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Managing Women's Matter: A Cross-Cultural Study of Doctor-Patient Relationship in Pakistan and Malaysia

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Abstract: Healthcare providers in the Muslim community take their profession as an obligation to serve the patients and community in humanistic way, that is described by the Islamic Law. The present study focuses on the doctor-patient relationship in two Muslim countries; Pakistan and Malaysia, to explore the ethical practices in the health profession. The study comprises of cross-sectional qualitative research design in which, in-depth interviews were conducted from female doctors and patients. Data was collected from female patients by visiting the clinics and hospitals for their concerns related to health. Sample of ten female patients and ten doctors (five from each country) were selected for the study. The findings highlighted the moderate relationship of doctors with patients and vice-versa. In Pakistan, majority of the doctors mentioned professional behaviors with the patients, as maternal healthcare is very sensitive and critical in nature. During their medical trainings, although they learnt professional ethics based on Islamic values and integrity however power of doctors over patients has been reported. Interestingly, most women who attended the menopause clinic in Malaysia accepted the doctor's dominance, because doctors talk to them about their problems and the women tend to accept their expertise. In conclusion, doctors in Pakistan and Malaysia have tried their level best to follow the professional ethics to treat the patients well. Doctors and patients need to realize each others perimeter in a larger setup and try to establish reciprocal relationship with one another.

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Keywords: Doctor-Patient Relationship; Islam; Professional Ethics; Malaysia; Pakistan

Abstrak: Penyedia penjagaan kesihatan dalam kalangan komuniti Muslim telah memandang profesion mereka sebagai satu kewajipan untuk berkhidmat kepada pesakit dan komuniti dengan cara yang humanistik sebagaimana dianjurkan oleh undang-undang Islam. Kajian ini memfokuskan hubungan antara doktor dan pesakit di dua negara Islam – Pakistan dan Malaysia dengan mengkaji amalan-amalan beretika dalam profesion kesihatan. Kajian keratan rentas kualitatif ini menggunakan kaedah temuramah dengan doktor dan pesakit wanita. Maklumat telah diambil daripada pesakit wanita yang hadir ke klinik dan hospital untuk tujuan berkenaan kesihatan. Seramai sepuluh pesakit wanita dan sepuluh orang doktor (lima bagi setiap negara) telah dipilih menyertai kajian ini. Dapatan kajian ini telah menunjukkan bahawa ada kaitan yang sederhana di antara doktor dan pesakit begitu juga sebaliknya. Di Pakistan, kebanyakkan doktor menyatakan keperluan untuk bersikap profesional dengan pesakit kerana penjagaan kesihatan wanita bentuknya amat sensitif dan kritikal. Pengaruh doktor ke atas pesakit telah dilaporkan dalam kajian ini walaupun ketika dalam latihan perubatan mereka telah mempelajari etika profesional berdasarkan nilai Islam dan integrti. Sebaliknya, kebanyakkan wanita yang melawat klinik menopaus di Malaysia menerima pengaruh doktor sebagai satu bentuk kepakaran dalam membicarakan masalah kesihatan mereka. Kesimpulannya, doktor-doktor di Pakistan dan Malaysia telah mencuba sehabis baik untuk menuruti etika profesional dalam merawat pesakit. Doktor dan pesakit seharusnya menyedari sempadan masing-masing dan cuba menjalin hubungan timbal balik antara satu sama lain.

Kata kunci: Hubungan Doktor-Pesakit; Islam; Etika Profesional; Malaysia; Pakistan

Introduction

Doctor-patient relationship based on; patient-centered care by taking into consideration patients' preferences, feelings and their health concerns. Patient-centered care is an important mechanism to achieve better outcomes and quality of care. Medical literature has very limited knowledge on doctor-patient relationship under Islamic ethics and values. Islam teaches the lesson of treating human beings in a fair and equal manner, therefore it has a strong influence on each and every sphere of life. To elicit the influence, Padela et al (2008) conducted a study

on immigrant Muslim physicians in the United States, to know how physicians are implementing their islamic cultural values and ethics. The findings of the study indicated that Islam has a very influential impact on the clinical practice of the Muslim physicians. It has great role in their interpersonal relations with the health seekers.

