. I looked at her and said, "can you tell that I am affected?" Dr R said that she actually recently saw a patient close to her age and was very much affected. She said that she usually is really affected when she sees children around her kid's age with cancer. It really affects you, the possibilities, the things that can happen. It almost sounded like contagion. In that moment, I wondered if I needed to call my analyst for an extra meeting this week, or if I actually need an Imam.

The door to the room opened and I saw that the patient and her father came out. It seemed that they finished the consultation. I walked in and Dr. Arwa forgot that I was there. She apologized and left the room for a couple of minutes.

Dr. Arwa sat down, started breathing deeply as she attempted to type up the notes on the case, saying that her heart hurt. Her face looked as pale as mine. She laid her hand on her forehead just to get a hold of herself. I said, awkwardly, that I was relieved that I was not the only one who could not bear that moment. I explained that I am just as shocked and affected, as I continue to punctuate the silence with an interspersed laugh, noting that it is masking my shock. I was still not able to process the whole thing. She smiled and kept breathing.

I explained that when I left the room, I felt the weight of the case as the door locked behind me and I could not imagine how she was feeling. Even though I was reticent to show any emotions, as I was calm and composed on the exterior, I was in utter turmoil inside as I heard her describe her symptoms evocatively and metaphorically through her technical and affective awareness of her illness. Dr. Arwa's eyes lit up and said "Yes. She's very knowledgeable."

She continued to explain that the patient was very young, aware of her symptoms, and everything that was going on in her body. She continued to state that it is usually difficult to tell patients that the illness may or may not respond to the treatment, but that the patient was aware because she had read about the effects of radiation on her particular illness. She then asked me if I heard about her brother. I said yeah, she mentioned it before I left.

"They're so young," she repeated.

I agreed and shared how she and I were close in age. I noted to Dr. Arwa that she was not far behind. She agreed stating that she was under the age of forty. She explained that as a physician one was habituated to hear about illness and withstand the effects, but sometimes there were cases that have a strong effect on you and that you have no control over it. It rarely happened, but when it does, it was very strong, she said.

She reiterated that the patient's awareness of her possibilities was astounding. I asked Dr. Arwa how she thought the father handled the situation. Dr. Arwa explained that her father was not as aware of her chances and that the family has strong hope in Allah. This is their second child to develop cancer.

Dr. Arwa needed another moment. She excused herself in order to message another doctor who had called her earlier. She took about another ten minutes to write her notes and to collect herself. Thereafter she asked me if I had any other questions. I asked her about the translation process between speaking technically about the illness, diagnosis, and prognosis in Arabic while writing in English.

Dr. Arwa explained that she was educated in medicine in Saudi but in the English language. I asked her how she learned the Arabic equivalence of medical terminology. She said you pick it up and it becomes easier. However, what is difficult is not so much the language but negotiating how you can communicate the depths of the case, diagnosis, and prognosis. Certain family members ask you not to speak the details of the illness to protect the patient from depression. Therefore, what she tries to do is speak as detailed as possible and then adjust the level of detail depending on the patient's response. Usually if the patient does not want to know or cannot handle the full extent of the diagnosis, she tries to simplify the way she is communicating. Dr. Arwa continues, "when families ask me to withhold certain terminology, I try to meet their wishes, but let them know I cannot lie if the patient directly asks me. I want to reveal as much as possible and be as honest as possible," she said. In that moment, I wondered, what is revealed?

When I asked her how she handled cases like today's, she said that she tries to speak with other colleagues:

It brings you a certain amount of relief. However, sometimes the subject matter (*mawdū'*) controls you. But then you remind yourself that this is a reward of hire (*ajr*) from Allah. Its effects continue in the long term to the extent that certain things in life become insignificant. You also begin to have *wiswās* (satanic suggestions), where you begin to speculate about certain family members by worrying about certain symptoms they may exhibit.

When I asked her how she dealt with that, she responded, “you have to convince yourself/soul (*nafs*).”

In the patient's containment of the illness, an otherness is uncontained. The illness here seeped out of the patient and began to tie knots in the physician and in me, as our own potential wounds opened up through the patient's own experience of her physical wound. For Dr. Arwa, the illness slowly worked its way as whispers and evil suggestions, shaping floating symptoms into constellations that the illness had drawn, and mapping them onto her family members. That experience, what Dr. Arwa calls “the hold of the topic/matter/situation,” and what literally translates to something dropped on your lap, led to an account of the self/soul and its relation to the other, the divine, and the family. The patient's experience of her illness triggered an accounting and reflection of the trials, both potential and latent, that both Dr. Arwa and I face within our lives, shifting the temporality of our present beyond the here and now, beyond our body, and into relation with our souls, other bodies and souls, the afterlife, and the divine. In this way, the illness takes hold of your thoughts, actions, intentions, and reactions. The illness becomes a force that disciplines, demarcates, evaluates, metabolizes; it acts as a witness to the silences gaping before it. This kind of reflection and accounting related to your actions and your intended future actions takes you out of the present and into a possible relation to the past, future, and afterlife, staging different temporal frames. It allows the suspension of the temporality of a life through the simultaneous expansion and truncating of present time including the past and the eventuality of future death and the afterlife. In this frame, human signification recedes, and opens the present and the past to alternative explanations, logic, reason, or a deferral to the unknowledge of the Divine and the afterlife. Receiving such a weight from the other is not without its rewards. Dr. Arwa's openness to receiving the other was in the service of the divine. If Dr. Arwa is open to both the remembrance of God and satanic suggestion through her vocation to receive and treat the illness, then she also encounters the unknown, the uncertainty of life, and the certainty of death through the mortality of the body and the immortality of the soul.

