Exploring the integration of Islamic practice in a tertiary shariah-compliant hospital: A qualitative study

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ABSTRACT

Introduction: *Shariah*-compliant and *ibadah*-friendly hospitals have been established in the Malaysian healthcare system for nearly two decades to support the religious needs of Muslim patients. In parallel, the Islamic input in the medical program curriculum has been designed to train healthcare professionals, particularly doctors, to integrate Islamic principles into their medical expertise, as they are expected to incorporate Islamic values into their daily practice. However, the practice of doctors with this Islamic integrated medical curriculum has not been thoroughly investigated. Thus, to what extent they embodied the Islamic values within their practice and the challenges they faced in realising this is not known. Therefore, this study aimed to explore the experiences of doctors and patients related to the integration of Islamic principles within Shariah-compliant hospital services.

Materials and Methods: A single-site qualitative case study design was employed, recruiting 20 doctors and 18 adult patients receiving treatment in the Orthopaedic wards and clinic of a Shariah-compliant teaching hospital. In addition, 19 relevant documents have been sampled and included. The study was conducted using multiple data collection methods including individual in-depth interviews, non-participant observations and document analysis between June 2023 and February 2024. The data analysis was done according to framework technique facilitated by NVivo software version 5.

Results: Four key themes emerged: (1) fulfilling religious and spiritual needs through clinical interactions and services; (2) practising therapeutic communication guided by Islamic values such as compassion, honesty, and patience; (3) upholding privacy, dignity, and autonomy in patient care; and (4) the importance of an effective training program and a sustainable working environment. Doctors expressed varying levels of confidence and consistency in applying Islamic principles, often influenced by personal understanding, workload, and institutional support. Patients generally appreciated the effort to integrate religious values but noted inconsistencies in delivery and expectations.

Conclusion: This study highlights both the perceptions and actual practices of doctors in integrating Islamic principles into their clinical roles, as well as how patients perceive and respond to such efforts. While both groups value the integration of Islamic values, variations in interpretation and practice reveal gaps between the intended Shariah-compliant model and its implementation on the ground.

KEYWORDS:
Medical practice management; religion and medicine; islam; qualitative research

INTRODUCTION

Attending to the religious and spiritual needs, particularly within the hospital setting, is critical for patient-centred and holistic care delivery. It yields substantial benefits, including improved psychological well-being, enhanced patient satisfaction, and better overall health outcomes.[1] With a 63.5% Muslim population, the Malaysian healthcare system has started to focus on supporting Muslim patients by facilitating patients performing their ritual prayers and by providing *halal* medications through the *ibadah*-friendly hospital initiative.[2] However, focusing solely on these two aspects didn't fulfil the role of an Islamic healthcare, which is comprehensive and holistic.[3] In response to this shortcoming, a *shariah*-based quality management standard system (MS 1900:2014) was developed by the Standard and Industrial Research Institute of Malaysia (SIRIM) for hospitals that have achieved the benchmark.[4] The Malaysian ministry of health also recognised Islamic medical practice as one of the designated forms of traditional and complementary medicine under the Traditional and Complementary Medicine Act, 2016. Islamic medical practice utilises supplications from the Quran and *hadith* (recorded sayings, actions and silent approval of the Prophet Muhammad (peace be upon him)), in its treatment.

Despite the growing emphasis on Islamic holistic healthcare, these initiatives have predominantly involved the hospital's supporting staff and collaboration with religious authorities, rather than directly engaging doctors, who are the core healthcare service providers. While the infrastructure and supportive services for shariah-compliant healthcare may be in place, the direct clinical application of Islamic medical practice by the primary caregivers, the doctors, remains an area that has not been adequately addressed.

