

ERD 2020

Education, Reflection, Development, Eighth Edition

RABBINIC AUTHORITY VS. MEDICAL BIOPOLITICS: ULTRA-ORTHODOX ISRAELI WOMEN ENCOUNTER THE MEDICAL ESTABLISHMENT

Adi Sharabi-Nov (a, b)*, Stefan Cojocaru (a)

*Corresponding author

(a) Department of Sociology and Social Work, Alexandru Ioan Cuza University from Iasi, Romania, contact@stefancojocaru.ro

(b) Tel-Hai Academic College, Israel and Ziv Medical Center, Zefat, Israel, Adi_nov@hotmail.com

Abstract

Research Objective: The present study contends that there is a gap between the way in which the Israeli dominant medical discourse, representing the secular majority, contextualizes and manages the female body, sexuality and menstrual cycle vs. how these are defined and managed by the ultra-Orthodox minority group. This gap can cause uncomfortable meetings with medical professionals, and disrupt the medical care offered to patients. **Research Method:** Scientific analysis of the literature in the fields of menstrual management in Judaism vs. Western modern medicine, biopolitics and sexual education, multiculturalism and asymmetry between doctors and patients. Also, data from the researcher's experience in medical sessions with ultra-Orthodox women in an Israeli hospital. **Findings:** Several gaps were found in such encounters: By turning to the dominant secular health system, the religious women meet another authority - the medical professional, as opposed to the rabbi who customarily determines her life practices. Whereas the discourse on the body in ultra-Orthodox society is closed and alienated, in the medical world it is open and direct. Finally, the way in which the medical establishment proposes to manage body hygiene differs from the customary religious practices in Orthodox Judaism. **Implications:** Similarities and differences between the conventional medical discourse on the body vs that of the ultra-Orthodox are revealed. The study also illustrates the asymmetrical interaction when medical professional and religious patient meet, the tensions that occur, and the possible ways to reduce them for optimal medical care.

2357-1330 © 2021 Published by European Publisher.

Keywords: Menstrual cycle, doctor patient asymmetry, biopolitics, sexual education, ultra-orthodox women



1. Introduction

Sexual socialization and education occur both inside the home through parents and siblings and outside, where youth is exposed to community norms and messages about sexuality through channels such as the media, schools, and the medical establishment (Hochhauser et al., 2019; Naziev, 2017). Perhaps members of one culture are exposed to the same knowledge and base themselves on similar schemes of cultural thinking (Ritzer, 2006), but in multicultural societies, the various groups often hold different interpretations of sexuality and body management, some overlapping and others conflicting (Trager, 2010; Ram, 2005).

The present article seeks to argue, based on literature review, that in the context of the female body and the management of menstrual practices in Israeli society, there is a gap between the secular dominant medical discourse representing the State's biopolitics and the religious Rabbinic authority. The former seeks to educate the general public regarding how female body health is managed, while the latter seeks to impose its rules and perceptions on the ultra-Orthodox minority group in Israel, who are subject to rabbinic authority. The two clash when ultra-Orthodox women need to approach the secular medical establishment for care and treatment.

These gaps in sexual discourse can create uneasiness and discomfort between professionals and patients, and impair the process of medical healthcare offered to the female patient. The awkwardness is primarily based on the excessive conversation surrounding sexuality and the body, and the need to go into details and subtleties, all of which characterize the protocols for offering proper healthcare (Foucault, [1976] 1996). Contrast this with the religious patient's need to downplay the topic and maintain the values of modesty and restraint when speaking of the body, which are characteristic of ultra-Orthodox discourse on the subject (Adler, 2008; Marmon Gromet, 2013). Therefore, the purpose of the present article is to understand the difference between these types of attitudes and discourse, and to recognize their effect on ultra-Orthodox patients in their encounters with medical caregivers.

