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CLASSIFICATION OF AURAT BOUNDARIES IN MEDICAL PROCEDURES: A SHAFI'I FRAMEWORK FOR URBAN MUSLIM HEALTHCARE

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ABSTRACT: This study aims to classify the boundaries of *aurah* (parts of the body that must be covered) in medical procedures according to the Shafi'i school of Islamic jurisprudence, with particular reference to **urban Muslim healthcare settings**, where patients frequently face cross-gender examinations, a limited availability of same-sex practitioners, and standardized hospital procedures. It addresses a gap in previous literature that has discussed the topic only partially, either limited to a single type of medical procedure or lacking a consistent, madhhab-specific analytical framework. This research employs a qualitative-conceptual library research method, using primary classical texts of the Shafi'i school (including *Tuḥfat al-Muḥtāj*, *Mughnī al-Muḥtāj*, *Ḥāsyiyat al-Bājūrī*, and *Ḥāsyiyat al-Syarwānī*) as the main sources, analyzed through content analysis adapted to the framework of Islamic legal reasoning (*istinbāṭ*). The findings show that the boundaries of *aurah* in medical practice are shaped by the interaction of four variables: the bodily zone exposed, the gender relation between patient and practitioner, the level of medical urgency (*ḥājah* or *ḍarūrah*), and the availability and competence of medical personnel. The body is divided into two zones with differing conditions, same-sex treatment is comparatively more lenient than cross-gender treatment, and a hierarchy of preferred practitioners applies, though it may be overridden by considerations of expertise and cost. The novelty of this study lies in its systematic classification that integrates classical Shafi'i concepts of *aurah* with contemporary medical procedures not explicitly addressed in classical fiqh literature. Theoretically, it demonstrates the

continued applicability of the legal maxims *al-ḍarūratu tubīḥu al-maḥẓūrāt* and *al-ḥājah tanzilu manzilat al-ḍarūrah* to contemporary medical issues. Practically, it offers a reference framework for Muslim medical practitioners, Islamic medical and midwifery education institutions, and policymakers of Sharia-compliant hospitals in urban areas in designing standard operating procedures.
Keywords: *Aurah* boundaries; Islamic medical ethics; Medical procedures; Shafi'i school; Urban Muslim healthcare.

ABSTRAK: *Penelitian ini bertujuan untuk mengklasifikasikan batasan aurat dalam tindakan medis menurut madzhab Syafi'i, khususnya dalam konteks layanan kesehatan Muslim perkotaan, di mana pasien kerap menghadapi pemeriksaan lintas jenis kelamin, keterbatasan tenaga medis sejenis, serta prosedur rumah sakit yang terstandar. Penelitian ini mengisi kesenjangan kajian terdahulu yang membahas topik ini secara parsial, baik terbatas pada satu jenis tindakan medis maupun tanpa kerangka analisis yang konsisten dalam satu madzhab. Metode yang digunakan adalah penelitian pustaka (library research) dengan pendekatan kualitatif-konseptual, dengan kitab-kitab primer madzhab Syafi'i (antara lain Tuḥfat al-Muḥtāj, Mughnī al-Muḥtāj, Ḥāsyiyat al-Bājūrī, dan Ḥāsyiyat al-Syarwānī) sebagai sumber utama, yang dianalisis melalui teknik analisis isi (content analysis) yang diadaptasi ke dalam kerangka istinbaṭ hukum Islam. Hasil penelitian menunjukkan bahwa batasan aurat dalam tindakan medis dibentuk oleh interaksi empat variabel: zona tubuh yang dibuka, relasi jenis kelamin antara pasien dan tenaga medis, tingkat urgensi medis (ḥājah atau ḍarūrah), serta ketersediaan dan kompetensi tenaga medis. Tubuh pasien terbagi ke dalam dua zona dengan syarat berbeda, pengobatan sesama jenis kelamin relatif lebih longgar dibandingkan lintas jenis kelamin, dan berlaku hierarki prioritas tenaga medis yang dapat dilonggarkan oleh pertimbangan keahlian dan biaya. Kebaruan penelitian ini terletak pada klasifikasi sistematis yang mengintegrasikan konsep aurat klasik Syafi'iyyah dengan ragam tindakan medis kontemporer yang belum dibahas secara eksplisit dalam literatur fikih klasik. Secara teoretis, penelitian ini menegaskan relevansi kaidah al-ḍarūratu tubīḥu al-maḥẓūrāt dan al-ḥājah tanzilu manzilat al-ḍarūrah dalam menjawab persoalan medis kontemporer. Secara praktis, penelitian ini menawarkan kerangka rujukan bagi tenaga medis Muslim, lembaga pendidikan kedokteran dan kebidanan Islam, serta pengambil kebijakan rumah sakit syariah di wilayah perkotaan dalam menyusun standar operasional prosedur.*
Kata Kunci: *Batasan aurat; Etika medis Islam; Madzhab Syafi'i; Tindakan medis; Layanan kesehatan Muslim perkotaan.*

INTRODUCTION

Advances in modern medicine have brought significant progress in the diagnosis and treatment of disease. Medical practice, however, is not merely a technical and scientific matter. It also intersects with ethical values and religious norms. In the Islamic context, one recurring issue concerns the boundaries of *aurah*, the parts of the body that must be covered, during medical examination. Physical examinations that require certain parts of the body to be exposed present a particular dilemma for Muslim patients who seek to preserve their dignity in accordance with

Islamic law [1]. This dilemma is felt most acutely in urban muslim communities. There, healthcare is dominated by general and referral hospitals with standardized procedures. Duty rosters do not always take gender concordance into account, and many medical procedures require patients' bodies to be exposed. The issue is therefore not merely practical. It also has a normative dimension that calls for in-depth study, particularly since the boundaries of *aurah* themselves remain a matter of disagreement among scholars of the four schools of Islamic jurisprudence [2].

Empirically, medical practice in various healthcare facilities shows that interactions between healthcare providers and patients often do not fully take Islamic legal considerations into account, particularly regarding the protection of *aurah*. In some situations, patients must be examined by providers of the opposite sex. In others, they must undergo procedures that expose certain body parts without any alternative. The limited number of same-sex providers, emergency conditions, and the general nature of the healthcare system add to the complexity of the issue. This is evident in the handling of women in labor by male obstetricians amid a shortage of female obstetricians [3]. Data from the Indonesian Society of Obstetrics and Gynecology (POGI) for 2023 make this imbalance concrete. Of the 5,270 registered obstetrics and gynecology specialists, 3,460 were men and only 1,810 were women [4]. On the patients' side, the preference for same-sex providers remains strong in Muslim societies. A survey in Taif, Saudi Arabia, found that embarrassment was the main reason respondents chose an examiner of the same sex [5]. This reality shows that modern medical practice frequently faces situations that are not entirely ideal from the perspective of Islamic law.

