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# Muslim patients and cross-gender interactions in medicine: an Islamic bioethical perspective

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## ABSTRACT

As physicians encounter an increasingly diverse patient population, socioeconomic circumstances, religious values and cultural practices may present barriers to the delivery of quality care. Increasing cultural competence is often cited as a way to reduce healthcare disparities arising from value and cultural differences between patients and providers. Cultural competence entails not only a knowledge base of cultural practices of disparate patient populations, but also an attitude of adapting one's practice style to meet patient needs and values. Gender roles, relationship dynamics and boundaries are culture specific, and are frequently shaped by religious teachings. Consequently, religion may be conceptualised as a cultural repertoire, or dynamic tool-kit, by which members of a faith adapt and negotiate their identity in multicultural societies. The manner in which Islamic beliefs and values inform Muslim healthcare behaviours is relatively under-investigated. In an effort to explore the impact of Islam on the relationship between patients and providers, we present an Islamic bioethical perspective on cross-gender relations in the patient-doctor relationship. We will begin with a clinical scenario highlighting three areas of gender interaction that bear clinical relevance: dress code, seclusion of members of the opposite sex and physical contact. Next, we provide a brief overview of the foundations of Islamic law and ethical deliberation and then proceed to develop ethicolegal guidelines pertaining to gender relations within the medical context. At the end of this reflection, we offer some practice recommendations that are attuned to the cultural sensitivities of Muslim patient populations.

## CASE VIGNETTE

A 35-year-old female presents to an urgent care clinic complaining of leg pain after a fall. The nursing documentation notes that the patient has refused to put on a gown and is accompanied by a male relative. When you enter the examination room you notice a well-appearing African-American female wearing a *hijāb* (a Muslim religious head covering). As you put out your hand to introduce yourself she states 'Are there any woman doctors around?'

## INTRODUCTION

Medical practice is becoming increasingly racially, ethnically and culturally diverse, resulting in a plurality of value systems at play in the clinical arena. These multiple value systems may present obstacles to quality care when clinicians and patients fail to understand one another or to agree on modes of healthcare delivery and therapeutics.

Further, ethical dilemmas may arise when the culture, or legal considerations of medicine, are in conflict with patient values.<sup>1</sup> These challenges may manifest themselves as healthcare disparities, since some minority patients may forgo treatment due to different concepts of illness, or may delay treatment due to cultural conflicts, or experiences of discrimination and lack of accommodation.<sup>2,3</sup>

Cultural competence and patient-centred care have been championed as a means to reduce healthcare disparities. Cultural competence training improves provider attitudes towards minority patients and enhances cross-cultural communication.<sup>4</sup> It does not entail learning a list of values important to specific patient populations; rather, it requires acknowledgement of the importance of cultural practices in patients' lives and working to minimise the negative consequences of cultural differences in medical care.<sup>5</sup> Culture shapes patients' notions of health, their understanding and perception of illness, their beliefs about health risks and their expectations of the doctor—patient relationship.<sup>3,6–8</sup> It also influences patients' adherence to doctors' recommendations and health outcomes.<sup>9</sup> In this vein we present Islamic ethicolegal regulations concerning cross-gender interaction during the clinical encounter. We use the Islamic ethicolegal tradition as a framework to derive bioethical regulations in three areas of clinical relevance: dress code, seclusion of unrelated or unmarried members of the opposite sex and physical contact. As these values are variably manifested in Muslim behaviours we close by offering practice recommendations for cross-gender interaction attuned to Muslim sensitivities.

## Islam, Muslims and healthcare disparities

Islam is a monotheistic faith that holds Muhammad ibn 'Abdullāh of 7th-century Mecca to be the final prophet from among a long line starting with Adam and including Abraham, Noah, Moses and Jesus. It is a cumulative tradition spanning 14 centuries that Muslims have developed and adapted in diverse ways to varied times, places and contexts. Muslims across time and place refer to a singular universe of meaning: that by submitting to God inwardly, one can attain true peace within oneself, manifest it outwardly in this life, and will find everlasting peace in the hereafter. From this follow the five pillars of Islam, which represent the obligatory external manifestations of faith, the many beliefs comprising a Muslim's internal faith (*īmān*), and teachings related to righteous and moral character (*Ihsān and/or Akhlāq*).