2. Literature Review

2.1. Sexuality and monthly menstruation in Orthodox Judaism

In Judaism the value of women is dualistic. On one hand, the woman is considered to be an equal partner with full rights, examples of which can be seen in the Ketuba (marriage contract), the commandment to honor women, the prohibition of polygamy and descriptions of her beauty and wisdom in Judaism's holy books. On the other hand, her status is considered inferior to that of a man and she is prohibited from studying Torah and performing public functions. Furthermore, the rules of modesty are designed to control women and their sexuality, which is considered overflowing and dangerous. The Jewish woman, as opposed to the Christian one, cannot be asexual, since she must establish a family unit and care for her husband's desires (Sharvet, 2008), but her sexuality is perceived as an emotional sexuality (Englander & Sagi, 2013), the longing to connect with her husband in body and mind (Wolfson & Shakuri, 2011).

Studies on religious sexual education have found that girls are given negative messages about their bodies and sexuality and the dangerous power inherent in them. Physical contact and sexual desire are

prohibited, and are characterized as inappropriate for a religious girl. The central message is "Modesty of the King's daughters", who were not allowed to be interested in, talk or think about sexual issues, which would defile their souls. Thus, a religious girl should be asexual and alienated from her body (Marmon Gormett, 2013).

Sex education in the religious Jewish world is wrapped in a framework of laws dealing with the purity of the family and the ritual of Niddah (Marmon Grumat, 2013). The Niddah laws are a set of rules and regulations designed to become habitual in women's everyday lives and known to the entire family. For example, during menstrual bleeding, a woman is not allowed to touch her husband or hand him objects from her hand to his. They must not sleep in the same bed, eat from the same dishes, nor may she pour wine into her husband's glass. Niddah, the five days of menstrual bleeding and the seven days following, is considered the height of impurity, a time when a woman defiles not only objects, food and beverages but also other people. During those seven additional days, the woman must check daily that she is indeed free of bleeding by inserting a clean white cloth into her body before sunset. After that time, she is allowed to immerse her body in the ritual bath (mikvah) to be finally cleansed (Yanai & Rapaport, 2001).

Adler (2008) terms the discourse on sexuality in religious society as an official language and a mechanical act, to which the rabbi has the ultimate say on dilemmas that may arise. This set of rules defines mechanical practices common to all religious women, and the language that describes them is formal, wrapped in religious discourse and justification. Thus, religious women live shrouded in deliberate silence, where sexual language is foreign, alienated and removed from all discussion.

2.2. The relationship of the ultra-Orthodox population to health services

Although the ultra-Orthodox leadership increasingly relies on medical justifications for religious imperatives, ultra-Orthodox society harbors a suspicion of anything 'establishment' and therefore its members tend to obtain information from non-professional sources. The family serves as an important source of assistance, followed closely by the rabbinic authority. The third option is professional care, and ultra-Orthodox patients prefer to receive that care from a religious professional (Simchi, 2013).

The attitude of classical Jewish sources toward the world of medicine has been ambivalent for many years. The essential contradiction between the ideal of believing in the healing and limitless power of God and the need for flesh-and-blood doctors, whose source of authority is their professional ability rather than their religious adherence, creates unavoidable tension. In the ultra-Orthodox society, the Rabbi is the authority that determines not only religious matters, but all aspects of life, including health, education of children and family relationships. Members of the ultra-Orthodox community listen more to rabbinic authority than to medical authority (Simchi, 2013). In fact, it can be said that in the ultra-Orthodox community there is a fundamental conflict whose central issue is whether to seek assistance from external sources or to solve the problems within the 'confines of home', i.e., with the help of rabbis or other legitimate authoritative figures from the community. Still, because it lacks professional resources, the community tends to seek assistance from external factors in two main areas: the fields of physical health and mental health (Knesset Research and Information Center, 2014).