Padela et al. (2011) emphasized on Islamic bioethical discourse to explain the doctor-patient relationship under Islamic values and cultural beliefs. There is an intellectual gap in producing bioethical discourse based on Islamic ethico-legal framework. Due to this gap, scholars and researchers find complexity in the discourse analysis of Islamic bioethics. Due to influence of western bioethics, Islamic philosophy on bioethics is undermined.

Discourse is an important concept in social sciences that has been the subject of debate for decades. Originally derived from the field of linguistics, 'discourse' in its most elementary sense refers to speech or conversation. The term discourse is defined in *The Compact Macquarie Dictionary* (1994) as communication or conversation of thought by words, but in addition to the spoken language, it also includes written and signed language and other forms of communication, for example visual communication. Although early linguistic approaches judged the unit of discourse to be larger than the sentence (Thompson 1981), discourse ranges from silence, single utterance, a novel, newspaper articles or a conversation (Strega 2005). Post-modern theorist Michel Foucault (1972) has applied the concept of discourse to social sciences from its linguistic formation. His definition of discourse is referred to as a system of thoughts that are composed of ideas, attitudes, beliefs and practices that create the world of what they speak.

Bioethics discourse discusses the ethical and moral values, that Muslim health care providers need to adopt while interacting with patients and their attendents. It provides a framework of interaction among the religious leaders, academicians, policy scholars and healthcare providers to incorporate the Islamic tradition and culture of serving humanity. Very few studies measured the women's satisfaction or dissatisfaction with the provider's perspective which is crucial to be taken into consideration for exploring the doctor-patient relationship. This gap was found in the existing literature, therefore the present study aimed to examine the doctor-patient relation from both perspectives, doctors and patients.

Literature Review

Doctor-patient relationship depends on communication between the stakeholders at healthcare systems which is influenced by language, cultural values and by the religion also. Degni et al. (2012) explored doctor's communication in providing maternity healthcare to Somali women in Finland. The findings highlighted some cultural barriers in terms of language and religious differences to establish better communication between the physicians and the patients. The language barrier was the biggest problem in communication with the patients which was highlighted by all the physician and nurses providing maternity care to Somali women in Finland. Due to cultural differences and religious beliefs some women opted out to be examined by male doctor or to do caesarean which make the situation difficult for the physicians.

Frequency of interaction between the healthcare providers and patients enhances the quality of care as well as patient's satisfaction with the care (Gabe, Bury & Elston, 2004). Literacy is another important factor highlighted by **(**Bennett et al, 2006) which determines level of communication between doctor and patient. The study explored the relationship of high and low literacy and doctor-patient communication among African-American women. Findings of the study illustrated that women with both low and high level of literacy had poor utilization of parental care due to weak communication with healthcare providers. Most of the women reported inability to communicate and understand the patients' perspective and if patients are unable to understand their perspective, they do not clarify the problem to the doctors. Therefore, poor utilization of parental care not solely associate with the patient's level of literacy, but the doctor's communication skills need to be upgraded according to the patient's level of understanding.

Berhane and Enquselassie (2016) mentioned six attributes to investigate the effectiveness of the healthcare services from patients' perspective such as; waiting time for consultation, doctor-patient communication, nursing communication, availability of medicines in the pharmacy inside the hospital, continuity of care and diagnostic and treatment facilities. Patient selection and preferences of healthcare are associated with their willingness to wait, patients' focused treatment and the value of services delivered by the hospitals. Communication with

doctors and nurses as well as availability of drugs and other diagnostic services contribute to the patients' satisfaction of healthcare services, leading towards the preferences to access particular hospital.