The phenomenon is consistent with an earlier study on the care of pregnant women and childbirth by male obstetricians. That study emphasized that such care is prone to exposing the patient's *aurah* extensively. It therefore still requires a sharia-based exception under certain circumstances [6]. Subsequent studies show that the standard for this exception is not uniform. Some limit it to emergency conditions [7]. Others also permit it to meet a need (*ḥājah*), that is, a genuine hardship that falls short

[1] Monawarah Monawarah and Anwar Hafidzi, "Etika Fikih Dalam Pengobatan Tradisional Terbuka Aurat (Sampel Mandi Buka Aura) Studi Kasus Desa Manarap," *Indonesian Journal of Islamic Jurisprudence, Economic and Legal Theory* 3, no. 4 (2025): 3780–89.
[2] Arip Purkon, "Batasan Aurat Perempuan Dalam Fikih Klasik Dan Kontemporer," *Risalah : Jurnal Pendidikan Dan Studi Islam* 9, no. 3 (2023): 1046–61.
[3] (Sahputri & Badar, 2024)
[4] (Afrillianti et al., 2024)
[5] Layla M Alkhaldi et al., "Population Preference of Surgeon's Gender for Surgical Care and Their Attitudes Toward Female Surgeons in Taif, Saudi Arabia," *Cureus*, August 14, 2022, https://doi.org/10.7759/cureus.28017.
[6] Zulhamdi Zulhamdi, "Tinjauan Hukum Islam Terhadap Perempuan Melahirkan Pada Dokter Kandungan Laki-Laki," *Al-Qadha*, no. Vol 4 No 2 (2017): Al-Qadha : Jurnal Hukum Islam dan Perundang-Undangan (2017): 74–97, https://journal.iainlangsa.ac.id/index.php/qadha/article/view/314.
[7] Illona Maharani Zulhan et al., "Hukum Dokter Obgyn Laki-Laki Dalam Pandangan Etik Kesehatan Dan Islam," *Jurnal Religion: Jurnal Agama, Sosial, Dan Budaya* 1, no. 5 (2023): 929–34.

of an emergency but still warrants relief [8]. Religious scholars and midwives in Sumedang both place maternal safety first. They require, however, that a *maḥram* (a close relative whom one is permanently prohibited from marrying) be present and that the *aurah* be exposed only to the extent necessary [9]. These differing standards underline the need for a more systematic framework.

Normatively, Islam, through the principles of jurisprudence (*fiqh*), provides clear guidance on the obligation to cover the *aurah*. It also prohibits looking at or touching the *aurah* without justification [10]. Within the Shafi'i school, the boundaries of *aurah* are firmly defined. The school also recognizes two levels of exception. The first is necessity (*ḍarūrah*), a condition in which life, a limb, or a vital bodily function is under threat. The second is pressing need (*ḥājah*), as defined above. These exceptions are affirmed by the legal maxim *al-ḍarūratu tubīḥu al-maḥẓūrāt* ("necessity renders the prohibited permissible"). Under this maxim, the *aurah* may be exposed only to the extent required by genuine medical treatment [11]. This permission is not absolute. It is bound by specific parameters: the existence of necessity, the absence of permissible alternatives, verification by medical experts, and proportionality of the procedure [12]. Within the framework of *maqāṣid al-syarī'ah* (the higher objectives of Islamic law), the preservation of life (*ḥifẓ al-nafs*), one of the five essential objectives of the sharia, must be balanced with the preservation of the patient's dignity in every clinical decision[13]. The same applies to care provided by healthcare workers of the opposite sex. Its permissibility in emergencies remains subject to strict sharia limits in order to safeguard the patient's dignity [14]. Ideally, therefore, medical practice carried out by Muslims should protect the patient's dignity, give priority to same-sex providers, and limit the exposure of *aurah* to what is strictly necessary. These values form an important foundation for healthcare services that are consistent with Islamic principles.

However, a gap remains between the ideal provisions of *fiqh* and the realities of medical practice. Not all healthcare facilities can provide adequate numbers of same-

[8] Khairul Fahmi S, "Keberadaan Dokter Ahli Kandungan Laki-Laki Dalam Tinjauan Hukum Islam," *PENDALAS: Jurnal Penelitian Tindakan Kelas Dan Pengabdian Masyarakat* 2, no. 2 (February 1, 2022): 89–95, https://doi.org/10.47006/pendalas.v2i2.101.
[9] (Afrillianti et al., 2024)
[10] Purkon, "Batasan Aurat Perempuan Dalam Fikih Klasik Dan Kontemporer."
[11] Monawarah and Hafidzi, "Etika Fikih Dalam Pengobatan Tradisional Terbuka Aurat (Sampel Mandi Buka Aura) Studi Kasus Desa Manarap."
[12] Afifi Azahar, Firdaus Mohammad, and Ahmad Mohamad, "Towards Understanding the Concept of Fatwa on Medical Treatment Involving Forbidden Sources Tinjauan Terhadap Pemahaman Konsep Fatwa Dalam Rawatan Perubatan Yang Melibatkan Sumber-Sumber Haram," *Journal of KATHA* 20, no. 1 (December 31, 2024): 1–21, https://doi.org/10.22452/katha.vol20no1.1.
[13] (Hashi, 2022)
[14] Jheehan Abdul Halim and Siti Khatijah Ismail, "Kedudukan Rawatan Oleh Perawat Lelaki Menurut Syarak [The Position Of Treatment By Male Healthcare Providers According To Islamic Law]," *Malaysian Journal Of Islamic Studies (MJIS)* 8, no. 2 (December 24, 2024): 45–54, https://doi.org/10.37231/mjis.2024.8.2.260.

sex providers [15], Nor can all medical procedures be performed without exposing the *aurah* more extensively. At the same time, the understanding of sharia boundaries among both the public and healthcare workers remains uneven. Many healthcare workers have not been adequately equipped with an understanding of Islamic ethics in their clinical practice [16]. Institutional efforts have in fact begun in urban areas. A sharia-certified hospital in Tangerang City, for example, has implemented Sharia Minimum Service Standards. These include hijab for patients, gender-appropriate ECG placement, the use of hijab in the operating theater, and mandatory training in patient *fiqh*, although the hospital still faces problems with record-keeping [17]. Efforts to strengthen a sharia code of conduct for healthcare workers in urban hospitals are also ongoing [18]. However, sharia hospital certification itself has not yet been integrated into the national health legal system [19]. As a result, standards for protecting *aurah* still depend on the policies of individual institutions. They also lack a detailed *fiqh* reference for each type of procedure. This situation creates tension between the demands of medical professionalism and religious obligations. An approach is therefore needed that can bridge the two proportionately.

This gap in healthcare workers' understanding of Islamic ethics is consistent with findings on religious development programs based on the study of *fiqh* and *'aqīdah*. Those findings show that limited religious understanding can only be significantly improved through structured and sustained programs [20]. Such programs require clear reference materials, including a classification of *aurah* boundaries that is ready to be applied in clinical practice.