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In parallel, Islamic values have been integrated into the medical curriculum for undergraduate students in several medical faculties in Malaysia, such as the International Islamic University Malaysia (IIUM) and Islamic Science University Malaysia (USIM).[5] However, the extent to which these Islamic values have been truly integrated and consistently practised in the daily work of doctors remains unclear. This raises a crucial question: if doctors are being trained in these values, why are they not the primary focus of implementation initiatives? The lack of clarity regarding the actual integration and daily practice of Islamic values by doctors represents a critical unaddressed area in the current healthcare landscape. This study aimed to explore the perception of doctors and their implementation of Islamic practice in daily activities in the shariah-compliant hospital. This study also explores the challenges faced by doctors in providing Islamic medical care in their daily practice.

MATERIALS AND METHODS

Study Design

A qualitative case study design was employed to explore experiences, perspectives and challenges of doctors in integrating Islamic principles in their medical practices and views and experiences of the patients receiving service and treatment from them.[6]

Study setting

This study was conducted at the department of orthopaedics, traumatology and rehabilitation, in a tertiary teaching hospital on the east coast of west Malaysia. This hospital has been certified as a *shariah*-compliant hospital by the Malaysian Quality Management System (MS 1900:2014), indicating that the hospital adheres to Islamic principles and law in its management and service delivery. The data collection sites include orthopaedic clinics, orthopaedic wards and operating theatres.

The hospital was selected because it offers a distinctive context as it is the only shariah-compliant hospital on the east coast of Malaysia, and it is affiliated with a medical faculty that has implemented an Islamic-integrated medical curriculum. This combination creates a practice environment where clinical care and Islamic principles are closely connected. Examining this setting allows for a deeper understanding of how these values shape everyday healthcare practices.

The orthopaedics, traumatology and rehabilitation department was chosen because it represents one of the most active and multidisciplinary areas within the hospital. It manages a broad range of cases across clinics, wards, and operating theatres, offering opportunities to observe practice at different stages of the patient journey. The dynamic workflow and high degree of teamwork provide a rich environment for exploring how practice unfolds in a real clinical setting.

Sampling and recruitment

Potential participants were identified using purposive sampling. The healthcare professionals, including medical officers, postgraduate trainees, specialists, and consultants responsible for providing medical services and teaching at the orthopaedic, traumatology and rehabilitation department, were invited to participate. Additionally, patients aged 18 years old and above, able to communicate in English or Malay, and receiving treatment at the orthopaedic department during the data collection period, were recruited.

Participant recruitment was guided by a maximum variation sampling strategy to ensure representation across a wide range of characteristics, including profession, years of experience, clinical roles, age and treatment received. Fifty eligible individuals (25 participants from each group) were invited; however, a total of 20 healthcare professionals and 18 patients agreed to participate. The sampling plan initially aimed for approximately twenty participants in each group, with flexibility to adjust based on the richness of the data and the point at which saturation was reached. Data saturation was achieved when no new themes or insights emerged from successive interviews and this occurred after 15 interviews with healthcare professionals and 12 interviews with patients. Additional interviews were conducted to confirm saturation and ensure robustness.

Informed consent was obtained after participants were briefed on the study's purpose, procedures, risks, and their rights, including voluntary participation and withdrawal without penalty. The participant information sheet and consent form were provided in Malay or English, depending on the participant's preference.

Documents related to the implementation of Islamic practice in the clinical setting within the case study sites, including the standard operating procedures of the hospital, content and report of Islamic integrated medical course, shariah-compliant policy at the hospital and relevant patients' or doctors' reports were retrieved.

Ethical consideration

The study was approved by the Kulliyyah of Medicine Research Committee and the IIUM Research Ethics Committee (IREC 2022-112), as well as the Institutional Review Board of the respective hospital.

Data collection

The data were collected through multiple methods, including in-depth, semi-structured individual interviews, non-participant observation, and analysis of relevant documents related to the implementation of Islamic practice at the case study site. The use of multiple data sources and units of analysis, a process known as triangulation, was a deliberate methodological strength. This approach allowed for cross-validation of findings and was instrumental in identifying discrepancies between what was stated in interviews, what was observed in practice, and what was prescribed in official documents. This systematic comparison directly contributed to uncovering the knowledge-practice divide central to the research questions.