The health care providers in the Muslim community took their profession as an obligation to serve the patients and community in a humanistic way described by Islamic Law. They are obliged to be sincere and humbly interactive with the patients with this intention that Allah knows everthing and to Allah we are all accountable for our actions (Gatrad & Sheikh (2001)).

Rassool (2000) highlighted Qur'an and Sunnah's perspective on health, he mentioned that Qur'an is not just a religious book, it provides foundation of healing and kindness of Allah. The Prophet Muhammad (PBUH) practiced the Qur'anic principles by his actions and preached to teach the Muslims about healthcare. Although the western world dominated the healthcare delivery, still Islam has not lost its identity and essence. Islam still guides Muslims about healthcare practice and utilizing health delivery system. Islam, in general discusses healthcare matters under the Qur'an and Sunnah perspective, but not particularly maternal and newborn health in terms of services provision. There seems to be a gap in the previous studies which will be highlighted in present study.

Effective communication of health care providers is mainly the leading cause for the distinctiveness of healthcare of patients (Berhane & Enquselassie, 2015). Although it is based on a very short duration (minimum of 10-15 minutes and maximum of an hour during one visit), it has high impact on the patient's satisfaction with health services in various settings. Ferguson and Candib (2002) stated racial and ethical disparities which affected the quality of doctor-patient relationship and interaction with each other. Language is an important predicator inference on effective communication between doctors and patients. Same language helps both the patients and the doctors establish good and friendly communication which enables them to understand the health matters efficiently and productively.

Methodology

A cross-cultural study examined the doctor-patient relationship in maternal healthcare in Pakistan and Malaysia. The sample of ten

doctors and ten patients (five from each country) was employed. By using qualitative research design, in-depth interviews and participant observation was made from the respondents. Qualitative method ensured to seek thorough data on the matter of concern from different perspectives. Qualitative research approach focuses on narrative and open-ended interviewing techniques to seek more in-depth information from the respondents. It is necessary to explore the meaning and understanding of the individuals attributed to the particular subject problem. It appears an inductive style of researching which focuses on individual meaning rather than the researcher's interpretation of the problem which is vital (Verhoef & Casebeer, 1997; Creswell, 2003). Qualitative research generally endowed with investigations on social life from the perspective of someone who deals with it on a daily basis (Neumann, 2003).

Qualitative content analysis is adopted by a thematic guide, emerged from the data. The transcribed data was read several times to attain good sense of the information to generate academic discussion. Initially various codes were highlighted from the data which was merged in different categories based on their similarities and differences. Furthermore, themes and sub-themes were generated from the categories. The respondents' voices have been presented under quotations to give the real meaning of the data.

As research ethics is essential to be followed by researchers at all phases of the study. Initially, permission was obtained from particular hospitals for data collection and then informed consent was achieved through direct contact with prospective participants through face-to-face interactions at the hospitals. Before the commencement of this interview, the confidentiality of the information was assured to the respondents. The participants were provided a form of consent enclosing information related to the researcher and intention of the study.

Results

This section is presented in two parts; part one explains the patient's experiences regarding the phenomenon under studied and part two elaborates the doctor's perspective on doctor-patient relationship. The collected data from patients and doctors is presented under different themes:

a) Theme 1: Patient's Experience Towards Doctor's Attitude

Patient's experience is an important factor in the doctor-patient relationship. If doctors are able to fulfill their expectations and positive association with their patients, satisfaction will be established (Wens et al, 2005). The process of measuring healthcare services determines on whether a patient receives ample and efficient care or not. It is defined as the interaction and anything that is performed as part of the encounter between a doctor and a patient such as providing information, emotional support, as well as patient's involvement in the decision of treatment and curing process.

A respondent mentioned:

> Although doctors provide good treatment but as they are so overburdened, it is impossible for them to stay polite all the time in their 30 hour work shifts. They become harsh because of their increased work load. Governments should also increase the number of doctors and duty staff so that the burden may not fall only on the doctors.

