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Integration of Modern Medicine and Thibbun Nabawi in Healthcare Services: Opportunities, Challenges, and Implications

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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Abstract

This article critically reviews the possible integration of modern medicine and Thibbun Nabawi in healthcare services by examining conceptual compatibility, clinical evidence, service implementation, and regulatory boundaries. A structured narrative review was conducted using a PRISMA-guided selection process. Literature was searched in Scopus, PubMed, SINTA, and Web of Science for publications from 2015 to 2026, using terms related to prophetic medicine, Islamic health traditions, integrative medicine, and healthcare services. From 142 identified records, 108 remained after duplicate removal, 65 were screened by title and abstract, 42 were assessed in full text, and 28 sources were included for qualitative synthesis. The review shows that integration is most defensible when Thibbun Nabawi is treated as a selective, evidence-sensitive, and ethically bounded complement rather than as a substitute for biomedical care. Cupping, honey, Nigella sativa, and ajwa dates have different levels of clinical plausibility, whereas ruqyah is more appropriately positioned as psychosocial and religious support. Safe implementation requires protocols, practitioner oversight, product standardisation, informed consent, and legal accountability. The article concludes that integration is possible only under clinical, ethical, and regulatory discipline.

Keywords: *Thibbun Nabawi; prophetic medicine; integrative medicine; healthcare services; Islamic health studies*

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1. INTRODUCTION

The global expansion of traditional, complementary, and integrative medicine has changed the way contemporary health systems interpret culturally embedded healing practices. Patients increasingly seek care that responds not only to biological dysfunction, but also to psychological, spiritual, social, and moral dimensions of wellbeing. This shift does not eliminate the authority of biomedical medicine; rather, it requires clearer criteria for determining when non-biomedical traditions can be accommodated within safe and accountable healthcare services (World Health Organization [WHO], 2025).

In Muslim societies, this debate is especially visible in relation to Thibbun Nabawi, commonly translated as prophetic medicine. Thibbun Nabawi refers to healing guidance, preventive conduct, substances, and practices associated with the Prophetic tradition, including honey, black seed, dates, cupping, dietary discipline, and spiritual forms of support. However, it should not be reduced to a fixed catalogue of remedies. The literature more appropriately frames it as a religiously mediated healing tradition in which bodily care is connected with moral discipline, devotional life, and inherited Muslim health culture (Adhi, 2023; AlRawi & Fetters, 2012; Yakub Ahmad et al., 2024).

The principal analytical tension lies in the different regimes of legitimacy that support modern medicine and Thibbun Nabawi. Modern medicine gains authority through empirical testing, reproducibility, clinical protocols, professional regulation, and risk management. Thibbun Nabawi, by contrast, gains meaning through scriptural association, religious trust, communal memory, and cultural continuity. These different bases of authority do not automatically make the two systems incompatible, but they do make unrestricted integration methodologically weak and ethically unsafe (AlRawi et al., 2017; Orayj, 2022).

Indonesia is an important setting for this discussion because it combines a Muslim-majority population, plural health-seeking behaviour, traditional healing practices, formal biomedical services, and strong community-based trust networks. In this context, prophetic medicine circulates not only as a therapeutic option, but also as a language of identity, prevention, education, and religiously congruent self-care. This social embeddedness explains why Thibbun Nabawi remains persuasive for many patients even when its clinical evidence is uneven (Cipta et al., 2024; Febriyanti et al., 2024; Harahap & Destiwati, 2023; Jahroni, 2020; Widayanti et al., 2020).

Current scholarship remains fragmented. Some studies discuss the theological and epistemological status of prophetic medicine, while others focus on particular products or practices such as cupping, honey, Nigella sativa, dates, and ruqyah. Other works examine service implementation, Islamic hospital settings, community acceptance, and regulatory boundaries. This fragmentation creates an interpretive gap: existing studies rarely connect conceptual legitimacy, clinical plausibility, service feasibility, and legal accountability within one coherent healthcare framework (Fadhlina et al., 2025; Hamdan et al., 2019; Mahat et al., 2024; Tang et al., 2024).