Dr. Arwa was very struck by the patient's grace and composure. The patient's ability to encompass her illness, her pain, and journey was overwhelming. Dr. Arwa had a difficult time managing during her residency, as she witnessed countless terminal and non-terminal cases. She was in awe of the patient's strength to speak beyond her body, as she vividly spoke of the discharges coming from the lesions that she described as attempting to crack open her skin from within. The patient was welcoming of the potential for the body to fail to respond to treatment, which located her strength elsewhere. Her embrace of her illness, of its reality, and resistance transformed both Dr. Arwa and me and called us to think deeply about our own bodies and what was beyond them. It is that strength that Dr. Arwa nor I could match. The patient's fortified soul was not mirrored by Dr. Arwa, in spite of her cultivation and habit of receiving many illnesses in her time as a doctor.

One week later, I found myself standing outside the patient's room in the hospital after news circulated on Twitter that a famous activist had died from cancer on the surgical floor,

which turned out to be the patient herself. It had only been a week since this young woman came into the radio-therapy clinic. It was my second day observing the radiotherapy oncologist. I couldn't have understood then that I only had a week to interview one of the first patients that deeply affected me, so I waited. I waited outside her room. Family members coming in and out. I stood there waiting. I did not know what I was waiting for, but I could not move my legs to leave. I would wait until they took her body. Perhaps, I would learn in which mosque they would perform the funeral prayer. I waited. I knew in that moment how ironic it was that I was waiting for a moment that I waited a little too long for and it escaped me.

Only an hour had passed since the medical intern had learned on Twitter that she had passed away. We went to the female ward and looked up her record. Her name came up in red, I could read DNR. The medical intern asked me what it said, and I told her DNR stood for "Do Not Resuscitate." We clicked on her name and a boxed popped up that stated, "patient is deceased." In disbelief, I walked toward her room. I spotted her father, whom I first met when he accompanied his daughter to her radio-therapy appointment with the oncologists I was shadowing at the clinic. He saw and recognized me, but I did not say a word. We walked over and about a half dozen medical students are whispering and running in circles. The father approached three of them and asked them if there's a place to wash his daughter before they pray the funeral prayer at the masjid? The medical students took their leave to find out. The father walked back to her room, no tears in sight, as poised as the last time I saw him-- graceful and patient. A woman then emerges from the room, who I recognized as her mother, a resemblance of her daughter. The medical intern whispered in my ear, "her mother is Indian." Although I was confused as to the relevance in the moment, I was not surprised, as Jeddah is a cosmopolitan city filled with Hijazis, Najdis, Ḥaḍramīs that have intermarried with Indonesians and Indians, as well as other Yemenis and Egyptians, Jordanians, Palestinians, and Syrians. She's mixed. She is not a Bedouin Saudi. The medical student turned to me and said she wanted to know what to do in these circumstances. Still in a daze and shocked that the woman I first was struck by in the radio-therapy clinic was now deceased, I began to blabber to the medical intern about how I had wanted to interview her. I never got a chance to ask her for an interview. I thought I had time.

The patient had a rare type of cancer, sarcoma, the medical intern informed me. We stood outside of her door as family and friends came by to visit her bed. Her immediate family were still around her bed, reading Quran, and reciting supplications. Many more visitors came, quietly weeping, while others emerge to console them.

"She's a martyr *shadhīdah*, *Allah yarḥamuha*." The medical intern continued, "Do you know the hadith that says there are those who are afflicted with an injury to the stomach, those who die with their stomachs open, those are martyrs (*shuhadā'*) from diseases? Did you see her face, it was filled with light *munawwar*. I hope I become a *shahīdah* I don't know exactly, but *inshAllah* she becomes a *shahīdah*."

After scrolling through Twitter that day, which I joined strictly to connect to physicians in Saudi Arabia, I realized that the patient had been a famous activist in Jeddah, one who was at the forefront of spreading awareness of the rising numbers of cancer cases in young adults in Saudi Arabia. Her activism began with her brother's condition which predated her diagnosis by a couple of years. She had been featured on the cover of a local magazine, sporting a shaved head and dressed in a white shirt, which I had read months before meeting her in the clinic, but had not recognized her. This was exceptional; even though many women in Jeddah had begun not to wear their hijabs, all of them continued to wear the long robe-like *abayas*.

Within and outside the hospital, many people discussed the rise in oncological cases in Saudi Arabia, some noted the role of better technology in diagnosing and detecting it in earlier stages, some the shift to sedentary consumer capitalist consumption as a result of a burgeoning oil empire, and still others the possible toxicity that is seeping from the west through imports of spoiled or poisoned manufactured good. One patient in my first week of shadowing in the oncology clinic asked the physician if cancer is caused by toxins brought to the Arab world from the West and if it is in the food they eat and in their drinks.

The discourse on the toxicity and the etiological uncertainty of illnesses within the hospital was not just a critical discourse on the shifting landscape, its architecture, and the ways the city has reshaped the desires of its population. The illness, though not contagious, made possible the transmission and mirroring of critical questions of decay, past responsibility, and futures. As it did for Dr. Arwa and me in our own lives, the illness articulated the social, political, and economic ills that haunts cities. Within the discursive space of the illness, which the illness itself opens up, the symptoms of city unfolds. In turn, the clinical space becomes a stage to recount a history, familial relations, accountability, and the social, economic, and political realities against which they are cast.

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Chapter 6: Between Fear and Fright: Psychic, Spiritual, and Physical Borders

Which Came First, the Fright or the Jaundice?

In September 2017, while on rounds with infectious disease attending physicians, we visited a patient whose jaundice had not improved and who had contracted further infections. When Professor Hakeem began to speak to the patient, whom I call Kareem, I recognized the latter's southern Yemeni accent. After the examination, Kareem asked Professor Hakeem if the treatment would really work. Professor Hakeem said, "We do what is within our capacity, and the rest is up to God."