Another respondent mentioned:

> Doctors are good, the behavior of the consultant, junior and trainee doctors is also good, but the nurses and lower staff's behavior is very rude, they have more authority and power than doctors. They manipulate their power and they treat everyone very harshly, that makes me depressed. Because I feel as a human being I also have some worth, and if I visit hospital I deserve to be treated well. Regarding nurses some are good in the labor room but some are unbearable because of their older age. So, I think at least over age nurses must retire and recruit young nurse. As I perceived that young staff behave very affectionately, and I experienced that young staff tend to remember patient's names more and it feels good when they call the patients by their names, we also feel that we are being valued by taking our names. But on the other hand the elder staff nurses called the patients by bed numbers.

Abdulhadi et al. (2007) also emphasized on patients' expectation and experiences of availing healthcare is an important tool to measure the performance of healthcare provider. Lack of communication between patients and the providers, negative behaviors of the providers, and

language barriers are some of the major problems encounter during doctor patient interaction. One of the respondent said:

> Treatment is good, but their behavior and attitude is very rude and taunting, they used very harsh language with the patients. There are long queues for the patients at doctor's room and everyone is in hurry. Everyone wants to be examined the earliest, and then doctors also misbehave with them. On the other hand, in private hospitals, doctors speak very politely in a teaching manner. But here doctors are very rude, they insult the patients.

In contrast to that another respondent quoted:

> Alḥamdulillāh my relation with the doctors and all staff is good; they are giving me good treatment. I have heard at some place that doctors and nurses mistreated the patients and behaved ill manneredly, but nothing happened with me, Alḥamdulillāh. Doctors cared and provided for me. I am feeling better within three days and now I can walk, every half hour doctors and staff comes, and treats us properly by injecting drips and injection.

Similar findings were noted in Malaysia. Doctors claimed they had tried their best to help the women to get the appropriate treatment. But many of the women were disappointed that the doctors and the menopause clinic in general did not go to enough trouble to communicate the information they needed to hear. They felt that the operating hours of the menopause clinic are very short and that the doctors spent too little time with them. They felt they needed longer operating hours and more time, where they could discuss their problems with the doctors, without the need to rush from their workplace to the clinic.

b) Theme 2: Communication Barriers

Holmstrom, Halford and Rosenqvist (2003) stated that good communication skills are needed by the healthcare providers to establish sound and positive relationships with their patients. Positive relationship increases the better outcome for both the patients and the doctors. Hassan and Rehman (2011) give importance to doctors' perspective regarding their relations with the patients. Mainly doctors report that examining many patients in few working hours with unattractive salaries do not motivate them to spend more time on one patient. Due to overcrowding of the patients in public hospitals, sometimes their misconduct is also

reported by patients. But still doctors are providing their best input to facilitate the patients as reported by one respondent:

> I think our profession is all about the doctor-patient relationship. As we are dealing with patients all the time in various capacities, we continuously need to communicate with each other, physicians and nurses. In that case clear communication is so important. When you have good relationships, it is easier to review and discuss the treatment administered. Many times we come across with such patients who are arrogant and uncontrollable and then we make agreements on how to approach and handle those patients. I think good relationship is helpful in the communication with the patient and with his/her family. I always involve the patient's family to diagnose the real problem, I believe that the discussion should be very friendly and in a comfortable environment.

In general, healthcare system and research studies pay less attention on doctor's perspective and their well-being. It also has a vital importance in doctor-patient relationship. Wallace et al, (2009) highlighted physician wellness to measure the performance of healthcare system to achieve quality of care. Whatever the circumstances are, doctors have to perform their duties and healthcare system should look at the challenges of health care providers in establishing good doctor-patient relationship. Similar thoughts were presented by one of the Pakistani doctor:

> We try our best to treat the patient well. We talk with them in a good manner so, they may understand what the doctor is asking and advising them. If our behavior remains good with the patient, they also behave well. In my ten years on the job my assessment is that if we politely talk and behave well with patients, they never misbehave with us. If we act well, patients will not behave violently.