There are over 1.57 billion Muslims in the world, with nearly 7 million in the USA, that can be

divided into two main branches: *Sunnī* and *Shīʿite*.<sup>10–13</sup> These two groups share beliefs, religious practices and legal structures, but vary on issues related to religious authority and prophetic succession. The majority of Muslims are *Sunnī*, while between 10 to 20% are *Shīʿite*.<sup>14</sup> In the USA, Muslims are the fastest growing religious group with nearly equal numbers of African-Americans, South Asians and Arabs.<sup>13</sup> Minority patient populations in the USA tend to receive inferior care across the board, from preventive measures to the management of chronic conditions to the treatment of acute ailments.<sup>15</sup> These disparities contribute to the lower life expectancy and increased disease-specific morbidity and mortality among African Americans, Hispanics and other minority groups, and exist despite comparable insurance status, access to healthcare and severity of conditions.<sup>15</sup> An accurate assessment of healthcare disparities specific to Muslims living in the West poses multiple challenges. First, Muslims comprise many different racial and ethnic groups, and systematic research has largely focused on specific ethnic and racial groups. Further, most healthcare databases do not capture religious affiliation precluding comparative analyses. Lastly, while qualitative investigations have focused on the cultural influences on Muslim healthcare behaviour, these studies often overlook the connection between cultural expression and religious dictates. Yet, Muslims as a group may suffer from healthcare inequity and inequality for several reasons.

Muslims may have different healthcare-seeking behaviours stemming from Islamic conceptions of disease and cure, and Islamic rulings about permissible therapeutics may contribute to different health outcomes. Furthermore post 9/11 discrimination and abuse may lead to increased psychological distress and mistrust of the healthcare system, which in turn may affect poor health outcomes.<sup>16</sup> Lastly, Muslims may be treated differently due to stereotyping or lack of familiarity with their cultural practices and values. Thus, enhancing the knowledge-base of providers towards Muslim health behaviours and values, will better equip them to serve this population based on nuanced understandings, thereby enhancing patient trust and satisfaction.

### Islamic medical ethics and Islamic law

Writing on Islamic medical ethics consists of two dominant genres.<sup>17</sup> The first is *Adab*; literature which aims to promote virtues and righteous conduct couched within Islamic terms. Ethicolegal writings comprise the second type and aim to expound the legal permissibility of medical interactions, procedures and therapeutics.

The Islamic ethicolegal structure or *Sharīʿah*, has two dimensions.<sup>18</sup> The first is as a corpus of legal rulings, precedents and statutes, and the second as the moral code of Islam. Since the *Sharīʿah* is not codified or used by modern states as the single source of law, it is better conceptualised as ‘the collective ethical subconscious’ of the Muslim community.<sup>19</sup> Muslim patients and practitioners alike may refer to the *Sharīʿah* when discussing therapeutic options, or seek assistance of Islamic legal experts when facing complex moral challenges around healthcare decisions. Similarly Muslim bioethicists may refer to the *Sharīʿah* when debating ethical constructs.

*Sharīʿah* is often confused with the term *Fiqh*. *Fiqh* linguistically connotes insight and is used to mean law.<sup>17</sup> *Fiqh* bears resemblance to Anglo-American case law with an added moral component as *fiqh* can represent both the formulated legal ruling on, and the moral value assigned to, a particular action. In order to arrive at the *fiqh* an intricate knowledge of the science that identifies sources of *fiqh*-law and elaborates how to weigh these

sources against each other is necessary. This science is known as *Usūl al-fiqh*. While the theoretical corpus of all *fiqh*-laws is the *Sharīʿah* during ethicolegal deliberation the debate centres on *fiqh* as one tries to assess the moral value of, and derive a legal ruling concerning, a given topic.