However, previous studies on the boundaries of *aurah* and medical treatment have tended to be partial. Purkon (2023) mapped the differing views of the four schools in general terms without relating them specifically to medical procedures. Monawarah and Hafidzi (2025) examined the application of the maxim of necessity in a single case of traditional medicine. Sahputri and Badar (2024) limited their study to one type of procedure, namely pregnancy care and childbirth by male physicians. Tiara et al. (2025) highlighted the implications of Islamic values for midwifery services in general, without detailing the boundaries of *aurah* across different medical

[15] Sena Sahputri and Badar, "Pandangan MUI Kabupaten Langkat Mengenai Mekanisme Kerja Dokter Ahli Kandungan Laki-Laki Dalam Menangani Wanita Hamil Dan Melahirkan (Studi Kasus RSU Mahkota Bidadari Gebang)."
[16] Tiara et al., "Pandangan Islam Terhadap Kesehatan Maternal Dan Implikasinya Pada Pelayanan Kebidanan," *Jurnal Kajian Ilmiah Interdisiplinier* 9, no. 7 (2025): 165–74.
[17] Fitri Yuli Mardiyati and Dumilah Ayuningtyas, "Analysis of Implementation Standards of Sharia Minimum Services in the Hospital: Case Study at Sari Asih Sangiang Hospital 2018," *Journal of Indonesian Health Policy and Administration* 6, no. 1 (January 30, 2021), https://doi.org/10.7454/ihpa.v6i1.3145.
[18] Wahyu Sulistiadi et al., "Health Personnel Improvement in the Implementation of Shariah's Ethical Code of Conduct in Tangerang Hospital, Indonesia," ed. Md Nazirul Islam Sarker, *Journal of Environmental and Public Health* 2022, no. 1 (January 9, 2022), https://doi.org/10.1155/2022/5548840.
[19] Fadillah Mursid et al., "Legal Construction of Sharia Hospital Certification: Juridical Dynamics and Complexity Fadillah," *Nurani: Jurnal Kajian Syari'ah Dan Masyarakat* 26, no. 1 (2026): 72–90.
[20] Ali Mutashom, Fadli Aziz, and Fazar Sodik, "Pembinaan Keagamaan Berbasis Kajian Fikih Dan Akidah Bagi Warga Binaan Untuk Persiapan Reintegrasi Sosial" 4, no. 1 (2026): 75–85.

procedures. More recent studies likewise focus on a single procedure or relationship. These include urinary catheterization by nurses of the opposite sex [21], childbirth assisted by male physicians [22], female circumcision from the perspective of Imam al-Shafi'i [23], and care by male nurses in general [24]. Meanwhile, the literature on sharia hospitals in Indonesia has focused mainly on management, service quality, and patient satisfaction and loyalty [25]; [26]; [27], It has paid less attention to the detailed *fiqh* of protecting *aurah* in each procedure. No study has yet been found that systematically classifies the boundaries of *aurah* across various types of medical procedures, from general examination and surgery to childbirth. Nor has any study done so within a single consistent school of jurisprudence, namely the Shafi'i school, with an orientation toward the needs of urban Muslim healthcare.

The study addresses two questions. First, what are the provisions on the boundaries of *aurah* according to the Shafi'i school in the context of medical examination and treatment? Second, how can these boundaries be classified across the various types of medical procedures that have developed in the modern era, particularly those commonly encountered in urban healthcare facilities? Accordingly, this study aims to explain the Shafi'i provisions on the boundaries of *aurah* in the medical context. It also aims to classify these boundaries according to the range of contemporary medical procedures. The target community of this study comprises Muslim patients and healthcare workers in urban healthcare settings, in both general hospitals and sharia-certified hospitals.

The significance of this study lies in its systematic, school-specific mapping of the boundaries of *aurah* in medical practice. Such a mapping has not previously been available in comprehensive form in the literature. The classification is expected to serve as an initial reference for Muslim healthcare practitioners, Islamic medical and midwifery education institutions, and policymakers in sharia hospitals in urban areas. It can be used to design standard operating procedures and mandatory patient *fiqh* training materials. Malaysia's experience in formulating a sharia-compliant medical services framework shows that such a framework can be operationalized institutionally [28].

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[21] Fathurrohman Jamil et al., "Pemasangan Kateter Urin Pada Pasien Lawan Jenis Dilihat Dari Sudut Pandang Islam," *Jurnal Keperawatan Galuh* 7, no. 1 (January 24, 2025): 1, https://doi.org/10.25157/jkg.v7i1.17097.

[22] (Afrillianti et al., 2024)

[23] Shafira Amalia Assalwa and Ilham Fikri Ma'arif, "Pelarangan Mutlak Khitan Perempuan Bertentangan Dengan Syariat? (Tinjauan Atas Fatwa MUI Perspektif Maqasid Al-Syari'ah)," *Al-Syakhsiyyah: Journal of Law & Family Studies* 6, no. 2 (2024): 169–92, https://doi.org/10.15408/ajis.v12i2.964.2.

[24] Abdul Halim And Ismail, "Kedudukan Rawatan Oleh Perawat Lelaki Menurut Syarak [The Position Of Treatment By Male Healthcare Providers According To Islamic Law]."

[25] (Hayati et al., 2025)

[26] (Ngatindriatun et al., 2026)

[27] (Rahman et al., 2023)

[28] Farrah Ilyani Che Jamaludin et al., "Developing a Shariah-Compliant Medical Services Framework in Malaysia: An Expert System Approach Using Fuzzy Delphi Method and Interpretive Structural

METHOD

This study is library research with a qualitative-conceptual approach. Its object of study is the norms and legal maxims of the Shafi'i school, rather than field data on the behavior or perceptions of research subjects. It combines a doctrinal approach with a conceptual approach. The doctrinal approach examines legal rules as they are stated in authoritative texts, which in this study are the classical works of Shafi'i jurisprudence. The conceptual approach then builds analytical categories from those rules. Through these two approaches, the concept of *aurah* in the corpus of Shafi'i jurisprudence is traced and then brought to bear on a range of contemporary medical procedures not explicitly discussed in the classical texts. This pattern is common in contemporary studies of medical *fiqh* based on the textual analysis of sharia sources [29]; [30]. The aim is not to test hypotheses. It is to formulate a coherent conceptual classification grounded in systematic juristic reasoning. This classification is then applied to urban Muslim healthcare as its application context.