After rounds I sat across from Kareem in a plastic chair while his cousin at his bedside looked on. What began as a short conversation about the lingering of Kareem's jaundice, his ambivalence about biomedical treatments, and the limited insight of physicians into certain illnesses led to a two-hour-long conversation about his inability to return to Yemen in the midst of the war in order to be healed by an indigenous healer (a *mushfi*). This inability to return to Yemen out of fear (*khawf*) also brought to light the fright that inhabited Kareem during his crossing of the Saudi/Yemeni border and its return months prior to his hospitalization.

Kareem is a migrant worker from Hodeida, a city in the Tahama region, a coastal western province in Yemen. As the only male in the family, he was expected to earn a living for his wife, mother, father, and sisters. He migrated to Saudi Arabia in search of work due to impoverishment (*faqr*). He described the Hodeida he left as a destitute place—arid and dead. He reminisced about the time of abundance and sustenance during the reign of the later-assassinated socialist President Ibrahim al-Hamdi in the mid-1970s. Kareem recounted how during al-Hamdi's presidency, people lived off their land in addition to receiving state resources, a story I often heard as told by my own mother. This was a time prior to the 1994 civil war between the republic of North Yemen (backed by the US) and the communist South Yemen and before the reallocation of resources, not just from south to north but also to the partisan tribes of former Yemeni president Ali Abdullah Saleh. In an attempt to trace the current catastrophe back to Western intervention and Saudi's imperial aspirations, a number of documentaries have been produced by Qatari media, attempting to trace the assassination of al-Hamdi back to Saudi Arabia and the US as another proxy for the cold war.¹ Qatar, which is in a standoff with Saudi Arabia and where many Yemeni journalist have fled, has been attempting to paint the current conflict in Yemen as a repetition.

The impoverishment and famine that plagued Hodeidah and that had driven Kareem to migrate to Saudi Arabia were exacerbated by the current war, which began in March 2015. The closure of the Hodeidah's ports, which handled 70 percent of Yemen's imports, following the bombing campaigns from the Saudi-led coalition that supported the restitution of the current president Abdou Rabu Hadi, contributed to the blockade of aid—exacerbated by the Houthi rebels' initial seizure of the port.² Under these conditions, Kareem could not and cannot return to Yemen. Neither could I, he reminded me throughout our interview.

It is in this hospital in the south of Jeddah that I had discovered people of southern Yemeni descent, Yemeni laborers, and Yemeni traders. The hospital was unique among other Saudi governmental hospitals in that it was filled with many Yemeni migrants and Palestinian

¹Ahmed Zabibah, "After 42 years, Sana'a Discovers the Murder Plot of President Ibrahim al-Hamdi," YouTube, November 28, 2019, <https://www.youtube.com/watch?v=MfuSD3x7s-g>.

²Mark Mazzetti and David D. Kirkpatrick, "Saudi Arabia Leads Air Assault in Yemen," *New York Times*, March 25, 2015, <https://www.nytimes.com/2015/03/26/world/middleeast/al-anad-air-base-houthis-yemen.html>.

and Syrian refugees who did not possess governmental insurance or could not afford private hospitals. This hospital in Jeddah was nonetheless a twenty-first-century, state-of-the-art university hospital with multiple facilities, including outpatient clinics, cancer center, medical university campus, dental school, and pharmacology school. Yet many patients often questioned whether the physicians' treatment would really cure them. Kareem was no different.

The prospect of returning to Yemen was important for Kareem as he had already been cured once from jaundice six years ago, prior to migrating to Saudi Arabia for work. Kareem's father had traveled with Kareem to the home of the *mushfi* 'in in a nearby village. The *mushfi* 'in are indigenous healers, ranging in age from eight to ninety years old. They vary in gender too. *Mushfi* ' comes from the word *shafa* ' which means double, intercessor. They are considered to employ a form of magic oriented toward Quranic healing, when seen from the standpoint of Islamic jurisprudence (*fiqh*). This is magic in the sense that the magician arrogates the power to cure, which ultimately belongs to God. By particular strains of Sunni theology this is seen as an affront to the oneness of God, the core principle of faith. However, by their own communities they are seen as God's chosen and blessed healers granted a power to heal with their sputum and touch, just as the Prophet Muhammad had done.

Kareem attested, "*Mushfi* 'in have cures for illnesses you've never seen before. There are people (in Hodeidah) who have illnesses that return every three days. You have not seen anything until you come to Tahama."

I noticed three cautery scars on his arm and asked whether those were traces of attempts to cure the jaundice. Kareem said no. "These were to get rid of the fear (*khawf*) that overwhelmed me when two Saudis almost ran me over with their car while I was working as a guard at the physician's building."

His cousin chimed in, "Fear (*khawf*) can cause jaundice (*safr*)."

"How did the illness start?" I inquired.

Kareem said, "It began in the eyes, then it spread everywhere."

"And why didn't you seek treatment by cautery?" I continued.

Kareem and his cousin looked at me, puzzled. "There is no such a thing: the *mushfi* 'in 'cauterize' with their spit."

Whereas cauterization is usually a surgical medical practice that involves burning a part of the body, the *mushfi* 'in did not concretely burn nor utilize any instruments. The attempt to physically cauterize Kareem (hence the scars on his arm) was a desperate attempt to replicate the healing of the *mushfi* ', which was seen as a treatment rather than a cure proper. Biomedicine was a desperate and inadequate double of the real healing enacted by others.

"Are you convinced about this treatment?" I asked, inquiring as to whether he would follow the biomedical treatment prescribed by the physician to treat the jaundice.

Kareem explained that the physician, whom he works for as the guard of a rented medical clinic building, was able to put in a word with Professor Hakeem, and who eventually got him admitted. It had been hard for him to be admitted at the hospital as a patient and he did not want to ask this favor. "The first time I came to the hospital," he added, "I was kicked out because my residency permit (*iqama*) had expired."