Another doctor also pointed out:

> We are also human being and feel tired when do lot of work, just like that if you have to meet with hundred people in a day you will also get tired, so same happens with us, we are also get tired. Some household related worries and tensions are going on in our mind. So I think in this state of mind, how can we deal with patients with a good and sympathetic heart? Also patients ask again and again very strange and irrelevant questions that irritate us.

Many patterns of miscommunication between the doctors and patients at the menopause clinic in Malaysia were noted. Most of the doctors claimed that Malay women needed to be informed and counselled about menopause. They felt that most women preferred to listen to stories from friends or relatives who were not educated in the medical field, and were therefore likely to be an unreliable source of information.

The power and influence of doctors varied in Malaysia due to various factors such as; kind of training the doctors undertook, their socio-demographic background, their experience, their personality, the type and location of the medical practice. Through observations in the menopause clinic it was discovered that a verbal communication problem existed, not just between the doctors and patients, but also in a general sense between the patients and health professionals. The women attending did not understand the medical jargon that was used regularly and this was evident when they asked the nurse to explain the medical terms in words that they could understand. At times they even sought the researcher's help in translating terms, but they did not understand. The researcher was not permitted to enter the doctor's rooms when patients were with them, her observations were confined to the registration counter and waiting room where sometimes she was called to assist the nurses during peak hours, usually from 2pm until 3.30pm. Some of the women who came to the clinic found it difficult to convey their problems to the nurses at the registration counter. Among the problems that the researcher noted were that some: i) had never heard of the symptoms, particularly in medical terms, and this was especially true for women who came to the clinic for the first time; ii) were unable to remember the names of medicines if they were using medication; iii) were unable to describe their condition in such a way that it showed that it was meaningful to them; and iv) did not appear to take the situation seriously, though clearly there was a reason for them attending the clinic.[1] The following excerpt from the researcher's field notes serves to highlight some of the communication problems in the menopause clinic, particularly the challenges in understanding some of

1 Women were not embarrassed to speak about their conditions at the registration counter. The nurses who are in-charged at the counter are in the same age group as the women. Other women who sat in the waiting room could not hear them talking because the counter and the waiting room were quite a distance apart so a level of privacy was ensured.

the medical terminology, as well as describing symptoms in medical terms. The nurses expected the patients to describe their symptoms by using specific medical terms. However, on the other hand, patients had to struggle to describe their conditions in a way that made sense to the nurses and they expected the nurses to pick up the meanings they were trying to convey. This is not surprising, as the researcher has already noted that Malay women do not generally talk openly about menopause and tend to use euphemistic language to convey ideas about menopause.

c) Theme 3: Reasons for Patient's Dissatisfaction

Patient's complaints about doctor's misconduct is usually reported from patient's experience but less consideration is given to the doctor's perspective about such behavior. One of the respondents mentioned:

> If one doctor is sitting here, she has to attend 50 patients and it's obvious that she will become tired and feel fatigue, but still doctors ignore the patients attitude because they are thankful to the hospital to recruit them as there is much competition.

Another respondent shared:

> I think, the hospital have a lack of staff, due to which one doctor has to examine so many patients in a day almost 200 patients from 8 to 2 pm, so it can happen that they may use some harsh words with the patients, which may lead to dissatisfaction of patients in public hospitals. But doctors never go beyond their professional ethics. They can never insult the patients or misbehave, even that many times, patients misbehave with doctors but doctors never react on it.

Regarding giving priority to the patients who come with some references, some patients become angry and compliant to higher authority as well. As reported by respondent:

> It happens sometimes, some high class patients want extra care and attention and when it is not provided to them, they usually complain about the doctors and system.

d) Theme 4: Doctor's Power

Due to dominance of health professional, in Pakistan as well as in many non-western cultures, doctors have decision making power.