Studies (Rier et al., 2008 as cited in Simchi, 2013) examining the use of health services among ultra-Orthodox women who did choose to utilize these external sources, have highlighted specific characteristics

of these women in their use of health services, including their tendency to avoid health services in certain fields. One specific characteristic is that ultra-Orthodox women do not seek to be treated by one regular doctor or primary care worker; rather, there is a high turnover rate. More ultra-Orthodox women vs. secular women reported that they had not obtained medical help in the previous year, and that in general they have a preference for female physicians, especially gynecologists. There was also a significant difference between the two groups relating to prescription drugs, as more ultra-Orthodox women did not purchase a drug because of its cost. (It should be mentioned here that the ultra-Orthodox community is largely a poor community, with lower earnings than the remainder of Israeli society.) In fact, the study's findings emphasized several issues: 1) Low-income people forego medical treatment more often, 2) religious and cultural values dictate the choice of medical professional, and 3) the use of healthcare services is influenced by cultural differences, socio-economic status and the patient's residential area.

Research studies have shown that when religious women, who are educated on the values of modesty and the invalidation of their body and sexual desire, encounter a different discourse concerning the body, they experience dissonance and sometimes an identity upheaval (Rosenbaum, 2013). Another study of religious women after their marriage examined how they coped with the sharp transition to sexuality and the discovery of their body after years of modesty and concealment. The findings showed that the initial reaction to body discovery is often one of surprise, and the bride who is already in the advanced stages of preparing for her marriage does not know what to call "that hole." The complete inability to relate to her bodily orifice shows the alienation and remoteness she feels towards parts of her own body, and it is apparent that sexual intercourse and pleasure are inaccessible and unspoken topics for religious women (Prince, 2013).

Another study on pre-marital bridal training found that ultra-Orthodox women participants experienced total shock and dissonance at the bridal counselor's messages about the sacredness and beauty of the body and sexuality, so contrary to the warnings throughout their adolescence to suppress their sexuality and desires. Many even experience this sudden transition as a traumatic experience, finding solace in the strict observance of the laws of Niddah, which revert them again to the pre-wedding prohibitions, forbidding them to touch and lure the husband. His punishment in the Torah for disobeying the laws of Niddah is the harshest punishment, the divine punishment of untimely death or eternal excommunication. Again ultra-Orthodox women are confronted with a confusing and duplicitous message with which they must struggle each month: crossing the boundary between denying their sexuality on certain days and perceiving sexual relations as a commandment and an enjoyable act on other days (Marmon Grumat, 2013).

A search of the professional literature yielded no studies examining the encounter of ultra-Orthodox women in Israel with representatives of the medical establishment and with the medical discourse on the woman's body, which is very different from the religious discourse, especially with regard to female reproductive organs and monthly menstrual management.

2.3. The medical discourse

In modern times, control of sexuality has been transferred from religion to medicine and science (Foucault, 1976; 1996), whose practitioners have sought to establish themselves and their field as an undisputed, objective authority beginning in the 19th century. This process is called "medicalization," one

in which science and medicine define various social problems and phenomena in a scientific discourse and as issues that are essentially medical, thus setting the framework for the norm, its deviation, and its treatment (Tiefer, 2012). In modern society, such definitions replace a wide range of more traditional definitions, mainly religious or legal (Noy-Kenyon & Mishori, 2009).

Each period is characterized by some type of discourse which is not merely language but a system that structures reality. In modern times, science has established sexuality as a topic to be talked about more and more, to confess, to describe the act itself in detail, the sensations, the practices it encompasses, and so on, to enable "experts" to analyze it "scientifically". Only the experts - doctors, psychologists, psychiatrists, have the power to establish the limits of the legitimacy and normality of sex and sexuality, and also that which deviates, that is, the pathological symptoms. Thus, sexuality became a device of control and supervision. The discourse on sexuality has been institutionalized, its medicalization has deepened, and it has been domesticated into a reasoned and formal field of knowledge, disengaged from the political and detached from its influence on the structure of cultural power relations (Foucault, [1976] 1996).

In fact, Foucault ([1976] 1996) uses an analysis of the sexuality discourse to link the concept of knowledge to the concept of power, since power is realized in the various knowledge regimes in scientific, philosophical and political forms and these are part of the art of "life management", or biopolitics. This term refers to the total rational practices used by a government to monitor and manage its population's life necessities, and includes practices such as health, sexuality, hygiene, natural reproduction, life expectancy, education, etc. It is about managing the life of the social 'body', including enforcement of prevention and separation procedures, healing, financial control and the like, as well as supervision and control over the body; that is, applying knowledge/power to the private, family, or public body through educational procedures such as emphasizing hygiene. Thus, medical personnel become major agents through whom the population is socially monitored.