Kareem's experience was not unique. In response to patients' demand for '*afiya*, as it extended to the Real, physicians were often called to address the oppression proliferating outside the doors of the hospital. Some physicians provided medical care to non-residents (migrants and refugees) by using pseudonyms and sealing their identities. Other physicians leveraged state laws

that enable medical care for non-citizens as preventive measures for public health safety.³ This demand came in the form of patients' supplications pleading for assistance and exceptions from hospital staff, the presence of abandoned bodies of refugees and migrants in the emergency room, and pressure for favors from family friends and neighbors. Simultaneously, the hospital was also a space of despair and repetition in the denial of care for non-residents and refugees and the exclusion of pharmaceutical provisions for non-citizens. For every physician acting as pious as the prophet in the hospital, there was another physician acting as an accreditation protocol officer spewing the superior ethics of the streamlined criteria of global biomedical ethical procedure.

Yemen: Before and After the Wars

Prior to the Gulf War, Yemenis were not historically required to possess residency status to move in and out of Saudi or benefit from public resources. Ali Abdullah Salah's alignment with Saddam Hussein led to the deportation of close to a million Yemeni from the Gulf countries.⁴ Many Yemenis even willingly chose not to acquire Saudi citizenship, when it was sold for less than one dollar during King Faisal's reign, because they aspired to return to Yemen. This mobility was only reinforced by economic trade and intermarriages.

The movement between Saudi Arabia, Yemen, and neighboring countries was intensified in the city of Jeddah, the western coastal city along the Red Sea region in Saudi Arabia known as the Hijaz. Once it extended all the way from Jordan to Hodeidah in Yemen. It is a space of commerce and a pilgrimage site, forty minutes away from the holy city of Mecca and four hours away from the Prophet's Mosque in Medina. It is a cosmopolitan city made up of Saudis of diverse ethnic backgrounds, including southern Yemenis (Hadramis), Palestinians, Syrians, Turks, Egyptians, and Moroccans. Hadramis were deeply integrated into Saudi society, intermarrying with other Hijazis, with many acquiring citizenship as early as the 1920s. Many were prominent physicians, ministers, imams, and entrepreneurs. Many physicians in the hospital were Hadrami Saudis. Some were amongst the wealthiest families in Jeddah. Many of their own families, traveling from Turkey, Syria, Palestine, Bosnia, India, Indonesia, and southern Yemen, remained after their pilgrimage to Mecca.

Hijazis are distinguished from Saudi Bedouins from Najd and other Saudis in Medina and the Meccan tribes. To my surprise, Saudi Bedouins acknowledged a tribal lineage with central Yemeni tribes. My own family hails from Ibb, a province in central Yemen, which contains some of the most prominent southern tribes and Qahtani roots, relating to the old classification of an imagined affinal relation between Qahtan ('pure' Arabs) and Adnan ('Arabized' Arabs). As imaginary as this shared ancestry might be, it had palpable (and political) effects whereby Bedouin Saudis shared sympathy for the plight of the Ibb tribes among the resurgence of the Houthi rebels and takeover of the Yemeni capital, Sana'a; they welcomed me as a guest rather than an intruder. Ibb was also a neutral region in that conflict. Although my embodiment of Arabness ('*urba*'), was often placed in doubt because I grew up in America, its very presence as a thing to be evaluated and measured was a form of access and witness to my trustworthiness

³ Healthcare benefits in Saudi Arabia are available in government hospitals to all citizens and non-citizens with residency visas. Due to rumors of corruptions and bribery of hospital staff, physicians now have the sole authority to open case files for all patients. Physicians lobbied the government to recognize certain transmittable disease, including HIV and AIDs. They made HIV retroviral drugs accessible and free for all citizens while they privately fundraised for non-residents. They also demanded that therapies for other infectious disease are made available to everyone, including refugees, migrants, and non-citizens.

⁴ Steven C. Caton, "History," in *Yemen* (ABC-CLIO, 2013), 76.

(*amana*) and value of honor, making it possible to maintain ties and enter into exchange with. This affinity, operating as it did along multiple registers, was critical to my access to a multinational and cosmopolitan space, which was also spatialized by citizenship and reified by national borders. My access was ultimately made possible by my American citizenship.

Although he had reiterated that we were both barred from Yemen similarly, Kareem's access in Saudi Arabia was not as clear. He migrated from Hodeida, the western province that was part of the Hijaz prior to the unification of Saudi Arabia and the militarization of the border after the Gulf War. During the late twentieth century, Bedouin Saudis considered people from the Hijaz to be *tarsh al-bahr*, "the vomit of the sea," the migrants, tradesmen, and pilgrims who remained in the country and bought their citizenship. This question of difference is now extenuated by access to resources, social networks, and social capital. The current pressure to subvert one's ethnic origin for Saudi citizenship in an attempt to produce a collective identity, the hiring of Saudi nationals in the Saudization of the economy, and the restriction of medical care to Saudi citizens had left many migrant workers jobless and in exile. Under these conditions, Kareem found himself the a guard of a building, making very little money in a shifting economy, barred from the hospital, and terrified of the physician's No!

The superimposed state regulations are experienced as the end of a hospitality that Yemenis once received across the Middle East and North Africa. This exclusionary politics is the reason that everyone else then re-experiences Yemen as the sublime of medieval Arabia: untouched, pristine, and undeveloped. Many westerners and even Arabs flock to Yemen to experience a timeless Arabia, understood to be the ancestral home of all Arabs that has retained its premodern soul. Until the 1960s, the north of Yemen was in fact closed off from the world, as the ruling Zaidi Imam refused to build roads and infrastructure after World War I in order to impede colonial forces after the withdrawal of the Ottomans from Sana'a. It also worked to keep the British from moving beyond the south of Yemen, as they assumed control over Aden as a protectorate.