They have authority to take decision about patient's health matters (Moazam, 2000). On the other hand, doctors' and patients' knowledge about particular treatment contributes excessively to the outcome of the healthcare. Medical technological intervention increases doctors' control over patient with respect to extensive use of technology during the process of maternity care, even while not having much knowledge about the use of these interventions. On the other hand, mothers are also not aware about the benefits of technology during the process of childbirth. But they trust on the knowledge of the physicain as they have power and authoriy to utilize the treatment that is most suitable for the patients.

Trust on doctor plays major role in establishing good relations between doctors and patients. Similar thoughts were explained by one of the Pakistani women:

> It is important for patients to have confidence and trust on hospital staff and feel they are able to communicate with them. Yes! I trust on the doctor, but I have heard from other patients that some time doctors did make mistakes and wrong diagnosis by the doctors created complications for the patients. But thanks to Allah nothing happened with me, I feel confident with my doctor as she is a very senior doctor.

Another respondent illustrated:

> I have strong trust on the doctor. Luckily my experience is good, my doctor is very competent and she does her work very carefully. Regarding consultancy, whatever I have seen and experienced then and they are very good and they treat patients carefully as well.

The assumption of doctor's control over patients relates to the Foucault ideas of medical power of knowledge. He identified the concept of power and knowledge has influences in clinical practices performed by the medical professionals (Henderson, 1994). A hypothetical insight of Foucault's writing about surveillance and power in medicine relates with the power of doctors to think decisively about the relevance of utilizing technology for healthcare (Forbat et al., 2009).

One of the respondents stated that:

> I always trust what the doctor says, because I trust my doctor and she always advises me in such a convincing manner that I feel this all about my health. And as her behavior is too authoritative which I think is good to some extent, sometimes I feel that her attitude should be softened, so that I may be able to ask something about the medication or treatment procedure.

A similar finding was reported by Malay women who attended the menopause clinic accepted the doctor's dominance, because doctors talk to them about their problems and the women tend to accept their expertise. As one woman stated:

> I trust what my doctor says. They have gone to medical school and learnt what I don't know. I feel comfortable with the medicine she gives me.

In short, discourse can be an institutionalized way of speaking about matters of the body, health and medicine, in which the discourse establishes what we say, what we do not say and how we say it. In the realm of medicine, medical professionals have gained more credibility and authority than non-medical people through the discourse that is used and this is translated into power that they can use in different kinds of ways.

The doctor's power and control can also be related with 'medicalization' occurs on three levels – the conceptual, institutional and interactional (Conrad 1992). At the interactional level, medicalization occurs when doctors define or treat patients' complaints as medical problems (Bell 1990). Nevertheless, studies have shown that there are many kinds of interactions between doctors and patients; for instance, patients who comply or do not comply with their doctor's prescriptions and advice. There are doctors who prescribe medication readily and there are those who take a more cautious approach to prescribing. It means that there are very different dynamics in the respective resultant interaction. Of course, it means that both doctors and patients have choices. For example, Lock (1993), who studied Japanese doctors, has revealed several factors that influenced doctors' decisions to prescribe HRT or otherwise. These factors included the kind of training the doctors undertook; their socio-demographic background, their experience, their personality, as well as the type and location of the medical practice. Similarly, Kaufert and Gilbert (1986) who studied women between the

ages of 40 and 59 years in the Province of Manitoba, Canada, revealed that there were a range of interaction patterns that took place between the patients and doctors. In Kaufert and Gilbert's study some women agreed with the biomedical model and shared the doctor's view that menopause is a medical event. As a result, they took HRT. Other women did not take HRT, but acknowledged that the doctor was their main source of information.

Mahmud (2009) also mentioned that doctor-patient relation is the core aspect in measuring quality of care which is reflected by the patient's trust on doctor. For patients, confidence on doctor's competence is crucial, while for doctors, establishing good rapport with the patients is imperative.