The data sources consist of primary and secondary sources. The primary sources are Shafi'i texts that discuss the chapters on *aurah* and the ruling on looking (*naẓar*). These are *Minhāj al-Ṭālibīn* by al-Nawawī [31], *Tuḥfat al-Muḥtāj* by Ibn Ḥajar al-Haytamī [32], *Mughnī al-Muḥtāj* by al-Khaṭīb al-Syarbīnī [33], *Nihāyat al-Muḥtāj* by al-Ramlī [34], *Ḥāsyiyat al-Bājūrī* [35] and *Ḥāsyiyat al-Syarwānī* [36]. Together, these works represent the school's positions at three levels: the base text (*matn*), its commentaries (*syarḥ*), and its glosses (*ḥāsyiyah*). The secondary sources include journal articles on *aurah* and Islamic medical ethics [37]; [38], and studies of sharia hospitals in Indonesia [39]; [40], They also include fatwas issued by religious institutions on contemporary medical issues. These secondary sources serve as points of comparison and contextual updating.

Data were collected through documentary study. Primary and secondary texts were gathered manually from printed works and through digital databases of classical Islamic texts (*turāth*). This was done to ensure the accuracy of references to

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Modelling," *BMJ Open* 15, no. 1 (January 2025): e082263, https://doi.org/10.1136/bmjopen-2023-082263.

[29] (Abdul Halim & Ismail, 2024

[30] (Hashi, 2022)

[31] Yaḥyā bin Syaraf Al-Nawawī, *Minhāj Al-Ṭālibīn Wa 'Umdat Al-Muftīn Fī Al-Fiqh*, Edisi II (Darul Minhaj, 2011).

[32] Ibn Hajar Al-Haytami, *Tuḥfat Al-Muḥtāj Bi Syarḥ Al-Minhāj*, Edisi III, vol. 09 (Beirut: Dar al-Kutub al-'Ilmiyyah, 2012).

[33] Al-Khatib Al-Syarbini, *Mughnī Al-Muḥtāj*, vol. 04 (Beirut: Darul Fikr, 2009).

[34] Muhammad Al-Ramli, *Nihāyat Al-Muḥtāj Ilā Syarḥ Al-Minhāj*, vol. 06 (Beirut: Darul Fikr, 2014).

[35] Ibrāhīm Al-Bājūrī, *Ḥāsyiyat Al-Bājūrī 'alā Syarḥ Ibn Al-Qāsim Al-Ghazzī "Alā Matn Abī Syujā,"* Edisi VIII, vol. 02 (Beirut: Dār al-Kutub al-'Ilmiyyah, 2010).

[36] 'Abd al-Ḥamīd Al-Syarwānī, *Ḥāsyiyat Al-Syarwānī 'alā Tuḥfat Al-Muḥtāj*, Edisi III, vol. 09 (Beirut: Dār al-Kutub al-'Ilmiyyah, 2012).

[37] (Purkon, 2023)

[38] (Monawarah & Hafidzi, 2025)

[39] (Mardiyati & Ayuningtyas, 2021)

[40] Mursid et al., 2026)

the original sources. The data were then classified according to the types of medical procedures commonly encountered in urban healthcare facilities. These are general physical examination, diagnostic and radiological procedures, surgical procedures, obstetric and gynecological care, and emergency care.

The data were analyzed using content analysis, that is, the systematic reading of texts to identify, categorize, and interpret their meanings. This technique was adapted to the framework of *istinbāṭ*, the method by which jurists derive legal rulings from the sources of Islamic law according to established principles of legal theory (*uṣūl al-fiqh*) [41], A similar adaptation has been applied in formulating the parameters of medical fatwas based on classical and contemporary juristic sources [42]. The analysis proceeded in three stages. The first stage identified relevant texts and legal maxims, including *al-ḍarūratu tubīḥu al-maḥẓūrāt* ("necessity renders the prohibited permissible") and *al-ḥājah tanzilu manzilat al-ḍarūrah* ("pressing need is treated as necessity"). The second stage extracted categories of *aurah* boundaries from the primary texts. These categories are *aurah* between persons of the same sex, *aurah* before the opposite sex, and *aurah* in medical emergencies. The third stage was synthesis. Each category of medical procedure was mapped onto this framework through an iterative rereading of the primary sources. This ensured that the classification remained consistent with Shafi'i juristic reasoning rather than reflecting the authors' free interpretation.

The resulting classification is intended for application in general hospitals and sharia-certified hospitals in urban areas. It serves as a reference for drafting standard operating procedures, mandatory patient *fiqh* training materials, and codes of conduct for healthcare workers [43]; [44]. This application matters because sharia standards for hospitals have not yet been integrated into national health regulations. They therefore still depend on each institution's internal guidelines [45].

RESULTS AND DISCUSSION

Definition and Stages of Medical Examination

Medical examination is referred to in contemporary *fiqh* literature as *al-faḥṣ al-ṭibbī*. It is the first and most fundamental step in the treatment of any patient. Linguistically, the word *al-faḥṣ* denotes a thorough and earnest search into something. This is reflected in the expression *faḥaṣa 'anhu faḥṣan*, meaning to investigate or examine a person's condition carefully [46]. This meaning later developed into a technical term in medicine. *Al-faḥṣ al-ṭibbī*, commonly called clinical examination (*al-faḥṣ al-sarīrī*), is the physician's activity of examining the patient's

[41] Imam AL-Haramain AL-Juwaynī, *Al-Waraqat Fī Ushūl Al-Fiqh*, Edisi Pert (Oman: Darannoor, 2014).
[42] Azahar, Mohammad, and Mohamad, "Towards Understanding the Concept of Fatwa on Medical Treatment Involving Forbidden Sources Tinjauan Terhadap Pemahaman Konsep Fatwa Dalam Rawatan Perubatan Yang Melibatkan Sumber-Sumber Haram."
[43] (Mardiyati & Ayuningtyas, 2021)
[44] (Sulistiadi et al., 2022)
[45] Mursid et al., "Legal Construction of Sharia Hospital Certification: Juridical Dynamics and Complexity Fadillah."
[46] Ibn Manẓūr, *Lisān Al-ʿArab*, Edisi I, vol. 4 (Beirut: Dār al-Kutub al-ʿIlmiyyah., 2005).

body in search of signs of disease. It relies on the physician's powers of observation and senses. It is sometimes assisted by simple bedside instruments such as a stethoscope. It also explores the patient's complaints, such as pain, nausea, dizziness, and fatigue. It does not yet involve modern diagnostic tools such as radiology or laboratory tests [47].

The link between the linguistic and technical meanings deserves emphasis, because clinical examination is the basis of all other forms of medical examination. A careful initial examination allows the physician to avoid over-examination. An accurate diagnosis can thus be established without exposing the patient to avoidable risks, discomfort, bodily exposure, and costs. Clinical examination also determines which further examinations are truly necessary, thereby speeding up the entire treatment process.

Technically, medical examination comprises four sequential stages. The first stage is inspection, that is, observation of pathological signs. These range from the color of the skin and lips, body posture, and height-to-weight proportion to the condition of the teeth and eyes. This stage also includes observing the patient's body position, such as lying with the abdomen drawn in or sitting in a squatting posture. It further includes spontaneous behaviors to relieve symptoms, such as scratching or avoiding light. At this stage the physician makes use of all the senses. Examples include detecting the smell of acetone in a patient with diabetic ketoacidosis and hearing changes in breath sounds and coughing.