Individual interviews with doctors and patients were conducted at a time and date convenient to each participant. Most interviews took place in clinic rooms, ward areas, or

Table I: Demographics of healthcare professionals' participants

Participants' ID	Position	Age	Gender	Race	Religion
HCP 1	PG Student	33	Male	Malay	Islam
HCP 2	MO Service	30	Female	Malay	Islam
HCP 3	Specialist	53	Male	Malay	Islam
HCP 4	PG Student	33	Male	Chinese	Atheist
HCP 5	PG Student	33	Male	Chinese	Buddhist
HCP 6	PG Student	33	Male	Malay	Islam
HCP 7	MO Service	31	Male	Malay	Islam
HCP 8	Specialist	43	Female	Malay	Islam
HCP 9	Specialist	41	Male	Malay	Islam
HCP 10	Specialist	55	Male	Malay	Islam
HCP 11	Specialist	42	Male	Malay	Islam
HCP 12	Specialist	35	Male	Chinese	Buddhist
HCP 13	PG Student	32	Male	Malay	Islam
HCP 14	MO Service	31	Male	Malay	Islam
HCP 15	Specialist	53	Male	Malay	Islam
HCP 16	PG Student	33	Male	Malay	Islam
HCP 17	Specialist	54	Male	Malay	Islam
HCP 18	PG Student	33	Male	Malay	Islam
HCP 19	Specialist	53	Male	Malay	Islam
HCP 20	Specialist	52	Male	Malay	Islam

Abbreviations: HCP = Healthcare Provider, PG = Postgraduate, MO = Medical Officer

Table II: Demographics of patient participants

Participants' ID	Age	Gender	Race	Occupation
PT 1	20	Female	Malay	Student
PT 2	50	Female	Malay	Housewife
PT 3	21	Male	Malay	Student
PT 4	58	Male	Malay	Pensioner
PT 5	75	Female	Malay	Pensioner
PT 6	41	Female	Malay	Private Sector
PT 7	47	Male	Malay	Civil Servant
PT 8	45	Female	Malay	Housewife
PT 9	24	Male	Indian	Civil Servant
PT 10	25	Male	Malay	Unemployed
PT 11	49	Female	Malay	Housewife
PT 12	28	Female	Malay	Civil Servant
PT 13	33	Female	Malay	Private Sector
PT 14	23	Female	Malay	Student
PT 15	35	Male	Malay	Private Sector
PT 16	31	Female	Malay	Teacher
PT 17	25	Female	Malay	Freelancer
PT 18	44	Female	Malay	Housewife

Abbreviations: PT = Patient

other secluded spaces to minimise interruptions. Each interview lasted approximately 30–40 minutes and was audio-recorded with participants' consent. A semi-structured topic guide, developed from the literature and the study's research questions, was used to ensure consistency while allowing participants to express their views freely.

Immediately after each interview, the recording was replayed to check for completeness, and the interview was transcribed verbatim within 24–48 hours. Transcripts were produced in the language used by participants to preserve meaning and nuance. For data presentation, transcripts in languages other than English were later translated during the analysis phase. Following translation, the research team conducted peer checking to ensure that the original meaning and intent of participants' accounts were maintained

With participants' consent, non-participant observations were carried out during consultation sessions in the wards and clinics, as well as during procedures in the operating theatre. Both general and focused observations were guided by an observation schedule. Field notes were taken by the primary researchers throughout these sessions to capture interactions, behaviours, and contextual features relevant to the study. To reduce the potential for researcher bias, the field notes were subsequently reviewed by the first and second authors, who examined the observations for consistency, clarity, and alignment with the study objectives. This process helped ensure that the observational data were interpreted in a balanced and credible manner

Reflexivity/role of researchers

Data collections were primarily conducted by the third author and fourth author (MA & SS). Prior to the data collection a thorough discussion has been done with the

research team to identify the pre-conceived ideas that could influence the data collection and data analysis process. The prior experience and ideas possessed by the primary researchers related to the phenomena being studied was listed out (bracketed) prior to the commencement of the study. With the limited experience and the position of both primary researchers on the settings and phenomena being studied, it could be anticipated that, the influenced of the researchers in the data collection and analysis could be minimised. Furthermore, the preconceived ideas that being listed earlier has been revisited during the data analysis to ensure the findings generated are grounded from the data.