This article contributes to the literature by positioning the integration of modern medicine and Thibbun Nabawi as a healthcare governance issue rather than merely a theological or therapeutic debate. Its novelty lies in proposing a selective integration perspective: prophetic medicine may be accommodated only where the practice is evidence-sensitive, procedurally governable, ethically transparent, and legally accountable. The objective of this review is therefore to critically examine the opportunities, challenges, clinical relevance, implementation requirements, and policy implications of integrating modern medicine and Thibbun Nabawi in healthcare services.

2. METHODS

This study used a structured narrative review design. This design was selected because the literature on Thibbun Nabawi and modern healthcare is conceptually broad and methodologically heterogeneous, including conceptual papers, historical studies, socio-cultural analyses, clinical studies, systematic reviews, implementation reports, and

regulatory or policy documents. A narrative synthesis was therefore more suitable than a meta-analysis because the included sources did not examine a single intervention, population, or outcome measure (AlRawi & Fetters, 2012; Fadhlina et al., 2025).

The literature search was conducted through Scopus, PubMed, SINTA, and Web of Science. The search covered publications from 2015 to 2026, with selected earlier conceptual sources retained only when they were necessary to establish the theoretical basis of the discussion. Search terms combined prophetic healing discourse and healthcare integration, including “Thibbun Nabawi,” “Thibb al-Nabawi,” “prophetic medicine,” “hijrah medicine,” “integrative medicine,” “modern medicine,” “health services,” and “healthcare integration.”

The eligibility criteria included: (1) studies discussing Thibbun Nabawi, prophetic medicine, Islamic medicine, or religion-informed healing in relation to health; (2) studies addressing clinical relevance, implementation, health behaviour, service models, policy, or regulation; and (3) sources available in English or Indonesian. Popular media, unsupported opinion pieces, duplicated records, and materials not connected to healthcare integration were excluded.

The selection process followed a PRISMA-guided logic. The initial search identified 142 records. After duplicate removal, 108 records remained. Title and abstract screening retained 65 records, followed by full-text assessment of 42 sources. A final corpus of 28 sources was included for qualitative synthesis. The screening results are presented in Table 1.

Table 1. PRISMA-guided article selection process

Selection stage	Number of records
Records identified through database searching	142
Records after duplicate removal	108
Records screened by title and abstract	65
Full-text articles assessed for eligibility	42
Final sources included in the review	28

Data synthesis was conducted thematically. Each source was coded into one of five analytical domains: conceptual and epistemological foundations, Indonesian contextual studies, clinical and therapeutic evidence, healthcare service implementation, and policy-regulatory or ethical materials. The synthesis focused on identifying the conditions under which integration may be considered clinically responsible and institutionally defensible.

3. RESULTS AND DISCUSSION

3.1 Characteristics of Included Sources

The 28 included sources demonstrate that the integration of Thibbun Nabawi into healthcare services cannot be understood within one disciplinary frame. The corpus spans Islamic studies, public health, clinical medicine, health behaviour, integrative medicine, healthcare management, and regulatory governance. This distribution confirms that the topic is not merely a question of whether a prophetic remedy “works,” but also whether it can be translated into a safe, auditable, and ethically responsible service arrangement (Mahat et al., 2024; WHO, 2025).

The corpus was grouped into five domains. Conceptual studies clarified the epistemological status of prophetic medicine; Indonesian contextual studies explained its social relevance; clinical studies and reviews assessed selected practices and products; implementation studies examined service design; and regulatory materials defined the legal and ethical limits of inclusion. Table 2 summarises these clusters and their analytical roles in this review.

Table 2. Synthesised characteristics of included sources

Corpus cluster	No. of sources	Typical source types	Main analytical implication
Conceptual and global integrative perspectives	6	Conceptual papers, integrative reviews, bibliometric or trend analyses	Clarify the epistemological relation between prophetic healing traditions and evidence-based medicine.
Indonesian contextual studies	5	Historical, socio-cultural, community-based, educational, and ethnobotanical studies	Explain why Thibbun Nabawi is socially salient in Indonesian Muslim health-seeking behaviour.
Clinical and therapeutic evidence	9	Narrative reviews, systematic reviews, clinical studies, and therapy-focused articles	Differentiate practices with biomedical plausibility from practices that should remain supportive or spiritual.
Healthcare service implementation	4	Case-based, qualitative, management, and implementation papers	Identify protocols, role boundaries, referral logic, and institutional readiness as conditions for safe integration.
Policy, regulatory, and ethical materials	4	Regulatory documents, policy texts, formularies, registration rules, and normative guidance	Define legal accountability, product standards, ethical boundaries, and patient-safety obligations.