Conclusion

There are many factors that contribute to how people use and interpret meanings, for example they will be affected by the social class to which they belong, their ethnicity, gender, age, educational level and their place of residence; each will affect their world view. Consequently these factors indicate that meanings are the result of 'who talks to whom, when and where' (Rosenberger 1992, p. 238). Therefore, discourse emphasizes the power and knowledge of the speaker, what can be spoken, as well as where and how a person speaks. I will elaborate this point later in this chapter by providing an example based on the doctor-patient relationship. In addition, discourse is also understood as a conversation which has a certain agenda (Singer & Hunter 1999).

Since discourse has a certain agenda, it is tailored to establish a particular view which will be accepted by the society or a particular group of people. For example, in Foucault's work *Madness and civilization: A history of insanity in the Age of Reason* (1989), he argues that the discourse of madness produced by psychiatrists and psychologists is the way we have come to think and talk about it over time. It determines what we believe is madness and how a 'mad' person behaves. Consequently, madness is a shameful condition and therefore 'mad' people must be hidden or isolated (in prison or hospitals) from 'normal' people. In addition, not only does discourse have an agenda, it also exhibits to some extent, the power relationships within society and influences how individuals make sense of their experiences.

Discourse is an avenue to the exercise of power. Discourse, Foucault argued, goes beyond words whereby it is seen as a mechanism where people exercise their power at all levels through individual interaction, or from the government to the people (Foucault 2000). Doctor-patient interaction is a good example which can be used to illustrate the exercise of power as it reflects a kind of hierarchical arrangement. Since doctors and nurses can be expected to have sound knowledge about menopause and its treatment, menopausal women normally see them as the experts. One view may be that these experts have encouraged women to subjugate themselves to a particular medical decision. In this manner women may defer to the doctor or the nurse because they are perceived as having greater knowledge about menopause and therefore, because of this perception, they have greater power of influence. People's preferences towards healing practices give an insight into how they are led to accept a particular kind of treatment. These preferences are motivated by factors like cultural practices and the presence of scientific evidence which is often seen as having an aura of factuality.

References

Abdulhadi, N., Al Shafaee, M., Freudenthal, S., Östenson, C. G., & Wahlström, R. (2007). Patient-provider interaction from the perspectives of type 2 diabetes patients in Muscat, Oman: a qualitative study. BMC health services research, 7(1), 162.

Bell, S.E. (1990). Sociological perspectives on the medicalization of menopause, *Annals of the New York Academy of Sciences*, 192 (Special Issue: Multidisciplinary Perspectives on Menopause), 173-178.

Bennett, I., Switzer, J., Aguirre, A., Evans, K., & Barg, F. (2006). 'Breaking it down': patient-clinician communication and prenatal care among African American women of low and higher literacy. *The Annals of Family Medicine*, *4*(4), 334-340.

Berhane, A. & Enquselassie, F. (2016). Patient expectations and their satisfaction in the context of public hospitals. *Patient Prefer Adherence*. *22*(10), 1919-1928. DOI: 10.2147/PPA.S109982.

Casebeer, A.L. & Verhoef, M.J. Combining qualitative and quantitative research methods: Considering the possibilities for enhancing the study of chronic diseases. *Chronic Dis Can*., 18(3), 130-135.

Conrad, P. (1992). Medicalization and social control, *Annual Review of Sociology*, *18*(1), 209-232.

Creswell, J. W. (2003). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. 2 ed. California: Sage Publications.

Degni, F., Suominen, S., Essén, B., El Ansari, W., & Vehviläinen-Julkunen, K. (2012). Communication and cultural issues in providing reproductive health care to immigrant women: health care providers' experiences in meeting Somali women living in Finland. *Journal of immigrant and minority health*, *14*(2), 330-343.

Ferguson, W. J., & Candib, L. M. (2002). Culture, language, and the doctor-patient relationship. *FMCH Publications and Presentations*, 61.