Data Analysis

Data were analysed using Framework Analysis, supported by NVivo for data management. Several researchers were involved to enhance the credibility of the analysis. Transcripts were first transcribed by two researchers and independently checked for accuracy by two others. During familiarisation and initial coding, two researchers coded the transcripts separately, and their codes were then compared and discussed to develop a shared, agreed-upon analytical framework. This framework guided the charting and interpretation stages, with regular team discussions used to review theme development, resolve differences, and ensure consistency across the dataset. Although member checking was not feasible due to participants' clinical demands, the use of multiple coders, cross-checking of codes, and peer debriefing supported the trustworthiness of the findings. Data saturation was reached when no new insights were identified after 15 interviews with healthcare professionals and 12 with patients and later interviews confirmed the stability of the themes.

RESULTS

Data collection was done between June 2023 and February 2024. Twenty healthcare professionals and 18 patients were interviewed about their perception and experience of Islamic practice in medical care. A total of 18 observations were conducted throughout the data collection process. Nineteen documents pertinent to the implementation of the Islamic practice in the medical care at the case study site have been included as data sources.

The demographic characteristics of the healthcare professionals and patients who participated in the study are presented in Table I and Table II, respectively. The inclusion of healthcare professionals from diverse positions (Post-graduate (PG) student, medical officer (MO) service, specialist), races, religions (Islam, Atheist, Buddhist), genders, and ages provides a rich context for interpreting the findings, particularly concerning how IMP is understood and practised across different professional and personal backgrounds. Similarly, the patient demographics offer insights into the experiences of recipients of care from varied age groups, genders, races, and occupations.

Emergent Themes

Thematic analysis from interviews, observations, and document analysis revealed four major themes related to the integration of Islamic practice in clinical care. These include: (1) Fulfilling religious and spiritual needs, (2) Practising therapeutic communication (3) Respecting patient privacy, dignity, and autonomy (4) Importance of an effective training program and sustainable working environment. Direct quotations from participants are identified by codes: HP refers to Healthcare Professionals (doctors), and PT refers to Patients.

Fulfilling Religious and Spiritual Needs

All participating healthcare professionals demonstrated an understanding that Islamic medical practice extends to assisting patients with their daily prayers, including knowledge of methods for performing ablution and prayer when patients are physically unable to do so normally.

> *"Knows how the patient can pray as he is able… for example, when on cast, how he takes ablution." (HCP 2*)

It is also about reminding the patient about their religious obligation.

> *"during the morning round (you greet your patient) how are you uncle? Have you pray ? have you had you breakfast " (HCP 8)*
>
> *"Before starting the operation, the doctor who performed the surgery recited a prayer. When the Chinese doctor wanted to insert the epidural, he also asked me to recite a prayer. Even though he was a non-Muslim. He respected me as a Muslim patient." (PT 5)*

From the interviews, it is evident that the healthcare professionals, including non-Muslim doctors, were aware of the need to fulfil religious and spiritual needs. However, a notable observation was that some patients did not receive such spiritual guidance from their doctors:

> *"The patient has a cast on his leg and is hanging due to a broken leg. The doctor asked him how his leg was and called the nurse who was in the ward to assist him in doing a procedure. Then, the doctor trimmed the cast and left the patient. No further explanation or interaction was made after that." (Observation field note – August 2023)*

While *ibadah* education is stipulated in the shariah-compliant hospital guidelines and is part of *Fiqh* Ibadah training and clinical student syllabi, and the *shariah*-compliant department produces Islamic Spiritual Care (INSPIRE) guidelines and organises courses, direct observation in the wards revealed that doctors primarily focused on clinical management and did not regularly discuss ibadah-related issues with patients. This clear discrepancy between healthcare professionals' professed understanding of spiritual support and their inconsistent application in practice highlights a significant gap between theoretical knowledge and its practical implementation. It suggests that merely possessing the knowledge is insufficient without the practical tools, time, or institutional reinforcement to consistently apply it in a busy clinical environment.