3.2 Conceptual and Epistemological Foundations of Integration

The conceptual literature consistently frames Thibbun Nabawi as more than a set of isolated therapeutic products. It is a prophetic and culturally embedded healing tradition that combines moral guidance, preventive conduct, spiritual orientation, and selected therapeutic practices. This wider meaning explains why many Muslim patients regard prophetic medicine not only as treatment, but also as a form of religiously congruent bodily care (Adhi, 2023; AlRawi & Fetters, 2012; Yakub Ahmad et al., 2024).

Modern medicine operates through a different epistemic system. Its legitimacy depends on evidence hierarchy, reproducibility, clinical guidelines, professional licensure, pharmacovigilance, and liability structures. A prophetic association may make a practice meaningful to patients, but it does not automatically establish clinical indication, dosage, contraindication, efficacy, or safety. Integration must therefore move from symbolic legitimacy to procedural accountability (AlRawi et al., 2017; Orayj, 2022).

The strongest conceptual position is neither rejection nor unrestricted fusion. Total rejection ignores the cultural and spiritual dimensions of patient-centred care, while unrestricted fusion risks therapeutic misrepresentation and delayed biomedical treatment. A more defensible approach is selective integration, in which Thibbun Nabawi practices are placed within a clinical hierarchy: some may be tested as adjunctive interventions, some may be used as culturally responsive support, and others should remain outside formal healthcare recommendation until evidence and regulation are adequate (Alsanad, 2025; Fadhlina et al., 2025).

3.3 Indonesian Context: Social, Cultural, and Educational Expansion

In Indonesia, Thibbun Nabawi circulates through religious study groups, community networks, health education activities, faith-based clinics, social media, and informal therapeutic markets. This circulation shows that prophetic medicine is not only a clinical phenomenon; it is also a cultural and educational discourse through which Muslim communities interpret prevention, illness, trust, and bodily discipline (Harahap & Destiwati, 2023; Jahroni, 2020).

Indonesian health-seeking behaviour is plural. Patients may move between biomedical services, herbal products, traditional healers, religious consultation, and family-based advice. Such pluralism does not necessarily indicate resistance to modern medicine. In

many cases, it reflects attempts to combine biomedical treatment with culturally familiar forms of support. However, this pluralism becomes problematic when informal authority is presented as equivalent to clinical competence (Cipta et al., 2024; Febriyanti et al., 2024; Widayanti et al., 2020).

The Indonesian context therefore requires an integration model that respects religious meaning without compromising patient safety. Integration should not be left to market claims, social media persuasion, or unsupervised community practice. When prophetic medicine enters institutional healthcare, it must be translated into service standards, referral procedures, documentation, informed consent, and monitoring mechanisms (Subu et al., 2022; WHO, 2025).

3.4 Clinical and Therapeutic Evidence

The clinical literature is concentrated around a limited set of recurrent practices and products: cupping or hijamah, honey, Nigella sativa, ajwa dates, and spiritually oriented interventions such as ruqyah. These elements do not have the same evidentiary status. Some can be operationalised as procedures or products that may be evaluated through biomedical methods, while others primarily function as religious, emotional, or psychosocial support (Hamdan et al., 2019; Tang et al., 2024; Zein, 2022).

Cupping is the most visible procedure in the reviewed literature because it can be standardised more readily than other practices. Its possible integration depends on sterile technique, practitioner competence, contraindication screening, adverse-event reporting, and clear positioning as an adjunct rather than a replacement for medical diagnosis and treatment. Without these safeguards, cupping may move from culturally accepted practice to avoidable clinical risk (Abul A'la Al Maududi et al., 2026; Isdianto & Fitrianti, 2025; Zainnurrofiq et al., 2024).