In Amman and Jeddah, I was often told, "You know, all Arabs are from Yemen. Yemen is our origin." Yemenis are both the ancestors and the other. Yemenis today can no longer travel to Egypt, Jordan, or any other neighboring country without a visa, a privilege previously granted to them and every other country within the Arab League. Nor can they travel to the US under the current Muslim Ban. Therefore, Yemenis who have fled the war are not the only ones in exile. Those who remain in Yemen are enclosed and trapped within. The Yemeni traveler who once moved in and out of Saudi, enjoying certain provisions under customs of hospitality, is now the transgressor, the migrant, and the laborer. This fear of the intrusion of the exiled does not only circulate and repeat, but erupts from within the self. The Yemeni is the neighbor but he is also the romantic past of the Arabs: both excluded and enclosed.

Migrants and Refugees in the Hospital

It was with Professor Kareem that I saw the most refugees. He had established a fund to disperse HIV and other infectious disease medications to the dispossessed, through a foundation that a rich Saudi had endowed after Professor Hakeem saved his life. Professor Hakeem, as seen earlier in this dissertation, is both much beloved and feared in the hospital. As explained by many residents, the fear was due to his charisma (*hayba*). He is of medium height, wears glasses, and has a light one-inch gray beard. He is soft spoken and often walks silently. His presence often led women to check their hijabs and tuck in their hair and men to straighten their white robes and *'qal* (headpiece) and to stand straight and smile. Even I made sure my *abaya* buttons

were intact during his rounds. Once we bumped into two attending physicians from other specialties. The first joked about revealing something shameful in front of Professor Hakeem. The embarrassed physician warned his friend not to tarnish his image, as he was well regarded in Professor Hakeem's eyes, and they all proceeded to laugh. Even Professor Hakeem joked during our interview that his external appearance often depicted him as a pious person and this may be why his patients felt safe to discuss religious prescriptions with him. Yet what many felt around him stemmed not from the desire for his approval but from love of someone whose fear of God was a constant radiating presence of the unknown or unseen (*al-ghayb*).

When Kareem asked Professor Hakeem if his treatment would really work, he did so because Professor Hakeem did not chastise patients who had cautery scars. Instead he asked them if they helped. He did not question patients' usage of herbal or Quranic treatments. He treated refugees and migrants, including those left abandoned and unconscious at the hospital, because he felt that it was part of upholding the *amana* and redressing tribulation within the Muslim community.⁵ While many physicians were often perplexed at whether they fell under the clinic's mandate, Professor Hakeem insisted (and negotiated with the health ministry) that these patients qualified for hospital admission and treatment as part of the royal decree to treat everyone with infectious diseases.

In Jordan, migrants and refugees were not as fortunate to have someone like Professor Hakeem. In Amman, it was near impossible to be admitted into a public/government hospital if individuals were not residents or citizens. Private hospitals were expensive. Physicians in public hospitals did not have the authority to admit or treat patients. Often migrants and refugees were turned back at the door. The treatment outside the hospital was just as stark. When I arrived there in summer 2016, I was perplexed by a city that was at once multinational and estranged from itself. Sidewalks were non-existent. Very little public space existed outside of the old city (*balad*). Public parks were nowhere in sight (except for the bird park). Old mountainous neighborhoods were being gentrified, a change most readily apparent in the hipster cafes and restaurants marketed to expatriates. Neighborhood residents took advantage and started renting their spaces for the extra income. Migrants and refugees, meanwhile, were squeezed out, towards the outskirts of the main downtown. Outside of mosques, there was very little public space where people might gather for communal gathering. In Amman, I came to learn, community is forged almost exclusively through familial relations and their extended networks.

In search of a space to pray inside a mall, I found people who sat together in the mall cafes, often unable to afford the exuberant mall prices. Noticing my sulking around, a woman in one of these small circles invited me to sit down. When she recognized my mother's family name I was instantly deemed safe to enter their social circle. But even amongst trusted friends, politics were off the table. Women swapped stories about their terrifying housing situations and their inhospitable neighbors or overbearing landlords. At other times, they exchanged information on the resources available to them, like how to add one's name to the waiting list for UN refugee agencies. No one disclosed the specificities of where they had come from in Yemen, as locality would implicate them in the ongoing civil conflict, making them dangerously legible to the others in the circle. Civility in the mall required anonymity, a weak if crucial bulwark against a displacing terror. A hot topic was the Muslim Ban as it was being freshly rolled out (would I even be allowed back into the US, they wondered aloud, concerned for me).

Many of the Yemeni medical students and residents at the university I interviewed in Amman shared their feelings of isolation. They tended to remain in small groups among

⁵ See chapter 3 for a discussion on *amana* and Professor Hakeem.

themselves and tended to their studies. They had been unable to return home even for summer visits since the war began in 2015. They noted a shift in the way Yemenis were regarded in Amman after the war, as if their exile was seen as threatening in a city already filled with refugees from Syria and Palestine.

The Break of the Nafs/Self

As Kareem and I continued to speak to exclusions in and around the hospital, Kareem's cousin joined the conversation, speaking to his own fear of asking for tests for his kidney problems. He said, "We are not used to rejection; we are not used to being told No! I would never reject someone in need. We cannot hear it. It breaks me (*yaksr nafsi*)."