Providing therapeutic communication

Doctors widely recognised the importance of a strong doctor-patient relationship fostered through effective communication:

> *"We greet Muslims with salam and non-Muslims with good morning… even if they complain, we stay calm." (HCP 7)*
>
> *" its not just telling the patient how to pray during illness,….it*

more of how you treat your patients and how to make them at ease ….,the way you talk to them, the way you address them " (HCP 8)

Doctors emphasised that beyond reminding patients about prayer, effective practice involves how one treats patients, makes them feel at ease, and communicates with them. Giving the Islamic greeting "salam" and keeping patients informed during procedures were noted to enhance patient comfort and satisfaction. One patient shared:

"At first, the doctor greeted me with Assalamualaikum (peace be upon you). Then, he asked for my permission and explained he would mark the leg for surgery." (PT 10)

"The doctor asked me to sabar (be patient) and be strong... They told me that this is a test from Allah SWT. InshaAllah, (God willing) if we are patient... Allah SWT will give us more." (PT 10)

The reassurance and clear explanations provided by doctors play a critical role in easing these concerns. PT 10, for instance, felt calmer after the doctor confidently explained the procedure. The doctor's use of *"InshaAllah"* also offered spiritual reassurance, helping the patient feel at peace with the uncertainties.

During the observation in the operating theatre, good communication was established before any procedure was done on the patient:

"During a preoperative round, the doctor greets the patient and her husband. He explores, identifies, and attends to the patient's concerns about the surgery. He explains the procedure and the rehabilitation protocol to ease and comfort the patient." (Observation field notes – March 2024)

Hospital guidelines mandate staff to practice good manners *(adab)* and etiquette, including using polite language and avoiding sensitive statements related to religion or race. Communication skills are also taught in *Fiqh Ibadah* and spiritual care workshops. Observations in the ward confirmed that doctors consistently communicated with patients during examinations to minimise discomfort and expressed gratitude for patient cooperation.

Respecting Privacy, Dignity, and Autonomy

All doctors expressed strong awareness of the importance of preserving patients' modesty , particularly for female patients, by limiting unnecessary exposure while ensuring quality clinical evaluation:

"Unnecessary exposure of patients should be limited… their dignity should be protected and respected." (HCP 5)

"Getting a chaperone to examine a female patient is not just Islamic practice. It is a normal practice in general medical practice" (HCP 4)

This concern was echoed by PTs:

"He covered my aurah (intimate part of bodies that should be covered) and only exposed my leg. Before checking, he closed the curtain for privacy." (PT 10)

Observation in the male ward shows that the healthcare professional indeed practices respecting privacy, dignity, and autonomy:

"Then, I observed another male doctor in the ward greeting a patient on a bed with his chaperone. It is noted that the patient consistently smiles. As the doctor begins to inspect the patient, the nurse beside him covers the unnecessary parts of the patient to be inspected. The patient appears to be comfortable with the doctor and nurse. After that, the nurse closed the curtain to begin the inspection." (Observation field note – August 2023)

Respect for religious autonomy was also emphasised in cases involving non-halal treatments:

"For medications that contain porcine DNA, we need to get consent." (HCP 7)

"Patient's choices can be influenced by their healthcare, their culture, could be from their upbringing, their religion. Doesn't matter what it is, as long as when it comes to (patient) choice, I respect it nonetheless." (HCP 5)

Patients also prefer halal medication. They put their trust in the doctors if the use of non-halal medication is indicated.

"If possible, I want medication with halal sources. But I'm not sure what kind of law it is. But for me, I'm okay with non-halal medication because there may be no other medicine to treat. If there is only that, as long as it is not harmful, I can accept it. We also follow the doctor's recommendation only" (PT 10)

Hospital guidelines exist for general consent regarding aurah exposure, different gender interactions, and the use of non-halal medication. Observations corroborated these practices, with doctors greeting patients with a chaperone, nurses covering unnecessary body parts during examinations, and curtains being closed for patient privacy.