While the philosophical debates on the use of reason within the Islamic ethicolegal traditions is beyond the scope of this paper, Islamic bioethical reflection is shaped by two broad tendencies. The first is a tendency toward theological voluntarism or theistic subjectivism: God alone defines the standard of right and wrong, thus ‘good deeds are good only because God commands them, and evil is evil because God forbids it’.<sup>20</sup> This belief by itself would lead to a near-total dependence upon revelation to guide human conduct. However, the second tendency holds that God’s commands are purposeful and as such ‘human reason in dependence upon revelation can discern rules and apply them’, thereby allowing the intellect to enter into the equation.<sup>20</sup>

### Usūl al-Fiqh and the sources of law

A full discussion on the sources and mechanics of Islamic ethicolegal reasoning is beyond the scope of this paper. A brief overview, however, will aid the reader by introducing the framework for our subsequent discussion. The sources of Islamic *fiqh* are both material and formal. The former include the Qur’ān, held to be the literally revealed word of God through the angel Gabriel to the Prophet Muhammad, and the *Sunnah*, which represents the sayings, actions and silent affirmations of the Prophet Muhammad. Since he represents a life lived in accord with the ethicolegal code of Islam, he is both the normative case and the explainer of the code.<sup>21</sup> The *Sunnah* is accessed through collections of *ḥadīth*, which are single statements or behaviours of the Prophet. The two formal sources that are agreed upon by the four major schools of law in *Sunnī* Islam (*Hanafī*, *Shāfiʿī*, *Mālikī* and *Hanbalī*) are *ijmā* and *qiyās*. *Ijmā* refers to consensus agreement about the assessment of an act or practice, while *qiyās* involves reasoning by analogy. In application *qiyās* is nearly identical to Jewish *Halachic* reasoning. The *Sunnī* schools of law recognise different hierarchies, and admit subsidiary sources into the legal framework, while the *Shīʿite* sects replace formulaic *qiyās* with a generic form of logic-based induction and deduction.<sup>21</sup> To summarise the task of the juriconsult is to formulate *fiqh* by paying attention the sources of Islamic law and their prioritisation captured within *usūl al-fiqh* and paying attention to subsidiary considerations and principles of the Islamic ethicolegal structure, the *Sharīʿah*. These assessments are often captured within non-binding legal opinions called *fatāwā*.

### Islamic ethicolegal opinions (fatāwā) as a window into Islamic bioethics

*Fatāwā* (singular *fatwā*), or non-binding legal opinions rendered by juriconsults serve as a window into Islamic bioethical considerations. *Fatāwā* literature, akin to Jewish *responsa* literature, captures vital ethicolegal opinions making them accessible to disparate Muslim communities. Researchers use *fatāwā* as source texts for study, clinicians use *fatāwā* to understand the permissibility of medical interventions, and Islamic studies scholars use *fatāwā* as source texts to derive and prioritise principles for Islamic bioethics. *Fatāwā* have two essential aspects: they founded on the juridical sources and principles of the *Sharīʿah* and are formulated in the context of a question. Functionally they represent quasi-religious documents that inform action and policy.<sup>22</sup>

For the *fatwā*-seeker, different opinions allow for personal choice based on strength of argument. The choice of jurisconsult is frequently based on adherence to a specific school of jurisprudence, shared cultural background, or particular area of expertise.<sup>17</sup> The ethicolegal considerations around cross-gender interactions in medicine used in this paper are drawn largely from the extant *fatāwā* literature.