Honey and Nigella sativa occupy a different evidentiary position. Both are discussed as natural products with plausible bioactive properties and possible supportive roles in selected clinical contexts. Nevertheless, their use in healthcare requires product standardisation, dosage clarity, contraindication awareness, and careful differentiation between general health support and formal therapeutic claims. The same caution applies to ajwa dates, whose significance is often religious and nutritional rather than supported by mature clinical trial architecture (Hamdan et al., 2019; Sana et al., 2025; Tang et al., 2024).

Ruqyah requires even greater conceptual restraint. It may provide spiritual reassurance, meaning-making, and emotional support for patients who value Islamic therapeutic practice. However, it should not be framed as a substitute for psychiatric, neurological, or medical assessment when such care is clinically indicated. Its most defensible location within healthcare is therefore supportive accompaniment, not direct biomedical treatment (Subu et al., 2022; Zein, 2022).

Table 3. Clinical positioning of selected Thibbun Nabawi elements

Element	Evidence-sensitive interpretation	Required safeguards
Cupping / hijamah	Potential adjunctive procedure for selected wellness or symptom contexts; evidence remains condition-specific.	Sterility, practitioner training, contraindication screening, documentation, and adverse-event reporting.
Honey	Natural product with wound-care and nutritional relevance in selected contexts; not a universal remedy.	Medical-grade product control, contamination prevention, dosage clarity, and indication specificity.
Nigella sativa	Bioactive natural product with supportive evidence in metabolic and inflammatory discussions.	Standardised formulation, drug-interaction awareness, and avoidance of replacing prescribed medication.
Ajwa dates	Religiously meaningful and nutritionally relevant product; clinical claims require stronger testing.	Nutritional counselling, glycaemic consideration, dosage moderation, and clear distinction between food and drug claims.

Ruqyah	Spiritual and psychosocial support for patients who value religious accompaniment.	Informed consent, non-coercion, referral to clinical care when needed, and avoidance of medical substitution.

3.5 Healthcare Service Implementation

Implementation is most plausible when integration is designed as a complementary service arrangement rather than as a parallel system that competes with biomedical diagnosis. In clinics, primary care, or Islamic hospital settings, selected Thibbun Nabawi elements may be accommodated when they are clearly defined, clinically supervised, and connected to ordinary patient-safety systems (Ahsan et al., 2025; Maulizah & Fathurohman, 2024).

Several operational conditions are essential. First, institutions must define which practices are allowed, which are restricted, and which are excluded. Second, practitioners must work within competence boundaries and referral rules. Third, each procedure or product must be documented in the patient record. Fourth, patients must be informed that complementary practices do not replace medically indicated treatment. Fifth, implementation must include infection prevention, product traceability, and adverse-event response (Isdianto & Fitrianti, 2025; WHO, 2025).

A service-based model also requires communication discipline. Patients should not be told that a product or practice is clinically proven when the evidence remains preliminary, symbolic, nutritional, or supportive. The language of integration should therefore distinguish “religiously meaningful,” “nutritionally beneficial,” “clinically plausible,” “clinically evidenced,” and “medically indicated.” This distinction protects both patient autonomy and institutional credibility (Fadhlina et al., 2025; Orayj, 2022).

3.6 Regulatory, Legal, and Ethical Boundaries

Regulatory governance is the decisive boundary between informal religious healing and institutionally defensible healthcare integration. Once prophetic medicine products or practices are offered within healthcare services, questions of registration, labelling, formulation, storage, manufacturing quality, dosage, indication, practitioner accountability, and adverse-event liability become unavoidable (Badan Pengawas Obat dan Makanan Republik Indonesia [BPOM RI], 2023; Kementerian Kesehatan Republik Indonesia [Kemenkes RI], 2016).

The ethical issues are equally central. Integration may become harmful when patients are persuaded to delay biomedical treatment, when practitioners exceed their competence, when religious authority is used coercively, or when products are marketed with exaggerated therapeutic claims. Informed consent must clearly state the status of the intervention, the available evidence, the possible risks, and the fact that conventional treatment should not be discontinued without professional medical advice (Majelis Ulama Indonesia [MUI], 2022; WHO, 2025).