The second stage is physical examination (*al-faḥṣ al-jismānī*), which consists of three techniques. The first, palpation, is used to feel the pulse, lymph nodes, skin texture, and the abdominal area in order to detect tumors or inflammation. The second, functional examination, tests the range of joint motion or activities such as speaking, standing, and walking. The third, percussion, identifies the patient's condition through changes in the sound produced when the body is tapped with the fingertips.

The third stage involves simple supplementary instruments. These include auscultation with a stethoscope, blood pressure measurement, and testing of nerve reflexes with a reflex hammer, all of which can still be performed at the patient's bedside. The fourth and most complex stage involves advanced tools such as X-ray imaging, endoscopy, and laboratory tests of blood, urine, and stool. This stage is undertaken to confirm the diagnosis when the disease has not become clear through the three preceding stages [48].

Boundaries of *Aurah* Based on Body Zones

Before discussing the boundaries of *aurah* specifically, it should be noted that the recommendation to seek treatment in Islam is not without limits. Islam establishes the principle of seeking treatment and even commands it explicitly. The Prophet ﷺ said: "*Fa-tadāwaw*" (so seek treatment) [49]. This command also opens the

[47] (McLeod, 2020)
[48] (McLeod, 2020)
[49] (Al-Sijistānī, 2011)

door of hope for recovery from every illness. Another hadith affirms: "Indeed, Allah has sent down both disease and cure, and has appointed a cure for every disease" [50]. Nevertheless, this broad encouragement is limited by the boundaries of sharia. The Prophet ﷺ said: "Do not seek treatment with what is forbidden" [51].

This prohibition is general in scope. Its generality rests on the legal-theoretical maxim *al-nakirah fī siyāq al-nafyi tufīdu al-'umūm* (an indefinite noun in a negative context conveys generality) [52]. In the phrase *wa lā tadāwaw bi-ḥarām*, the word *ḥarām* is an indefinite noun (*nakirah*) preceded by the negative particle *lā*. The prohibition is therefore not confined to the type of medicine. It also covers the manner in which a physician treats the patient, including exposing the patient's *aurah* without a justifying need. This issue is the core of the discussion in this section [53]. On this basis, the Shafi'i school formulated provisions on the physician's gaze upon the patient's body. It divides the body into two zones, each requiring a different degree of caution.

The first zone covers all parts of the body outside the area between the navel and the knees. Within the general obligation to cover the *aurah*, this zone is treated as less sensitive than the navel-to-knee area [54]; [55]. In this zone, the physician may look at the patient's body subject to two relatively light conditions. The first is safety from temptation (*fitnah*). This means there is assurance that the gaze will not lead to sin. Such sin includes the arousal of desire leading to adultery, the misuse of seclusion (*khalwah*, being alone with an unrelated person of the opposite sex), or the abuse of medical authority to look at or touch beyond the needs of diagnosis. The second condition is the absence of desire (*syahwah*), meaning the gaze does not produce pleasure for the one looking [56]; [57];[58].

The principle of guarding the gaze is also consistent with the moral-educational values emphasized by Imam al-Ghazālī in *Bidāyat al-Hidāyah*. He treats guarding one's sight (*ghaḍḍ al-baṣar*) as one of the main pillars of preserving chastity. Its relevance extends to various contemporary contexts, including the professional interaction between healthcare workers and patients [59]. The second zone covers the area between the navel and the knees, including the private parts (*al-saw'atayn*). In this zone, far stricter caution is required. Both conditions of the first zone still apply. One crucial condition is added, namely a pressing need (*ḥājah*) that warrants uncovering that part of the body. Once this need is met, looking at the second zone becomes permissible, even at the private parts.

The *ḥājah* meant here is not need in the general sense. It is a condition equivalent to one that permits *tayammum* (*mubīḥ al-tayammum*), that is, a condition serious

[50] (Al-Sijistānī, 2011)
[51] (Al-Sijistānī, 2011)
[52] AL-Juwaynī, *Al-Waraqat Fī Ushūl Al-Fiqh*.
[53] AL-Juwaynī.
[54] (Purhasanah et al., 2023)
[55] Majri et al., 2024)
[56] (Al-Syarbini, 2009)
[57] Al-Ramli, 2014
[58] (Al-Haytami, 2012)
[59] (Rahman & Mutashom, 2026)

enough to allow a person to replace ritual washing with dry ablution. Examples include fear for one's life, a threat to the function of an organ, the prolongation of an illness, or the appearance of a serious disfigurement on a visible part of the body [60]. For the private parts specifically, the standard is even higher. Uncovering them must be justified to the point that it is not regarded as damaging one's *murū'ah*, that is, one's personal dignity and moral standing in society. Scholars define *murū'ah* in various ways. Some define it as the character of one's contemporaries who uphold the etiquette of sharia. Others define it as freedom from things that expose a person to ridicule, or as self-protection from base matters that tarnish one's reputation [61]. From these three definitions, it can be concluded that the need required for the private parts is not a trivial one. It must be genuinely justified by the prevailing custom (*'urf*) of its time.

This high standard of need is reflected in the contemporary debate on female circumcision. Some medical circles consider the practice to have no clear health benefit and even to be potentially harmful. This raises the question of whether it meets the standard of *ḥājah* equivalent to *mubīḥ al-tayammum* [62]; [63]; [64];[65]. Other studies argue that an absolute prohibition is more consistent with *maqāṣid al-syarī'ah*. The debate is now also being read from the perspective of Imam al-Shafi'i in light of Government Regulation (PP) No. 28 of 2024 [66]; [67]; [68]; [69].

The above provisions on looking (*al-naẓar*) essentially also apply to touching (*al-mass*). The jurists affirm that whatever is forbidden to look at is likewise forbidden to touch [70]. In some respects, touching is considered even more serious than looking. This is reflected in the case of the *amrad*, a handsome youth whose beard has not yet grown: touching him is prohibited just as looking at him is. Nevertheless, this rule of equivalence is not absolute. In certain situations, looking may be forbidden while touching is not, or vice versa. For example, a physician may be able to identify a disease merely by palpation without needing to look [71]; [72];[73]. This conclusion is consistent with studies of the *fiqh* of medical treatment in Malaysia [74]; [75].