Yaksr nafsi means to have one's soul or self break. The *nafs* means not only myself, but one's psychic or desiring state, one's breath, one's soul. By requesting a kidney test from the hospital physician, Kareem's cousin would have made his desire visible, appealing to the soul of the physician to refuse the exclusionary institutional and state policies in an act of generosity and Arab hospitality. The appeal would have been for the physician to fear God. The physician's potential to refuse care raises two questions. The first is the lack of recognition of an other's need. Second is the loss of the physician's cultivating his soul, in relation to another, through the enunciation of the No! The prospect of the No! reinforced institutional and national borders instead of transcending them. In contrast, the physician refusing to exclude would admit a form of recognition retained among Muslims and within the Muslim community; it would transcend or dissolve borders. The shattering of the refusal and the end of hospitality that once flourished in the region, marked by a shared lineage and mutual reciprocity, was described by Kareem as the shattering of one's soul, an externality that breaks the self.

Kareem anticipated the "No!" because he was not admitted to the hospital without the intervention of mutual acquaintance. He understood that this rejection came from state-imposed regulations of residency status and provisions allotted for residents. As our conversation was coming to an end, Kareem and his cousin grew silent. I was beginning to thank them for their time when, attempting to assuage their fears, I encouraged Kareem to ask about his treatment if he felt ambivalent. I said, "They would be more than happy to explain your treatment."

In response, and as if unrelatedly, Kareem offered a meditation on fear. He said, "There is no human being that is not subjected to fear. Each one of us is subjected to fear. From the moment I entered the hospital, I began to fear. My heart cannot bear the weight. I fear needles."

I asked, "Is there a lot of fear in Hodeida?"

Kareem explained the origin of the fear.

The fear came after we crossed the borders. When you travel, within the borders, you risk (*taghmir*). You should see what the border was like. There are mountains, wolves, snakes, darkness. You can't take any baggage with you or light the way. That might get you caught. It was three days of traveling with no sleep. You have to keep moving and constantly be watchful.

According to Kareem, to cross the border one has to gamble (*ghamir*; to immerse oneself and throw oneself). Just as much as there was something to gain with the crossing, there was also an uncertainty that was physically, spatially, psychically, and spiritually charged. Yet, the thrownness of the self and the risk does not itself result in a break of the self.

Kareem's cousin looked at me and asked, "You know what fright (*fag'a*) is, right?" Distinguishing another form of fear, the cousin went on to explain how fright occurred. "Usually this happens after sunset. You begin to feel feverish and you are overtaken by insistent and obsessing thoughts of demonic origin. You need to come out of that state of fright, so you have someone cauterize your hand. This way you come back to yourself, and can resume eating and feeling better."

Astounded by the journey these men endured, I began to reflect on the *fag'a*/fright and the prior *khawf*/fear: the car accident, its congealing in the jaundice and alienation. While Kareem and his cousin did not hesitate to risk themselves (*ghamar*) in the journey across the border, however dangerous and potentially deadly, they restrained themselves from the risk and radical psychic exposure that came from a request for medical care at the Saudi hospital. That latter exposure would have led them to contend with a much more painful reality, the end of hospitality and loss of fear of God.

In Kareem's example, fear (*khawf*) had two meanings in this context: fear of God, which is anticipatory and imaginal, and fright of worldly matters, that did not depend on the desire of an other. Tracking the distinction between fear and fright, and their effects on the heart, the imagination, and the psyche, I here turn to Abu Hamid al-Ghazali and Ibn Sina alongside Sigmund Freud. In one sense, al-Ghazali explains that fear is "fear of God," for everything is ultimately through the divine will and command. This fear is understood as a relation to the proximity of and distance from God, divine bounty, and the mystery of the unseen (*al-ghayb*). This fear of God is an alterity that deters one from transgressing the limits of the soul (one's own and that of others), but also makes certain passages possible, strengthening one's soul and orientation to the world. The fear of God gives way to a malleability that is open to the light of God. In this case there is a demand for the doctor to transcend earthly limits (such as imposing state sanctions and withholding medical care).⁶

According to Freud, fear and fright are distinguished by the absence of an object in fright: "Fear requires a definite object of which to be afraid. Fright, however, is the name we give to the state a person gets into when he has run into danger without being prepared for it; it emphasizes the element of surprise."⁷ In *Group Psychology*, Sigmund Freud argues that collective panic presupposes loose libidinal ties rather than a certain magnitude of danger. The fear that breaks the *nafs* has an object and presupposes the end of hospitality and the replacement of membership within the Muslim community with national-state identity. Whereas we might consider the crossing of the border as far more dangerous to the person's physical wellbeing than the anticipation of the No!, the latter exemplified a presupposed "relaxation in the libidinal structure of the group,"⁸ which breaks the self. Nor is it that Kareem actually asked for medical care and experienced the end of hospitality. He anticipated the refusal, which made impossible to enter into an exchange with another in one's community. As such, it set panic-fear into motion. By arguing that panic fear arises from presupposed libidinal ties, Freud located panic fear at the level of the body, just as Kareem's cousin insisted. This was a psychic pain.

In another sense, fear is also what Kareem's cousin called *fag'a*, fright, an injection of a sudden intrusion and infliction of grief, suffering, and distress that is of a worldly nature, but once set into motion resembles the fear felt from the anticipated 'No!' This fear is felt at the level

⁶ Abu Hamid al-Ghazali, *Disciplining the Soul and Breaking the Two Desires*, trans. Timothy Winter (Cambridge: Islamic Texts Society, 1995).

⁷ Sigmund Freud, *Beyond the Pleasure Principle*, trans. James Strachey (New York: W.W. Norton, 1920), 11.