A responsible integration model must therefore be bounded by three forms of discipline: evidentiary discipline, because claims must be proportional to evidence; procedural discipline, because practices must be standardised and documented; and ethical discipline, because patient autonomy and safety must remain superior to symbolic or commercial claims. These three disciplines form the basis of the proposed framework shown in Figure 1.

Figure 1. Conceptual framework for the selective integration of Thibbun Nabawi and modern medicine in healthcare services

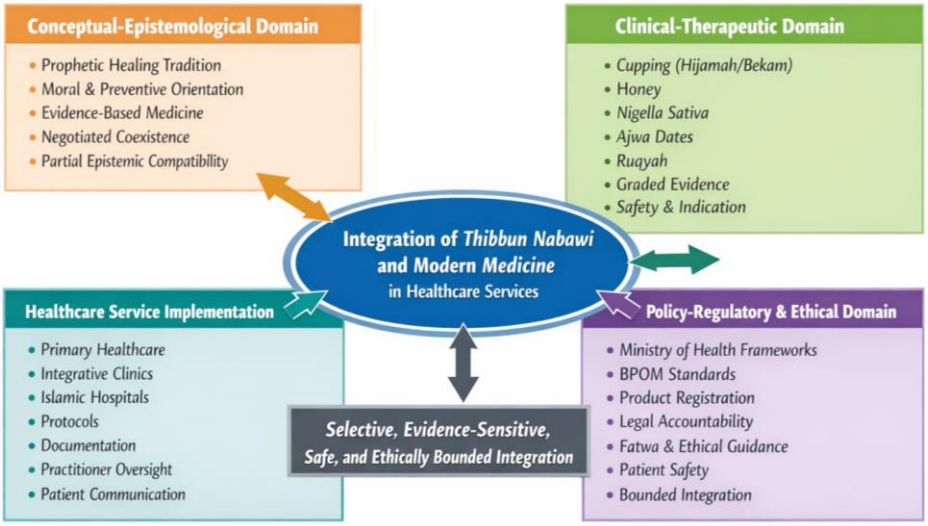

Figure 1 positions integration as the intersection of four domains: conceptual-epistemological meaning, clinical-therapeutic evidence, healthcare service implementation, and policy-regulatory ethics. The framework does not authorise broad fusion. Instead, it argues for selective, evidence-sensitive, safe, and ethically bounded inclusion. In this sense, Thibbun Nabawi may enrich culturally responsive care, but only when institutional governance prevents it from becoming an unregulated substitute for modern medical practice.

4. CONCLUSION

This review concludes that integration between modern medicine and Thibbun Nabawi is possible, but only in selective and controlled forms. Thibbun Nabawi remains socially meaningful and religiously resonant, particularly in Muslim-majority contexts such as Indonesia. However, healthcare services cannot rely on symbolic authority or cultural acceptance alone. Any institutional inclusion must be justified through evidence-sensitive interpretation, clinical supervision, legal accountability, product standardisation, informed consent, and patient-safety safeguards.

Practices such as cupping, honey, Nigella sativa, and ajwa dates should be differentiated according to their evidentiary maturity and clinical function. Cupping is best treated as a procedurally governed adjunct; honey and Nigella sativa require product and dosage control; ajwa dates are most defensible as nutritional and preventive support; and ruqyah should be positioned as spiritual and psychosocial accompaniment rather than as a biomedical replacement. The central recommendation is that healthcare institutions should develop written protocols before adopting any prophetic medicine-related service.

5. RECOMMENDATIONS

For policy makers, the priority is to strengthen standards for practitioner competence, product registration, labelling, adverse-event reporting, and public communication. For healthcare institutions, the priority is to establish referral pathways, consent forms, contraindication screening, and clear communication that complementary practices do not replace medical treatment. For researchers, future studies should move beyond general claims and examine specific interventions, populations, outcomes, dosage, safety, and mechanisms using stronger clinical and implementation research designs.

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COMPETING INTERESTS DISCLAIMER

Authors have declared that they have no known competing financial interests or non-financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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