As a result of medicalization expansion, many of the processes in women's lives that were previously considered natural and unavoidable such as menstruation, pregnancy, childbirth and menopause, as well as fertility, contraception, abortion and even parenthood, have moved from the private space of the home to the public spaces – the hospital, the clinic and the health maintenance organization (HMO). The processes which were once managed by women are now managed by professionals (mostly men) and are supervised by them; once a natural-biological event, they are now medical and technological events perceived as a "complication" (Noy-Canyon & Mishori, 2009; Tiefer, 2012). So, in fact, while science and medicine view themselves as being opposite and contrary to the old-fashioned religious discourse, they also supervise the body and female sexuality and define it according to its biological functions, despite being wrapped in a new and sparkling "modern" discourse, open to sexuality and its discussion (Mandziuk, 2010).

In today's dominant medical establishment there are three different types of discourse, often intertwined, which are an example of transcribing relationships of control over women. The first discourse is the dominant medical theory that views menstruation as a kind of illness. Physicians advised women to guard against systemic attrition by resting during menstruation, as they saw it as a sign of weakness and female frailty (Mandziuk, 2010). The menstrual cycle is further described in the scientific literature as evidence of failure to become pregnant, followed by tissue death. This biomedical discourse perceives women as suffering from a "pathology" and harboring a process of wear and tear and deterioration in their

bodies, revealing the patriarchal nature of the field (Martin, 1991). In fact, the female reproductive mechanism is seen as having the potential for danger and disease, and therefore socio-medical arrangements must be made that will monopolize and control these processes, defining what is "desired" and what is "undesirable" (Amir, 1995). This approach is known as the "morbid approach" and is part of the dominant medical discourse.

The second approach is the "natural approach" based on the rationale that the changes occurring in the female body (menstruation, pregnancy, menopause) are natural processes. Thus, femaleness has been portrayed as a direct result of the reproductive system, and as such, does not need treatment, but rather the acceptance of these "natural" processes. Women who complained of severe side effects were labeled as "unstable" or "psychiatric cases". The "natural" approach, therefore, led to an absurdity: doctors dismissed the women with an emphatic statement that they should come to terms with the side effects of a "natural phenomenon", while those who dared to complain were labeled as neurotic or disturbed (Liebermansch, 2008).

The third approach is the "hygienic approach", which focuses on sanitation. This approach flourished after World War I and the influenza epidemic that swept the world during those years. With the growing fear of germs, companies began to produce and advertise female hygiene products, emphasizing them as "sanitary" and "hygienic," thus playing on the fear of bacteria and establishing this discourse (Mandziuk, 2010). This approach still prevails today (see, e.g., Farage et al., 2011; Iroegbu et al., 2018) and suggests that monthly menstruation is considered hygienically challenging, and is dependent on access to sanitary services and absorbent products while many girls are unaware to hygienically manage their body. This condescending medical discourse perceives menstruation as dirty and contends that science must alert and educate girls for its proper management in order to improve their quality of life and health. In other words, this is an example of contemporary medical discourse that views the female body as having pathological potential that must be understood in order to be managed, all, allegedly "for the good of women."

It becomes apparent that there are overlapping points as well as differences between the religious Jewish discourse and the dominant medical discourse. While science and religion are perceived as opposing forces, both seem to have worldviews that define women's cultural socialization within the boundaries of their physical processes (Mandziuk, 2010). Religion regards menstruation as impure and female sexuality as something that should be marginalized and not discussed (Faye-Koren, 2009; Secunda, 2012; Yanai & Rapaport, 2001); medicine regards menstruation as a health and hygienic challenge and sexuality as a topic that should be discussed in detail, openly and specifically, in order to be analyzed scientifically (Farage et al., 2011; Foucault [1976] 1996; Mandziuk, 2010).