Importance of an effective training program and a sustainable working environment

While all participants had been exposed to various Islamic programs, whether as postgraduate students, service medical officers, or lecturers, the effectiveness of these programs was questioned:

"We have lectures and case write-ups… but what you practice in clinic or OT depends on individuals." (HCP 8)

"Undergraduates have modules… for postgraduates, we don't have yet." (HCP 8)

Many programs were delivered as online lectures and group presentations, with a notable lack of hands-on application in the ward setting. Furthermore, there was no formal assessment of participants' knowledge or practical application of Islamic practice in daily medical care. This indicates a disconnect between theoretical exposure and practical competency, hindering the translation of knowledge into consistent clinical practice.

The understanding and integration of Islamic medical practice were found to be influenced by doctors' prior educational backgrounds. Some healthcare professionals, particularly those whose primary and secondary education did not focus on Islamic values, expressed a need to learn these principles. There was also a perception among some that religious and spiritual matters were less important than physical health problems, leading to their occasional omission during ward rounds. A concerning trend noted was the discontinuation of compulsory Diploma in Islamic

Studies programs for lecturers, which previously ensured a foundational understanding of Islamic values:

"The difficulty is our basic education wasn't grounded in Islamic values. We need to learn." (HCP 10)

A major impediment to the sustainability of Islamic practice was the busy hospital environment. Many doctors were unable to participate in organised courses due to heavy workloads with time constraints, including operations, on-calls, clinics, and ward duties:

"We want everyone to join, but with OT and on-calls, it's hard to get everyone involved." (HCP 7)

This time pressure meant that even when doctors remembered to advise patients on spiritual matters, the busy schedule often led to them forgetting or prioritising other clinical tasks:

"Sometimes we forget to advise patients… depends on the individual." (HCP 1)

This hectic environment is not merely a challenge but a fundamental root cause that exacerbates other issues, such as ineffective training and the knowledge-practice gap. It creates a systemic barrier where time pressures consistently override the integration of spiritual care, despite doctors' awareness of its importance. This suggests that solutions must address not just what is taught, but how it can be realistically integrated into a high-pressure clinical setting

DISCUSSION

The findings of this qualitative study offer a different perspective on how Islamic values are integrated into daily clinical routines within a shariah-compliant hospital. The qualitative approach allowed for an in-depth exploration of the implementation of Islamic practice, providing rich contextual detail. A notable strength of this research is its diverse study population, which includes doctors and patients from various religious backgrounds, experiences, and levels of expertise. This diversity yielded perspectives on the integration of Islamic practice that extend beyond a singular viewpoint. Furthermore, the inclusion of patients, as the direct recipients of care, provided invaluable feedback on the tangible impact of Islamic integration on their healthcare experience.

To our knowledge, this is among the first qualitative studies that focus on the integration of Islamic principles among the doctors in a shariah-compliant hospital. In Indonesia, the integration of Islamic values into medical practice is primarily introduced during undergraduate education. Elements such as the doctors' ethical code, competence in the *fiqh* (Islamic rulings) related to illness, observance of aurah and gender-specific services, provision of spiritual care, and ensuring halal medication are incorporated within the shariah hospital standard issued by the National Sharia Council and the Indonesian Ulema Council (Dewan Syariah Nasional – Majelis Ulama Indonesia, DSN-MUI). Nevertheless, these aspects are only addressed briefly.[7] Another study conducted focused on the organisational structure of a hospital that practices Islamic medical services, which was explored through in-depth interviews with top management personnel.[8] In Iran, studies on spiritual care among nurses have shown that the quality of spiritual care work is moderate because nurses often lack sufficient training and frequently feel unqualified to provide spiritual care.[9] Similarly, a qualitative study in a maternity unit in the north west of England among the midwives, nurses, support workers, and sonographers found that their understanding of the needs of the Muslim patients was inadequate and emphasised the need for a further training program that would help them to provide quality patient-specific care.[10] A survey on the religious perception among doctors in a tertiary hospital in Saudi Arabia found that most doctors believe that religion has a positive influence on health; however, half of them never ask about their patients' religious issues.[11]