## GENDER RELATIONS IN ISLAM

The overarching Islamic ethic pertaining to cross-gender interaction is maintaining modesty. The Prophet stated: 'Every *dīn* (religion/way of life) has an innate character, the character of Islam is modesty (Muwatta Imam Malik)' and *īmān* (faith) has over 70 branches, and modesty is a branch of *īmān* (Sahih Muslim).<sup>23–25</sup>

### Dress code

The Qur'an tells both men and women to 'lower their gaze and guard their modesty' and further addresses women to 'not display their beauty and ornaments except what (must ordinarily) appear thereof; that they should draw their veils over their bosoms (Al-Nur, 24:30–31).<sup>25</sup> The verse continues by mentioning audiences in front of whom women are exempted from this regulation including certain relatives and persons without sexual desire. The second verse specifically mentions the act of veiling using the term *khimār*. The *khimār* was a head-covering worn at the time of revelation that covered the hair and neck and was tied in the back, in this verse women were enjoined to wear the head-covering draping it over the bosom, thereby establishing the practice of what is known today as *hijāb*. A statement of the Prophet goes further 'it does not suit (a woman past the age of menarche) that she displays her parts of body except this and this' pointing to the face and hands (Sunan Abu Dawud).<sup>24</sup>

These verses and multiple Traditions from the Prophet form the basis of an Islamic dress code, specifically the regulations of *'awrah*, the areas of the body that must be clothed.<sup>26</sup> These regulations are 'intended to safeguard ... honour and dignity' and vary such that 'where ... risks of temptation are greater, rules of covering are stricter, and where risk is minimal, rules are minimal'.<sup>27</sup> The regulations of *'awrah* are divided into categories based on the audience one is front of. Briefly, for males the minimum *'awrah* consists of the area from the navel to the knees while covering the shoulders is recommended. For women, the regulations are more elaborate. The pertinent categories for this discussion are: in front of Muslim women, in front of non-Muslim women, and in front of non-*mahram* males, that is, those not related by blood, through marriage or through the same wet-nurse. The consensus opinion, *ijmā'*, is that a Muslim woman may uncover parts of her body save the area between her navel and knees in front of other Muslim women.<sup>26 27</sup> In front of a non-Muslim female audience, a difference of opinion arises based on the interpretation of the Qur'anic verse:

And say to the believing women ... that they should draw their veils over their bosoms and not display their beauty except to their husbands, their fathers, their husband's fathers, their sons, their husbands' sons, their brothers or their brothers' sons, or their sisters' sons, or their women, or the slaves whom their right hands possess, or male servants free of physical (sexual) needs, or small children who have no sense of the shame of sex (24:31)<sup>28</sup>

The category of 'their women' according to Mālikī and Hanbalī jurists includes non-Muslim women and thus only the area from the navel to the knees must remain normally

covered.<sup>27</sup> Yet Hanafī scholars disagree and hold that a non-Muslim female is akin to a non-*mahram* male, hence only the face, hands and feet may be uncovered.<sup>26</sup> Within the Shāfi'ī school both opinions are considered valid.<sup>27 29</sup> The final category of audience includes non-*mahram* Muslim, and non-Muslim, men. According to *ijmā'*, a Muslim woman must cover her body except for the hands, face, and feet in this case.<sup>27 29</sup> It bears mentioning that the *niqāb*, face covering, is not governed by consensus nor obligated by Islamic law, yet some scholars recommend this practice.<sup>26</sup>

### Seclusion

Protection of dignity is one of the main objectives of Islamic law. Growing from this objective arise the regulations of *khalwah*. *Khalwah* is defined as the situation where a 'man and a woman are both located in a closed place alone and where sexual intercourse between them can occur'.<sup>30</sup> This situation is prohibited between non-*mahram* adult members of opposite sexes in order to prevent the accusation, and committal of, illicit relations.<sup>30</sup> This prohibition stems from Prophetic traditions stating that when a non-*mahram* male and a female are alone 'Satan' is the 'third among them' and his stating that 'a man must not remain alone in the company of a woman' (Sahih al-Bukhari).<sup>29 31</sup>