2.4. Asymmetry in the medical encounter between doctor and patient

While these two worldviews subordinate women to external male authority, whether rabbinic or medical, the gap between silencing and speaking at length about the menstrual and reproductive organs reflects the paradox that underlies an ultra-Orthodox woman's encounter with a representative of the medical establishment. There is a conflict between the values and the limitations on which she was

educated, and the medical establishment's requirement to freely discuss details: description of genitalia, types of secretions, level of bleeding type, frequency of intercourse and more.

It should also be mentioned that the meeting between physicians and patients is always an asymmetrical one. Research has found that physicians initiate 91% -99% of all questions asked in the interaction and that about 40% of the physician-patient verbal encounter consists of the physician's questions about the patient's symptoms, the treatment to be offered, and the instructions to the patient, while the patient initiates only about 3% of the questions (Frankel, 1990; Ong et al., 1995; Roter, 1984; Li et al., 2007).

Research further shows that physicians exert control and authority over patients in different ways, direct or indirect and symbolic, not only by dominating the conversation, but also by interrupting the patient's speech, on average within 18 seconds from its start, in about 69% of all sessions (Frankel, 1990; Li et al., 2007). Physician's gender also plays a role. Female physicians have longer meetings with both women and men and tend to treat them more equitably. Male physicians tend to talk longer with female patients than with males and to express more empathy, but they have also been found to treat women less respectfully than men, and to take their concerns less seriously than those of male patients. Male physicians tend to cut off their female patients' speech and ask for intrusive information in an offensive manner more often than with male patients (Li et al., 2004; Weijts, 1994; West, 1984).

In fact, every man and woman who consults a doctor experiences an asymmetrical encounter. The physician has the medical knowledge, the skill and the patient's medical information on hand. He/she controls access to services, technologies, and medications, placing him/her in a position of strength relative to the patient. Furthermore, the encounter occurs on the physician's turf – he/she determines the duration of the examination, the type of examination, and the subsequent treatment. When the encounter is with a patient from a different religious group and accustomed to a different type of discourse surrounding the body and reproduction, this meeting can be particularly jarring.

3. Research Method

The research method of the present article is a scientific analysis of the literature review at the intersection of menstrual management in Judaism, menstrual management in Western modern medicine, biopolitics and sexual education, multiculturalism and asymmetry in physician-patient encounters, all of which present diverse perspectives and worldviews.

The purpose of the present article is to identify the discrepancies between these discourses, to study them and to understand their impact on ultra-Orthodox patients when they meet with medical personnel.

4. Analyses and Findings

4.1. The ultra-Orthodox population's attitudes towards health services, sex education and menstrual management

As of 2019, the ultra-Orthodox represent 12.5% of Israel's population, numbering about 1,125,000 men and women (Kahaner & Malach, 2019). Their ambivalent and suspicious attitude toward the medical

establishment is a given situation, one that medical teams must recognize, understand and learn how to overcome in order to provide this population with proper medical care.

The literature suggests that this community does not nullify the medical and scientific establishment as a whole, but increasingly uses justifications from these areas to anchor religious imperatives (Yanai & Rapaport, 2001). Still, the doctor's authority ranks at the bottom of the scale of authority to which they adhere. The family serves as an important source of assistance to which they first turn when a problem or health issue arises, followed by rabbinic authority, and only then by a medical authority who is preferably also religion-oriented (Simchi, 2013). Meaning that only when internal resources are lacking do, they tend to utilize the assistance of external factors, such as physical health (Knesset Research and Information Center, 2014).

In light of the above, it is no wonder that ultra-Orthodox women have unique characteristics in utilization of medical services. Their behavior is characterized, first and foremost, by avoidance of this service as long as there is such a choice. If and when it is imperative to seek medical healthcare, they prefer a team consisting of women. They also tend to seek out different physicians rather than stay with a chosen one, to purchase fewer medications due to the cost, and exhibit many cultural and socio-economic differences (Rier et al., 2008 as cited in Simchi, 2013).