The study underscored the centrality of holistic care in applying Islamic principles within daily clinical practice. This model addresses not only the physical dimensions of illness but also the psychological, social, and spiritual well-being of patients. Islamic spiritual care—comparable to chaplaincy services in western contexts was found to play a vital role by providing emotional support, religious guidance, and prayer. However, the research revealed a notable gap between healthcare professionals' theoretical understanding and their practical application of Islamic practices in hospital settings.[12] Although many practitioners possess sound knowledge of these principles, they seldom educate patients about religious concessions or rukhsah during illness. This disconnect is largely attributed to the fast-paced, high-pressure nature of clinical environments, where medical treatment tends to take precedence over spiritual care.[13]

The study also pointed out other challenges, including a lack of effective training programs and high turnover of doctors. Although a program to integrate Islamic principles into the medical curriculum has existed for decades, its application is not always visible in practice, especially among postgraduate students. The study suggests that to overcome these issues, medical teachers should take the lead in integrating Islamic practices into clinical sessions. By acting as role models, they can demonstrate how to apply these principles in real-life medical scenarios, which the study suggests is more effective than formal lectures alone.

Many values central to medical professionalism such as respect for patient autonomy, preservation of dignity, and compassionate care closely resonate with Islamic principles. The key distinction, however, lies in the foundation: Islamic values are rooted in faith and reliance upon Allah, the Creator.[14-15] This spiritual grounding is reflected in everyday practices, including expressions such as Insha'Allah (God willing) and Assalamu'alaikum (peace be upon you), the recitation of supplication or Bismillah (in the name of Allah) before performing medical procedures, and the preference for halal-certified medications.

Although the aims and objectives of the study have been fulfilled, several limitations can be noted. The unit analysis of this study focuses only on orthopaedic doctors as a case study. In a Shariah-compliant hospital, other stakeholders such as patients, nurses, medical assistants, Shariah compliance officers, clerks, and administration make the hospital function as a whole.

All stakeholders must be included to explore the extent of perspectives and the holistic practice of Islamic medical care. Furthermore, this study focuses only on a tertiary public university hospital. In Malaysia, other shariah-compliant hospitals, such as An-Nur Specialist Hospital and Hospital Universiti Sains Malaysia (USM) have also been accredited by a shariah-based quality managementsystem accreditation and standard, MS 1900:2014, by SIRIM Berhad. Different hospitals may have different governance and curricula when implementing Islamic medical practices. Thus, these differences shaped how healthcare professionals practice Islamic values in their daily clinical routine.

This study adopts an exploratory approach to examine the lived realities and operational dynamics within a Shariah-compliant hospital setting. The preliminary insights generated herein underscore the need for subsequent empirical investigations aimed at informing key stakeholders and facilitating the development of a robust framework and evidence-based guidelines for the effective implementation of Shariah-compliant healthcare institutions.

CONCLUSION

The successful implementation of Islamic practice in medical care hinges on four essential elements: fulfilling religious and spiritual needs, practising therapeutic communication, respecting patient privacy, dignity, and autonomy, and the importance of an effective training program and a sustainable working environment. This study identified a significant gap between Islamic knowledge and the actual practice of doctors within the shariah-compliant hospital. The findings underscore that the success of ibadah-friendly and shariah-compliant hospital programs in the orthopaedic department is not merely a clinical or educational issue but fundamentally a governance and strategic alignment challenge. Therefore, a critical need exists for robust, collaborative efforts between the university and the hospital to ensure the successful and sustainable integration of Islamic practice. This collaboration is crucial for translating theoretical knowledge into consistent clinical practice, fostering effective role models, and embedding Islamic practice as a core institutional value. The insights derived from this research contribute significantly to understanding the complexities of Islamic practice in medical care and provide a foundation for future policy and practice improvements in Shariah-compliant healthcare settings.

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CONFLICT OF INTEREST

The authors declare that they have no competing interests.

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