⁸ Sigmund Freud, *Group Psychology and the Analysis of the Ego* (New York: W.W. Norton, 1975), 36.

of the imagination. In the *Psychology of the Soul*, Ibn Sina links fear (*khawf*) directly with the work of the imagination. Fear is both intuited by an internal sense, the estimative faculty, meaning that it is received directly by the soul, and is the result of a weak soul that loses the grasp of the imagination. In the *Canon of Medicine*, jaundice results from an excess of yellow bile, leading to an imbalance of the humors that weaken the soul.⁹ A balanced body is important insofar as the soul requires it to acquire physical forms through abstraction; it is required for intellection, the internal faculties of perception, reception, and preservation of “sensible objects” and “non-sensible intentions.”¹⁰ As imagination and estimation are the bridge between the “material forms of sensibles and the absolutely abstract forms of intelligibles,” their passivity depends on the active predominates of the practical intellect, so that it “may have excellent morals.”¹¹ When a soul is weak, it is diverted from attending to the body’s appetite and bodily desires and intellection because the soul is attending to fear, giving the imagination free rein to impose illusionary images and overpowering the senses.¹²

Therefore, in both jaundice and fear the soul is captured by these images coming from without, which Kareem’s cousin called “demonic insinuations”. Fear is felt at the levels of the body and psyche. This psychic pain for Ibn Sina is what leads the mad and the fearful to be captured by these images coming from without, as if they were real. Whereas Freud has a topology of the self that involves the body and psyche, the work of al-Ghazali and Ibn Sina offer a different typology of the soul/self, involving the body, the heart, and the soul, illustrating how these variant topologies of wellbeing (*‘afiya*) speak to the polysemy of the soul.

When Kareem’s cousins noted that the state of fear follows a fever and decreases one’s appetite, he pointed to the intricate relationship between the body and the soul. More importantly, Kareem emphasized the treatment of cautery as a method to return to one’s self or return the soul to their self, which was indicative of the way the weakness of the soul allowed for demonic thoughts (or, as Ibn Sina argues, allowed the imagination free rein). For Kareem’s

⁹ Ibn Sina, *The Canon of Medicine of Avicenna*, trans. Oskar Cameron Gruner (New York: AMS Press, 1973 [1930]), 176, 275, 287, 351-352.

¹⁰ Ibn Sina, *Avicenna’s Psychology*, 31. See also Jon McGinnis, *Avicenna* (New York: Oxford University Press, 2010), 115, 124. Ibn Sina’s anatomy of the inner senses can be illustrated through the perception of a piece of flaky loaf of bread. One’s external senses are conduits, transmitting the flaky crust, the aroma, the warm loaf, and buttery rich taste, whereas one’s inner senses take in the images, divide and combine them, and intuit bread’s innocuous nature, its docility, as opposed to the danger emanating from seeing a wolf. As these sense impressions coalesce in the common sense (*al-hiss al-mushtarak*), producing a unified experience of warm and eatable bread, they are transmitted and stored in the passive imagination (*al-muṣawwira*). In the active imagination (*al-mutakhayyila*), the bread’s brownness, roundness, and fluffiness are separated from its direct sensible materiality through segmentation by way of abstraction. The active imagination turns into the cogitive (*mufakkira*) faculty in humans when it employed by the intellect and “combines and separates, giving rise to fantastical images.” The estimative faculty (*al-wahm*) receives the connotational attributes or intentions such as pleasure, pain, taste, time, and space directly received by the inner soul, while memory (*al-dhakira*) retains them. See Ibn Sina, *al-Qanun* (1958), 33; Ibn Sina, *Avicenna’s Psychology*, ed. Fazlur Rahman (New York: Oxford University Press, 1952), 31.

¹¹ Ibn Sina, *Avicenna’s Psychology*, 32, 53, 102.

¹² Drawing on the *Shifa* and *Isharat*, Herbert Davidson outlines the effects of a weak (or a preoccupied) soul on the inner senses. With “free rein,” an emancipated imagination can “fashion images at random,” and project them back into the retentive imagination and into the common sense. These images projected are as real as those coming from without, so that the mad and the fearful are as real as reality itself. Therefore, when a soul is weak (as in the example of *ikhtilat*—see Chapter 1), it is diverted from intellection, and its grip on the imagination is released. When the soul is neither weak nor strong, it puts the compositive imagination to work as the cogitative faculty, inhibiting the imagination from imposing illusionary images and overpowering the senses. *Al-Farabi, Avicenna, & Averroes on Intellect* (New York: Oxford University Press, 1992), 118.

cousin, the imagination can hold the soul captive from the self; the imagination produces alienation. Kareem and his cousin produced a theory of fright and fear that they locate both within the body and within the imagination.

The fear of the psychic pain anticipated by the No! is congealed by a stereotype of the Yemeni as backward, irrational, migrant, beggar, and refugee, intensified by the 2015 conflict, and repeated by Kareem's cousin as the return of a break of the *nafs*. The break is a pain that is felt at the level of the soul, as it erodes the image Yemenis had of themselves as extended kin of other Arabs, including Saudis, through a common ancestor—rather than the image of the neighbor behind the fence. As Kareem announced that to fear is to be human, he wondered whether he could engage in an exchange, a journey, with another who refused the obligation to enter into that exchange.

Both Kareem and his cousin transformed their desires from the pain of traversing the hollow, dark, lonely emptiness of the desert. They couldn't risk hearing the No! from the doctor, for in it resounded the fracturing of both the image of Yemenis and of the Muslim collectivity. The No! was a potential pain that would be internalized as a wound. The No! is the return of a trauma, of the operative force of the impoverished image of the Yemeni that cannot be abreacted under these conditions.

This form of grief and breaking of the soul is felt throughout the Middle East. In *Knot of the Soul*, Stefania Pandolfo poses this question through her ethnographic engagement with a Moroccan Quranic therapist, who addressed the despair and grief felt in Morocco due in part to exclusion and dispossession. In conversation with her, the therapist elaborates on the movement of "constriction and expansion of the soul." He demarcates a function of the soul's potentiality, and its affective and existential states in relation to theological visions, from what he dubs "soul choking" (*diq al-nafs*), distinguishing the pain impressed upon the soul to transform inclinations and desires from the pain "internalized as a wound" and "incorporated as despair".¹³ Some Moroccan youth who appear in her work migrate to Spain to avoid the wound that comes from such incorporation of despair. Kareem and his cousin had more fear navigating the medical institution across the border than in the actual mountainous journey, because requesting such medical care would implicate them as participants in the dissolution of the Muslim community.