Concerning the field of gynecology, it is imperative to understand the modest attitude of Judaism and the ultra-Orthodox community toward issues of female sexuality and monthly menstrual management (Adler, 2008; Prince, 2013). When these women encounter a different type of conversation concerning the body such as that of the medical establishment, they may experience discord, complete shock and surprise, trauma and an insurmountable chasm (Marmon Grumat, 2013).

Another type of conflict that arises in such meetings is the need to listen to and obey the medical authority, which is considered lagging behind the authority of the rabbi and the community officials. If the physician dictates a treatment that contradicts their beliefs, most likely, based on the literature, they will not abide by the physician's directive, and will forego the treatment. For example, if the physician recommends genital hygiene practice that is contrary to laws of Niddah, the woman will probably forego the treatment and refuse the doctor's recommendation.

While the ultra-Orthodox population in Israel is indeed a minority, their numbers are significant as is their percentage of the general population. Medical teams often encounter this population, and therefore it is important to recognize their ambivalence about the medical establishment, the characteristics of their health service utilization, especially among ultra-Orthodox women, the disparity between religious and medical discourse concerning the body, and the fact that rabbinic authority is stronger than that of the physician.

4.2. The medical discourse on the female body and asymmetry in the doctor-patient encounter

The literature suggests that although the medical profession's discourse presents itself as objective, absolute truth, and in contrast to religious-faith discourse, actually both are based on patriarchal sources that seek to govern the female body (Mandziuk, 2010). Moreover, the medical field is often a tool of the state to manage the population through biopolitical means, defining what is health versus sickness and how

to deal with and manage the body in situations of ill health (Foucault, [1976] 1996; Noy-Canyon & Mishori, 2009; Tiefer, 2012).

The key difference between religious and medical discourse is that while the former advocates concealment, avoidance of conversation, and, as mentioned previously, a mechanical and formal description of body management actions (Adler, 2008), the latter advocates excess discourse on all parts of the body, including reproductive organs, in order to allow "experts" to make a "scientific" analysis (Foucault, [1976] 1996).

Thus, it is important that medical professionals be aware of the patriarchal bias that lies beneath the three dominant discourses in medicine regarding the female body and menstruation (Leibermansch, 2008; Mandziuk, 2010; Martin, 1991) and their political-cultural baggage.

When a patient arrives at a medical encounter with a physician, he/she enters into an asymmetrical encounter (Amir, 1995) on the physician's turf with sometimes conflicting or opposing discourses surrounding the body and reproduction. Therefore, this meeting can be particularly jarring. In fact, the literature reveals that physicians tend to exert authority over their patients in a variety of ways, for example through domination of the conversation, interfering with the patient's speech, requesting sensitive information in an indiscreet manner, and lack of empathy, criticism, etc. (Li et al., 2007).

From this above we can only speculate how difficult it is for patients in such sessions, especially those who come from a minority group and feel uncomfortable with representatives of the establishment. They experience different levels of discord with the physician, not only a difference in values and beliefs, but also in the authoritative and patronizing attitude, and a sense that the doctor is in complete control.

The Western, ethnocentric biomedical approach described here can pose a significant threat to effective healthcare services and impair physician-patient communication. This system does not take into consideration and even negates patients who favor or espouse a different approach to health. These are tolerated only as long as they do not interfere with the scientific treatment protocol, including surgery, medication and other therapeutic interventions such as antibiotics, food supplements, vitamins and minerals (Bakic-Miric, 2017). It is therefore appropriate to ask how the interface with the medical establishment can be adapted for a patient from a religious minority group.

4.3. Adapting the medical meeting to a patient from a religious minority group

Research shows that patient trust can have a significant impact on treatment and the overall medical process (Bakic-Miric, 2017; Kelley et al., 2014). A high-quality and safe relationship between the physician and the patient is essential for both parties, when their encounter is shaped by an approach to illness, life, proper care and management that is aligned with both the physician's and the patient's values. This type of encounter between the two will lead to information sharing regarding the patient's condition, will allow the physician to obtain a more comprehensive picture of the patient and thus improve the possibility for correct diagnosis and treatment. Discord in the encounter is likely to lead to concealment of information, silence, lack of cooperation with the medical procedure, suspicion and perhaps misdiagnosis, inappropriate treatment and dire health consequences. Therefore, any health care provider should be aware that a lack of understanding of cultural and religious diversity can negatively affect communication with patients and prevent their cooperation, thus increasing the possibility of misdiagnosis.