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[60] Sa'īd bin Muḥammad Bā'asyan, *Busyrā Al-Karīm Bi Syarḥ Masā'il Al-Ta'līm*, Edisi II (Dār al-Minhāj, 2008).
[61] Al-Syarbini, *Mughnī Al-Muḥtāj*.
[62] (Amin & Lendrawati, 2022
[63] Trisna Wati, 2025
[64] Sariyah et al., 2023
[65] (Rahmani & Zakiyah, 2023)
[66] (Assalwa & Ma'arif, 2024)
[67] Rambe & Iwan, 2024
[68] Mahmudi et al., 2024
[69] Basri et al., 2024)
[70] Al-Nawawī, *Minhāj Al-Ṭālibīn Wa 'Umdat Al-Muftīn Fī Al-Fiqh*.
[71] (Al-Syarbini, 2009
[72] Al-Ramli, 2014
[73] Al-Haytami, 2012)
[74] (Abdul Halim & Ismail, 2024
[75] Abdullah & Zabidi, 2021)

Boundaries of *Aurah* in Same-Sex Treatment

The preceding section set out the division of body zones and the general conditions for the medical gaze. The discussion now turns to their application in two relational contexts. The first is treatment between persons of the same sex (*ittiḥād al-jins*). The second is treatment across sexes (*ikhtilāf al-jins*). This distinction matters because the degree of caution required by sharia differs between the two contexts, as the following discussion will show.

In same-sex treatment, the provisions are relatively simpler. A physician may look at or touch the body of a patient of the same sex in any zone, whether the first or the second. The only requirement is that the necessary *ḥājah* is met, as explained in Point 2. This relative simplicity stems from the absence of *ikhtilāṭ*, the mixing of unrelated men and women, which is the main source of concern about temptation. It is also consistent with the tendency of Muslim patients to choose an examiner of the same sex, primarily out of embarrassment [76]; [77]. Nevertheless, the general conditions still apply. These are safety from temptation, the absence of desire, and exposure limited to what is needed in the navel-to-knee zone. The reason is that temptation and desire cannot be entirely ruled out even in same-sex relationships.

Boundaries of *Aurah* in Cross-Sex Treatment

Unlike same-sex treatment, cross-sex treatment requires a more explicit textual basis. Sharia strictly limits relations between unrelated men and women. Moreover, patients' rights to a same-sex provider and to the presence of a *maḥram* are recognized within the framework of Muslim patients' rights [78]. The permissibility of cross-sex treatment is nevertheless affirmed by a number of authentic hadiths that record actual practice in the time of the Prophet ﷺ.

The first report comes from al-Rubayyi' bint Mu'awwidh on the participation of female Companions in caring for wounded soldiers: "We were with the Prophet ﷺ, giving water to and treating the wounded, and bringing the dead back to Medina" [79], A similar testimony comes from Umm 'Aṭiyyah al-Anṣāriyyah: "I took part in seven military expeditions with the Messenger of Allah ﷺ; I guarded their provisions, prepared their food, treated the wounded, and cared for the sick" [80], A report from Anas further confirms that the Messenger of Allah ﷺ went on campaigns accompanied by Umm Sulaym and a number of Anṣārī women. These women gave water to and treated the wounded [81], The report of Yazīd bin Hurmuz, conveying Najdah's question to Ibn 'Abbās, affirms the same practice [82].

These four reports explicitly establish that women may treat men. Some scholars then derived the converse permission, namely that men may treat women, from the hadith of al-Rubayyi'. They did so by analogy (*qiyās*), that is, by extending

[76] (Alkhaldi et al., 2022
[77] Alhomayani et al., 2025)
[78] (Muhammed-Mikaaeel et al., 2025)
[79] (Al-Bukhari, 2004)
[80] (Al-Muslim, 2010)
[81] (Al-Muslim, 2010)
[82] (Al-Sijistānī, 2011)

a ruling from one case to another that shares the same effective cause (*'illah*). The shared cause here is the pressing need for treatment, which does not depend on the sex of the person in need of help [83].

Beyond the context of war, *Ṣaḥīḥ Muslim* contains a report from Jābir through the chain of Qutaybah bin Sa'īd and Ibn Mawhab, from al-Layth, from Abū al-Zubayr. It states that Umm Salamah asked permission to be cupped, and the Messenger of Allah ﷺ instructed Abū Ṭaybah, a man, to cup her [84]. This report shows that the permissibility of cross-sex treatment is not limited to wartime emergencies. It also applies in peacetime. The issue had drawn the attention of hadith scholars from an early period. This is reflected in the chapter title given by Imam al-Bukhārī: "*Hal yudāwī al-rajul al-mar'ah wa al-mar'ah al-rajul?*" (May a man treat a woman, and a woman treat a man?) [85].

The evidence above establishes the permissibility of cross-sex treatment in principle. This permission, however, remains subject to the general conditions set out in the next section. These include the presence of a third party to prevent seclusion, the priority of Muslim healthcare providers, and the limitation of *aurah* exposure to what is needed [86]. The permission is therefore not unlimited. It is bound by a framework of conditions that safeguards the patient's dignity. Religious scholars and midwives in Indonesia uphold this framework in childbirth practice [87].

General Conditions for Permissibly Looking at or Touching *Aurah* for Treatment

Having distinguished between same-sex and cross-sex treatment, the next question is this: what concrete conditions must be met for a healthcare provider's gaze at or touch of a patient's *aurah* to be justified under sharia? The Shafi'i jurists, particularly in *Tuḥfat al-Muḥtāj* and *Mughnī al-Muḥtāj*, formulated a set of cumulative conditions. All of them must be met simultaneously. This pattern resembles the parameters of contemporary medical fatwas, which require necessity, the absence of alternatives, expert verification, and proportionality [88]; [89] [90].

The first condition is a safeguard against seclusion. A third party, such as the patient's *maḥram*, husband, or a trustworthy woman (*imra'ah thiqah*), must be present during the examination or treatment. This ensures that the healthcare provider and an unrelated patient are not left alone together [91]. The second condition is the unavailability of a competent same-sex provider. A provider of the opposite sex may

[83] Ahmad bin Ali Al-'Asqalani, *Fatḥ Al-Bārī Syarḥ Ṣaḥīḥ Al-Bukhārī*, Edisi I, vol. 13 (Beirut: Dār al-Kutub al-'Ilmiyyah, 2004).
[84] Al-Naysābūrī, *Ṣaḥīḥ Muslim*.
[85] (Al-Bukhari, 2004)
[86] Abdul Halim and Ismail, "KEDUDUKAN RAWATAN OLEH PERAWAT LELAKI MENURUT SYARAK [THE POSITION OF TREATMENT BY MALE HEALTHCARE PROVIDERS ACCORDING TO ISLAMIC LAW]."
[87] (Afrillianti et al., 2024)
[88] (Al-Syarbini, 2009)
[89] Al-Haytami, 2012
[90] Azahar et al., 2024)
[91] (Afrillianti et al., 2024)

treat the patient only when there is genuinely no same-sex alternative with the necessary expertise. This condition is often difficult to meet given the limited number of same-sex physicians in healthcare facilities [92]. It is also subject to exceptions in certain circumstances, as explained in Point 7.

The third condition is that the healthcare provider must be trustworthy (*amānah*). It is therefore not permissible to give priority to an untrustworthy provider when a trustworthy one is available. The fourth condition is that Muslim healthcare providers take precedence over non-Muslims (*dhimmī*) for both male and female patients. This order holds as long as no other factor reverses it. *Pesantren* scholars in Sumedang also uphold this order [93]. The fifth condition is safety from temptation, that is, the assurance that the process will not lead to sin.