When I asked Kareem and his cousin why they did migrate under these conditions, Kareem said, "We use to cultivate our land and eat from it, but [ex-president] Ali Abdullah Saleh ate everything."

This image of a single mouth piece that has devoured everything repeats the image not only of the poverty (*faqr*) of the land but the poverty of the host. What once enabled the fertilization of the earth, enabling hospitality and the movement of people and resources, is now devoured by a mouthpiece, by a hell-raising enunciation, No! The initial decision of the president of Yemen, Ali Abdullah Saleh, to support Saddam Hussein's transgression into Kuwait led to the enclosure of Yemen from the Gulf countries, leading to the characterizing of Yemenis' movement to neighboring countries as transgressive and illegal. This was followed by a secondary transgression: Saleh's accumulation of wealth (approximated at 50 billion dollars in offshore accounts) and the sinking of Yemen's own population into deprivation and starvation as pawns of the emerging imperial force that is Saudi Arabia.

When I got up to leave and supplicated for Kareem's recovery, Kareem said: "Recovery is in the hands of God. I can also try to return to Yemen and have the *mushfi* 'in heal me." What

¹³ Stefania Pandolfo, *Knot of the Soul: Madness, Psychoanalysis, Islam* (Chicago: University of Chicago Press, 2018), 326.

is barred in the hospital is the ability to reproduce desire itself, which comes out of an unsatisfied demand for a need. Giving that a demand depends on an image built by a fantastical illusion within the imaginary, according to Lacan,¹⁴ its insatiability gives rise to desire. Yet, since the symbolic structures the imaginary, the instability of the image of the Yemeni in the eyes of the other makes the risk to demand into a risk of being barred from desire. The break of the *nafs* that Kareem fears is the crush of his desire, the engine of his soul. Yet, with the *mushfi* 'in a demand to heal is open potentiality. The image of such proximity lay with the *mushfi* 'in, the indigenous healers.

What I discovered in the hospital and clinics among Yemeni migrants and refugees resembles what Franz Fanon saw in the overflowing psychiatric clinics, of dispossessed and unemployed agricultural workers during the French colonization of Algeria. Writing on Fanon's later clinical cases in Algeria, Azeen Khan notes:

In Fanon's work, the clinic thus first emerges as an oversaturated because overdetermined, vantage from which to understand how an experience of uprootedness—fermentation at the base—seeps into the bodies of colonized subjects. This experience of uprootedness, of being one of the uncountable, manifests as tics, nightmares, mysterious headaches, and bodily ailments, all of which begin to indicate to Fanon an unassimilated history of colonial violence that is registered as affective and psychosomatic residue.¹⁵

From within the clinic, Fanon witnessed “the effects of juridical and structural processes of alienation,” where the “Arab, permanently an alien in his own country, lives in a state of absolute depersonalization.” Therefore, psychiatry, which attempts to treat patients so as to resolve their estrangement, failed to reintegrate treated patients back into a colonial society that produced the conditions of their madness and pathologies. It is not surprising that throughout the Middle East, a reprisal of Prophetic Medicine, Quranic healing therapies, and a rethinking of the biomedical model has intensified alongside the call for reform of social, political, and economic structures. This is what leads Kareem to desire a return to the *mushfi* 'in.

As a space of communal possibility, despair, corruption, and hope, the hospital emerged as one of the few spaces in each of my three field sites (Sana'a, Amman, Jeddah) where a critical engagement, assessment, and evaluation of political, economic, and social realities unfolded. Whether I was in cafes, restaurants, afternoon tea gatherings, funerals, or weddings, there was an unspoken rule to withhold institutional, juridical, or state criticism. Your personal opinions were not simply an autonomous enunciation but placed everyone within reach at risk of state repression. If one criticized the state explicitly, someone always asked, “Do you want to be taken behind the sun?” Yet within the hospital, within these spaces of inclusion and exclusion, disciplinary and institutional apparatuses were upheld, contested, and dismantled. The hospital was the site of witnessing the effects of war, dispossession, and the regional crisis.

Psychic pain deals with one's relation to oneself, one's tradition and practices. What is at stake is the very conception of health and the knowledge that produces that conception. Both the fear of the anticipated refusal of medical care linked to the congealing of the impoverished image

¹⁴ Lacan writes, “The imaginary structuration of the ego forms around the specular image of the body itself, of the image of the other.” See Jacques Lacan, *The Ego in Freud's Theory and in the Technique of Psychoanalysis, 1954-1955*, vol. 2 (New York: WW Norton & Company, 1991), 95.

¹⁵ Azeen Khan, “The Subaltern Clinic,” *boundary 2: an international journal of literature and culture* 46, no. 4 (2019): 181-217.

of the Yemeni, and the paranoia felt resulting from geopolitical forces in the US, allow us to think about the crucial role that the psyche plays in a person's overall wellbeing. Wellbeing is as much located in the body as it is in the effects of technologies that structure that body's access to institutions, relation to itself and subjective being, and exchange with other bodies. If we consider *'afiya* in relation to questions of race and racism in the context of the US, anti-blackness, the genocide of indigenous people, and technologies that ultimately racialize minority groups, how would that shift responses to the effects of illnesses and contribute to unknotting these ills?

Returning to my initial question, which came first: The fright or the jaundice? It was neither. Fright and fear are not mere idioms of distress. The fright and the jaundice were each symptoms of the break, the No!, in its multiple registers and manifestations, and of postcolonial disorders.