In order to do so, the healthcare staff in medical institutions and medical school students must work together to know how to provide proper care. They must understand the implications of social and cultural factors, including the nonverbal aspects of culture, on beliefs and behaviors (Bakic-Miric, 2017).

In the context of ultra-Orthodox women, the social and cultural factors include their low tendency to utilize health services, the ambivalence with which they perceive medical authority, their values of chastity and modesty, and their reluctance to speak of bodily issues. Their alienation from their own bodies often renders them unable to be attentive to their body and to know how to describe in detail to a caregiver exactly what they feel, physically or emotionally (Marmon Gormett, 2013; Knesset Information and Research Center, 2014; Prince, 2013).

It is also necessary to take into account:

1) their preference for receiving treatment from a female rather than a male caregiver (Simchi, 2013), and then to equip the caregiver with appropriate tools and skills to deal with them appropriately, through training and education (Bakic-Miric, 2017);

2) knowing the religious explanation of the body's activities, female reproductive organs, religious imperatives and the like, as well as acquiring and using the terms that would minimize the shock of the open conversation on these topics;

3) learning ways to increase patient involvement in the medical process and to empower them by understanding their needs, being familiar with their difficulties facing the medical establishment, negotiating with them regarding the therapeutic process, and collaborating with them until effective therapeutic outcomes are achieved (Bakic-Miric, 2017).

In general, all medical professionals should be aware of the lack of symmetry in their encounter with patients and its potential consequences. In the encounter they should focus not only on the verbal differences in communicating with a patient belonging to a cultural or religious minority group (language, clothing etc.), but also on the non-verbal and non-visual aspects of the culture (communication styles, beliefs, values, ethics, emotions etc.). That is, they should familiarize themselves with the beliefs, values, ethics, conceptions of time and space, and the manner of emotional coping common in their country's minority groups.

5. Conclusion

Ultra-Orthodox women, like all minorities, find themselves in an uncomfortable position versus the medical authority, especially with regard to sensitive issues such as the female body and menstrual management practices, which limits their cooperation with the physician. As a result, the diagnosis, treatment, and general medical care may not be effective. Therefore, medical professionals should be trained first and foremost to understand the politics behind their status, the power that accompanies their knowledge, and its implications. They should also realize, however, the necessity not only of specializing in their medical field but of understanding the importance of deep cultural familiarity with the diverse groups they treat in order to overcome the clash between the different types of discourse. This is true not only for the religious and cultural subgroups in Israeli, but for every country and its own cultural and religious sub-groups (see, e.g., Bakic-Miric, 2017; Kelley et al., 2014)