The sixth condition limits the exposure of *aurah* to what is needed (*qadr al-ḥājah*). No part of the body may be uncovered beyond what is necessary for diagnosis or medical treatment. Urban sharia hospitals have translated this condition into their service standards. Examples include hijab for patients, gender-appropriate ECG placement, and hijab in the operating theater [94].

The seventh condition affirms that the required level of need differs according to the body zone. For the face and both palms, an ordinary need (*adnā al-ḥājah*, the lowest degree of need) suffices. For other parts of the body apart from the private parts, a need equivalent to *mubīḥ al-tayammum* is required. For the private parts, a condition of necessity is required, such that their exposure is not regarded as damaging *murū'ah*. Examples include childbirth requiring direct examination of the birth canal and surgery on the genital organs due to injury or serious infection. Further examples are urinary catheterization in acute urinary retention and emergencies such as testicular torsion, which may permanently threaten the function of the organ [95]; [96]; [97]. Conversely, exposing the same area without a genuine medical need does not meet the required standard. A routine examination without clinical indication, for instance, is still regarded as damaging *murū'ah* [98].

These seven conditions show that the permission to uncover a patient's *aurah* is not a loose one. It is bound by layered safeguards. These range from the presence of a third party, the availability of same-sex providers, and the integrity of the healthcare provider to the proportionality of exposure according to medical urgency.

Hierarchy of Healthcare Provider Priority in the Shafi'i School

In addition to these seven conditions, the Shafi'i jurists formulated an order of priority (*tartīb*) among healthcare providers that patients should follow. This formulation matters in practice. Especially in urban healthcare facilities with many

[92] (Sahputri & Badar, 2024)
[93] (Afrillianti et al., 2024)
[94] Mardiyati and Ayuningtyas, "Analysis of Implementation Standards of Sharia Minimum Services in the Hospital: Case Study at Sari Asih Sangiang Hospital 2018."
[95] (Jamil et al., 2025)
[96] Khairul Fahmi , 2022
[97] (Zulhan et al., 2023)
[98] (Al-Syarbini, 2009

available providers, patients and their families often have to choose whom to prioritize. Preferences regarding the physician's sex have also been shown to vary according to the type of procedure [99].

For a Muslim female patient, Ibn Ḥajar al-Haytamī in *Tuḥfat al-Muḥtāj* sets out the following order. First comes a Muslim woman, then the patient's *maḥram*, whether Muslim or not. Next comes a non-Muslim woman (*kāfirah*), then an unrelated Muslim man (*ajnabī*), and finally an unrelated non-Muslim man. The patient's husband, however, ranks above this entire order. He is therefore always the first choice whenever he is able and in a position to provide the treatment.

The position of the *maḥram* is subject to more detailed ordering. *Tuḥfat al-Muḥtāj* (9:40) details it as follows. First comes a Muslim boy who has not yet approached puberty (*ghayr murāhiq*), then one approaching puberty (*murāhiq*). Next comes a non-Muslim *maḥram* who has not yet approached puberty, then one approaching puberty, and so on. Other Shafi'i scholars do not fully agree with this detailed order [100]. *Ḥāsyiyat al-Bājūrī* (2:185) sets out a different order. After a Muslim woman comes a Muslim boy who has not approached puberty, then a non-Muslim who has not approached puberty, then a Muslim approaching puberty, and so on. Consequently, the positions of *murāhiq* and *ghayr murāhiq* differ between the two views [101].

A similar difference concerns the status of *al-mamsūḥ*, a person whose genitals have been severed. According to Ibn Ḥajar al-Haytamī, this group ranks above the *murāhiq*. According to al-Bājūrī, a Muslim *mamsūḥ* takes precedence over a non-Muslim woman. A non-Muslim *mamsūḥ* follows, then an unrelated Muslim man, and so on [102]. These minor differences reflect the jurists' care in balancing three considerations: kinship proximity, religious status, and biological maturity. Together, these determine who is most fit to handle a patient's *aurah*.

Exceptions to the Hierarchy: Expertise and Cost

The hierarchy set out in Point 6, however detailed, is neither absolute nor rigid. The Shafi'i jurists formulated two important exceptions that can reverse it. These exceptions may even give priority to a provider who formally occupies the lowest rank.

The first exception concerns expertise (*al-mahārah*). A more skilled provider (*al-amhar*) takes precedence over one with merely ordinary skill (*al-māhir*), even if the former ranks lower in the formal hierarchy. *Tuḥfat al-Muḥtāj* (9:40–41) states that a non-Muslim physician with far greater mastery of the field takes precedence over an available Muslim physician. Such a physician even takes precedence over a Muslim female physician. This provision does not contradict the second and fourth conditions in Point 5. The priority of a Muslim woman applies only when no one else

[99] Alhomayani et al., "Gender Preferences in Healthcare: A Study of Saudi Patients' Physician Preferences."
[100] (Al-Haytami, 2012)
[101] Al-Bājūrī, *Ḥāsyiyat Al-Bājūrī 'alā Syarḥ Ibn Al-Qāsim Al-Ghazzī "Alā Matn Abī Syujā."*
[102] Al-Bājūrī.

has greater mastery of the treatment than she does [103]. Contemporary scholars also affirm this consideration of competence. They permit a male physician when a female physician is unable to provide the treatment [104].

The second exception concerns cost (*qillat al-taklifah*). A provider willing to accept a fair fee (*ujrat al-mithl*, the standard market rate for the service) takes precedence over one who demands a higher fee. A provider willing to accept less than the fair fee still takes precedence, even if non-Muslim and at the lowest rank [105]. This shows that the jurists took the patient's financial capacity into account as part of the patient's welfare (*maṣlaḥah*, the benefit that sharia seeks to secure for people). They did not impose an ideal order without regard for its practical consequences.

These two exceptions reveal the fundamental nature of the hierarchy of priority. It is not an end in itself (*maqṣid li dhātihi*). It is a means of realizing the patient's substantive welfare (*maṣlaḥat al-marīḍ*). This is consistent with readings of *maqāṣid al-syarī'ah* in clinical services and contemporary medical procedures [106]; [107]. It confirms that the Shafi'i *fiqh* framework on *aurah* in medical treatment remains oriented toward the principle of *dar' al-mafāsid wa jalb al-maṣāliḥ* (averting harm and securing benefit) rather than rigid procedural formality. It also addresses the ethical dilemma between professionalism and religious values faced by healthcare workers [108].