### Physical contact between the sexes

The Qur'an exhorts 'Nor come nigh to adultery: for it is a shameful (deed) and an evil, opening the road (to other evils)' (17:32), and thus Islamic law not only prohibits adultery but also strictly regulates physical contact since the verse bars 'proximity' to adultery. The general rule is that non-*mahram* members of the opposite sex may not have any physical contact in order to block the means to impermissible relations.<sup>32 33</sup> However, some scholars qualify this prohibition by referencing *ijmā'* of the early jurists who believed that the prohibition is valid when one of three conditions exist: fear of provoking sexual desire, enjoyment of the touch by either party, or fear of temptation (to greater physical interaction).<sup>32</sup> This is based on traditions where the Prophet is noted only to have had physical contact with female relatives or children and older people. The reason for the difference of opinion is based on the interpretation of the term touch, *al-mass*, in the Prophetic statement, 'It would be better for one of you to have himself stabbed on the head with an iron needle than to touch a woman that is illegal (his non-*mahram* or of similar status) for him'.<sup>32</sup> Scholars who qualify the prohibition with the aforementioned three conditions consider the *al-mass* to have a sexual connotation, as it does in verses of the Qur'an, while those who consider the prohibition to be universal take the literal meaning.<sup>32 33</sup> One should note that permissible physical contact is limited to the non-*'awrah* parts of the body.

### Gender relations in the medical context

Given the Islamic ethics concerning cross-gender interaction one can understand how the medical arena may be uncomfortable for some Muslims. The challenge for providers is to understand, and recognise when, Islamic conceptions of modesty might make patients reticent to change their dress, to expose parts of their body, to be physically examined, or to be alone with a member of the opposite sex.

It is with cognisance of these sensitivities that Islamic bioethics designates a hierarchy of physicians to see when a Muslim patient falls ill. Preference is given to a Muslim physician of the same sex, followed by a non-Muslim of the same gender, then a Muslim physician of the opposite gender

and lastly a non-Muslim of the opposite gender.<sup>29 34</sup> Sex is given priority over religious creed because concepts of *'awrah* and seclusion pose less of a barrier in same-sex interaction. A provider of the same faith is recommended based on the assumption that a Muslim physician would be able to advise the patient when medical treatment takes precedence over religious obligations. This assumes however that both male and female physicians with the requisite skill sets are present. If technical expertise or other social constraints impose restrictions on physician choice one is advised to follow this ethic as much as possible.<sup>35</sup>

Islamic law does allow for deviation from normal regulations in cases of need and emergency. In these cases the principle of *aḍ-Ḍarūrāt tubīḥ al-maḥḍūrāt*, necessity makes for allowing the prohibited, is invoked.<sup>22</sup> This suspension is operative as long as the necessity is present and facilitates emergency situations.

### PRACTICE RECOMMENDATIONS

Culture, formed in part by religious beliefs and values, plays a significant role in shaping health-related behaviours. Culture is like the air we breathe, invisible but essential for life, often perceived only when quickly moving in the opposite direction. In the practice of patient-centred and culturally competent care the healthcare provider must recognise the importance of culture in patients' lives, tolerate and strive to understand patient values, and minimise negative consequences of cultural differences in the clinical encounter. Further, one must be willing to adapt his practice to accommodate patients' needs and values, and be willing to engage in the negotiation of healthcare treatments. An integral component to this practice style is effective cross-cultural communication. Effective communication leads to improved patient satisfaction, adherence to recommendations, and disease outcomes.<sup>36</sup> In this vein, clinic-based practices could include intake questionnaires asking patients to share potential concerns about patient-doctor interaction and important values. Service companies, such as airlines—and hospitals—routinely ask customers about their religion-based eating preferences (kosher, vegetarian). A similar ethos can be brought into the clinical encounter when the tenor of cross-gender interactions or choice of medical therapeutics may be influenced by religion. In addition, an effective communication tool for providers would be to begin, or end, clinical dialogue by asking 'Is there any way I can help make you more comfortable?' This question would solicit medical, as well as socio-cultural, concerns.