Forbat, L., Cayless, S., Knighting, K., Cornwell, J. & Kearney, N. (2009). Engaging patients in health care: An empirical study of the role of engagement on attitudes and action, *Patient Education and Counseling*, 74(1), 84-90.

Foucault, M. (1972). *The archaelogy of knowledge*, London: Tavistock Publications.

Foucault, M. (1989). *Madness and civilization: A history of insanity in the Age of Reason*, London: Routledge.

Foucault, M. (2000). *Power*, New York: New Press.

Gabe J, Bury M, Elston MA. Key concepts in medical sociology. London, Thousand Oaks: Sage Publication; 2004.

Gatrad, A. R. & Sheikh, A. (2001). Medical ethics and Islam: Principles and practice, *Arch Dis Child*. *84*, 72–75.

Hassan, R. & Rehman, A. (2011). Doctor patient relationship in gynecology department of public and private hospitals of Rawalpindi and Islamabad, *Pakistan Journal of Medical Research*, *50*(2), 75-79.

Henderson, A. (1994). Power and knowledge in nursing practice: the contribution of Foucault, *Journal of Advanced Nursing,* 20(5), 935-939.

Holstrom, I., Halford, C. & Rosenqvist, U. (2003). Swedish health care professionals' diverse understandings of diabetes care, *Patient Education and Counseling*, *51*(1), 53-58.

Kaufert, P.A. & Gilbert, P. (1986), Women, menopause and medicalization, *Culture, Medicine and Psychiatry*, *10*, 7-21.

Lock, M. (1993). *Encounters with aging: mythologies of menopause in Japan and North America*, California: University of California Press.

Mahmud, A. (2009) Doctor-patient relationship. Pulse Vol. 3(1), p12-14.

Moazam, F. (2000). Families, patients, and physicians in medical decision making: a Pakistani perspective. *Hastings Center Report*, *30*(6), 28-37.

Neuman, W.L. (2003). *Social research methods: Qualitative and quantitative approaches*, 5 ed, Boston: Allyn and Bacon.

Padela, A. I., Shanawani, H., & Arozullah, A. (2011). Medical experts & Islamic scholars deliberating over brain death: Gaps in the applied Islamic bioethics discourse. *The Muslim World*, *101*(1), 53-72.

Padela, A. I., Shanawani, H., Greenlaw, J., Hamid, H., Aktas, M., & Chin, N. (2008). The perceived role of Islam in immigrant Muslim medical practice within the USA: an exploratory qualitative study. *Journal of Medical Ethics*, *34*(5), 365-369.

Rassool, G.H. (2000). The crescent and Islam: healing, nursing and the spiritual dimension. Some considerations towards an understanding of the Islamic perspectives on caring, *Journal of Advanced Nursing*, *32*(6), 1476-1484.

Rosenberger, N.R. (1992). The process of discourse: Usages of a Japanese medical term, *Social Science & Medicine*, 34(3), 237-247.

Singer, D. & Hunter, M. (1999). The experience of premature menopause: A thematic discourse analysis, *Journal of Reproductive and Infant Psychology*, *17*(1), 63-81.

Strega, S. (2005). 'The view from the poststructural margins: epistemology and methodology reconsidered', in *Research as resistance: Critical, indigenous and anti-oppressive approaches*, eds L Brown & S Strega, Toronto: Canadian Scholars' Press.

Thompson, J.B. (ed.) 1981, *Paul Ricoeur hermeneutics and the human sciences*, Cambridge: Cambridge University Press.

Wallace, J. E., Lemaire, J. B., & Ghali, W. A. (2009). Physician wellness: a missing quality indicator. The Lancet, 374(9702), 1714-1721.

Wens, J., Vermeire, E., Van Royen, P., Sabbe, B. & Denekens, J. (2005). GPs' perspectives of type 2 diabetes patients' adherence to treatment: A qualitative analysis of barriers and solutions, *BMC Family Practice*, *6*(20), 1-10. DOI: 10.1186/1471-2296-6-20

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