Table 1. Recapitulation of the Classification of *Aurah* Boundaries in Medical Procedures

No	Aspect	Main Provisions	Sources
1	Definition of Medical Examination	*Al-faḥṣ al-ṭibbī* comprises four stages: inspection, physical examination (palpation, functional examination, percussion), simple supplementary instruments (auscultation, etc.), and advanced instruments (radiology, laboratory tests)	Ibn Manẓūr (2005); McLeod (2020)
2	Body Zones	Zone I (outside navel–knee): safety from temptation + absence of desire. Zone II (navel–knee, including private parts): additional requirement of *ḥājah* equivalent to *mubīḥ al-tayammum*; for the private parts, a level of necessity that does not damage *murū'ah*	*Tuḥfat al-Muḥtāj*, 9:41

[103] Al-Syarwānī, *Ḥāsyiyat Al-Syarwānī 'alā Tuḥfat Al-Muḥtāj*.
[104] (Afrillianti et al., 2024)
[105] (Al-Haytami, 2012)
[106] (Hashi, 2022)
[107] (Azizah et al., 2024)
[108] Christo Deksan Banunaek, Yustina Erti Pravitasmara Dewi, and Roos Kities Andadari, "Dilema Etik Pada Profesionalisme Perawat Terhadap Kualitas Pelayanan Keperawatan," *Jurnal Kepemimpinan Dan Manajemen Keperawatan* 4, no. 2 (November 30, 2021): 110–20, https://doi.org/10.32584/jkmk.v4i2.1143.

3	Same-Sex Treatment	Applies to all body zones provided *ḥājah* is met; relatively more lenient owing to the absence of *ikhtilāṭ*	*Tuḥfat al-Muḥtāj*, 9:41
4	Cross-Sex Treatment	Permitted on the basis of the hadiths of al-Rubayyi' bint Mu'awwidh, Umm 'Aṭiyyah, Anas, Yazīd bin Hurmuz, and Umm Salamah (cupping); remains subject to the general conditions	*Ṣaḥīḥ al-Bukhārī*, no. 2882; *Ṣaḥīḥ Muslim*, nos. 1812, 1810
5	General Conditions (7)	Safeguard against seclusion, unavailability of a competent same-sex provider, trustworthiness, priority of Muslim providers, safety from temptation, exposure limited to need, gradation of need by zone	*Tuḥfat al-Muḥtāj*, 9:41; *Mughnī al-Muḥtāj*, 4:327
6	Hierarchy of Provider Priority	Muslim woman → *maḥram* → non-Muslim woman → unrelated Muslim man → unrelated non-Muslim man (husband above all); details vary between Ibn Ḥajar and al-Bājūrī	*Tuḥfat al-Muḥtāj*, 9:40; *Ḥāsyiyat al-Bājūrī*, 2:185
7	Exceptions: Expertise and Cost	A more skilled provider (*al-amhar*) and one with a fairer or lower fee may reverse the hierarchy	*Ḥāsyiyat al-Syarwānī*, 9:40–41

The classification of *aurah* boundaries in medical procedures according to the Shafi'i school rests on the interaction of four variables. These are the body zone exposed, the gender relation between patient and healthcare provider, the level of medical urgency (*ḥājah* or *ḍarūrah*), and the availability and competence of healthcare providers. The four variables are interlocking. Leniency in one variable is always balanced by stricter requirements in another. A hierarchy that appears rigid can still be relaxed by considerations of expertise and cost. This layered structure answers the research questions of this study.

For urban Muslim healthcare, it has three implications. First, for healthcare workers, Table 1 can serve as a practical, procedure-specific guide and as material for patient *fiqh* training [109]; [110]; [111]. Second, for general hospitals and sharia-certified hospitals, Table 1 can serve as a basis for drafting standard operating procedures. These procedures can be more detailed than the existing sharia minimum service indicators. This matters because studies of sharia hospitals have so far focused mainly on management, quality, and institutional compliance. Their certification has

[109] (Sulistiadi et al., 2022)
[110] Rizkina et al., 2024
[111] (Putri et al., 2025)

also not yet been integrated into national regulations [112]; [113]; [114]; [115]; [116]; [117]. Third, for patients, the classification provides assurance that seeking treatment under conditions of *ḥājah* or *ḍarūrah* does not contradict sharia. There is therefore no reason to delay treatment, including as services develop toward sharia-friendly care and telemedicine [118]; [119]; [120].

CONCLUSION

This study set out to answer two questions. The first concerned the provisions on the boundaries of *aurah* in medical examination and treatment according to the Shafi'i school. The study finds that the school does not treat a patient's *aurah* as a single rigid prohibition. Instead, it treats it as a tiered system that measures bodily exposure in proportion to medical need. Every leniency in this system is balanced by stricter conditions elsewhere. The hierarchy of healthcare providers is ultimately subordinate to the patient's welfare, not the other way around.

Theoretically, this study shifts the discussion of *aurah* in medical treatment from case-by-case analysis toward an analytical framework. This framework can be re-tested on new medical procedures not addressed in classical *fiqh*. A similar pattern of reasoning already appears in contemporary medical *fiqh*. One example is the permissibility of corrective genital surgery for *khunthā* (intersex persons), provided it serves the *maqāṣid al-syarī'ah* and meets medical standards [121]. The framework of legal maxims and *maqāṣid al-syarī'ah* used here has also proven relevant beyond the medical field, such as in formulating a family resilience model for Indonesian migrant workers [122].

Practically, for urban Muslim healthcare, the findings call for three concrete steps. First, general hospitals and sharia-certified hospitals should give priority to the units dealing with the most sensitive body zones when scheduling same-sex providers and chaperones. These units are obstetrics and gynecology, urology, and emergency care. Second, informed consent forms should include the option of a same-sex provider and the presence of a chaperone. Third, the gradation of need by body zone should become core material in mandatory patient *fiqh* training.

[112] (Mardiyati & Ayuningtyas, 2021
[113] Maksum et al., 2022
[114] Nadratuzzaman et al., 2021
[115] Syafaat et al., 2023
[116] Hayati et al., 2025
[117] Mursid et al., 2026)
[118] (Che Jamaludin et al., 2025)
[119] Abdul Halim et al., 2024
[120] Syafaat, Qaiser Abdul Kareem Hamoode, and Muwahid, "Implementation of Shariah Hospital Management Fatwa and Good Corporate Governance Principles: Another Fact from Shariah Hospital."
[121] Muhammad April and Asrizal Saiin, "PERFECTION OF SEX FOR THE INTERSEX (KHUNṠA) TO GET MARRIED: Maqāṣid Syarīah Perspective on Corrective Surgery," *Al-Ahwal* 14, no. 2 (2021): 173–84, https://doi.org/10.14421/ahwal.2021.14205.
[122] Mursid et al., "Legal Construction of Sharia Hospital Certification: Juridical Dynamics and Complexity Fadillah."

Healthcare workers would then have uniform guidelines, and patients would not delay treatment out of religious doubt [123].

This study is conceptual and limited to a single school of jurisprudence. Future research should therefore test the application of this classification in urban hospitals. It should also conduct comparative studies across schools and extend the framework to telemedicine services.

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