As we make our recommendations below it is important to note that these are formed from our own experiences and reflect our opinions. Our focus is on Muslim sensitivities which are variably interpreted and practiced thus cannot be generalised to all Muslim patients. As providers we have to be cautious not to stereotype patients but on the other hand must create the space for patients to relay concerns, preferences and values. Thus for patients who appear to be Muslim one could easily offer the comment 'I know some people are very anxious about being examined or taken care of by someone who is not of their gender, do you have any concerns you want to share with me?' This could be followed up by asking 'Is there anything you want me to do differently or be cautious about during the physical exam?' These types of questions are significant in that they tell the patient that the provider has some knowledge of cross-gender boundaries, is willing to engage in a discussion about these, and is primarily concerned about the welfare of the patient. Our last caveat is that our recommendations below should not be interpreted as fully developed policy recommendations. There may be other more effective-methods to reach the same goals.

### Dress code

It is standard practice to ask a patient to change into an examining gown in the hospital and clinic. While this facilitates physical examination, and protects the patient's clothing from staining, the gown may insult a patient's sense of modesty. A more limited scope of this practice, in addition to effective communication explaining the need for gowning, is advocated. Alternatively, some hospitals offer patient gowns that are more covering and may allow patients the option to wear their own clothes in the hospital.<sup>37 38</sup> Such practices may be effective strategies as well. When the patient gown is a necessity, hospital staff could offer to keep the curtains drawn, or the door closed, so that patients could be saved from onlookers. Another effective intervention is a 'knock, wait, enter' policy by which staff knock, wait for permission and then enter patient rooms.<sup>39</sup> This would be especially helpful for Muslim women who wear the *ḥijāb*, as they may feel the need to cover their hair before someone enters the room, and in general benefits others who feel the need for more privacy during hospital stays.

Lastly, it must be stressed that the clinician uncover only that part of the body that needs to be examined, and cover those that are not part of the exam or have been examined already. Paramount here is effectively communicating the need to examine the body before proceeding to do so.

### Seclusion

Many patients may feel anxious when in seclusion with the physician for a variety of reasons. This concern is more prominent during internal examinations. Standard practice calls for chaperones when conducting these sensitive examinations. However this practice may not adequately address prohibitions against seclusion within the Islamic and orthodox Jewish faiths. Here one must strike a balance between the need for privacy and the prohibition against seclusion (if patients observe this practice). An ideal situation would be to have a chaperone, preferably of the same gender as the patient, present or in close proximity, who could potentially hear or see what occurs during the patient-provider encounter. Such a potential disrupts seclusion. Simply keeping the door slightly ajar or having a door with a window slit would meet the requirements of Islamic law.<sup>31</sup>

### Physical contact

Physical contact outside of the medical examination can be interpreted in different ways subject to cultural norms. A provider holding the hand of a patient who just lost a family member may be viewed as a boundary crossing by some and compassionate by others.<sup>40</sup> Effective communication and paying attention to non-verbal clues may guide clinicians in caring for the patient. Physical contact outside of the examination should always be approached with caution. During the physical exam one can employ innovative strategies that may reduce the trepidation of some patients. Two personal cases are illustrative. In the first case a female Muslim patient who wore the *ḥijāb* complained about hospital staff repeatedly uncovered her hair to place a thermometer in her ear. This situation could have been easily remedied by using an oral thermometer. In the second a Muslim male became anxious during physical examination by a female provider. By simply donning gloves the provider put the patient at ease.

### CASE RESOLUTION

'Unfortunately there are no female physicians around right now, is there some way I can make you feel more comfortable?' you ask. The patient tells you that she is a practicing Muslim and

feels uncomfortable with a male examining her and disrobing into a gown. After some discussion you both agree on a compromise. You will obtain the history and a female nurse practitioner will perform the physical examination under your direct observation, with you never being in the room alone with the patient. Ultimately the patient is discharged home with crutches, an ankle stirrup air cast and anti-inflammatory medication for her ankle sprain.

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