References

- Adler, R. (2008). *Jewish feminism, theology and morality* (pp. 151-156). Miskal Publishing founded by Yedioth Ahronoth and Hemed Books. [Hebrew]
- Amir, D. (1995). 'Responsible', 'committed' and 'wise' - Establishment of Israeli femininity in abortion committees. *Theory and Criticism*, 7, 247-254. [Hebrew]
- Bakic-Miric, N. M., Butt, S., Kennedy, C., Bakic, N. M., Gaipov, D. E., Loncar-Vujnovic, M., & Davis, B. (2017). Communicating with patients from different cultures: Intercultural medical interview. *Serbian Archives of Medicine*, 146(1-2), 97-101. <https://doi.org/10.2298/SARH170323149B>
- Englander, J., & Sagi, A. (2013). Body and sexuality in the new Zionist-religious discourse. *Hartman*, 176-179. [Hebrew]
- Farage, M. A., Miller, K. W., & Davis, A. (2011). Cultural Aspects of Menstruation and Menstrual Hygiene in Adolescents. *Expert Review of Obstetrics & Gynecology*, 6(2), 127-139. <https://doi.org/10.1586/eog.11.1>
- Faye-Koren, S. (2009). The menstruate as "other" in medieval Judaism and Christianity, *Nashim: A Journal of Jewish Women's Studies and Gender Issues*, 33-59. <https://doi.org/10.2979/nas.2009.-.17.33>
- Foucault, M. ([1976] 1996). *Sexual history: The desire to know*. HaKibbutz HaMeuhad. [Hebrew]
- Frankel, R. (1990). Talking in interviews: A dispreference for patient-initiated questions in physician-patient encounters. In G. Psathas (Ed.), *Interaction competence* (pp. 231-262). International Institute for Ethnomethodology and Conversation Analysis & University Press of America.
- Hochhauser, M., Zaitsev, Y., Feldman, A., & Klontrov, S. (2019). Intervention programs for healthy sexuality in the education system in Israel vs. developed countries throughout the world: review article. *Educational Counseling*, 21, 57-80. [Hebrew]
- Iroegbu, D. I., Adamu, V. E., Ekhatior, J., Ojike, A. N., Oyama, L. E., & Eze, C. C. (2018). Faith-Based approach to improve menstrual hygiene management (MHM): Challenges and success. *41st WEDC International Conference, Egerton University, Nakuru, Kenya*. <https://www.issuelab.org/resources/33410/33410.pdf?download=true>
- Kahaner, L., & Malach, C. (2019). Yearbook of Haredi society in Israel. The Israel Democracy Institute. <https://www.idi.org.il/haredi/2019/?chapter=29253> [Hebrew]
- Kelley, J. M., Kraft-Todd, G., Schapira, L., Kossowsky, J., & Riess, H. (2014). The influence of the patient-clinician relationship on healthcare outcomes: a systematic review and meta-analysis of randomized controlled trials. *PloS One*, 9(4), e94207. <https://doi.org/10.1371/journal.pone.0094207>
- Knesset Research and Information Center. (2014). The health of ultra-Orthodox women in Israel - a snapshot. <https://knesset.gov.il/committees/heb/material/data/maamad2014-11-12.pdf> [Hebrew]
- Li, H. Z., Desroches, N. G., Yum, Y. O., Koehn, C., & Deagle, G. (2007). Asymmetrical talk between physicians and patients: A quantitative discourse analysis. *Canadian Journal of Communication*, 32, 419-433. <https://doi.org/10.22230/cjc.2007v32n3a1959>
- Li, H. Z., Krysko, M., Desroches, N. G., & Deagle, G. (2004). Reconceptualizing interruptions in physician-patient interviews: Cooperative and intrusive. *Communication & Medicine*, 1(2), 145-157. <https://doi.org/10.1515/come.2004.1.2.145>
- Liebermansch, R. (2008). The construction of menopause in the popular Israeli-medical discourse (thesis for a master's degree in social sciences). Bar-Ilan University: Ramat Gan.
- Mandziuk, R. M. (2010). Ending women's greatest hygienic mistake: Modernity and the mortification of menstruation in Kotex advertising, 1921-1926. *WSQ: Women's Studies Quarterly*, 38(3-4), 42-62. <https://doi.org/10.1353/wsqa.2010.0015>
- Marmon Gromet, N. (2013). Does the guidance of brides and grooms in Zionist society prepare couples for living together? Contemporary Feminist-Religious Discourse: A Selection of Lectures from the Sixth and Seventh International Conferences on Woman and Judaism, 2010. *Kotar*, 123-132. [Hebrew]
- Martin, E. (1991). The Egg and Sperm: How science has constructed a romance based on stereotypical male-female roles. *Journal of Women in Culture and Society*, 16(31), 485-501. <https://doi.org/10.1086/494680>

- Naziev, A. (2017). What is an education? International Conference on the Future of Education. https://www.researchgate.net/publication/317545698_What_is_an_education
- Noy (Kenyon), S., & Mishori, D. (2009). Medical control and the dominance of physicians in the deliberations of the public-professional committee for examining the issue of egg donation in Israel. *Israeli Sociology*, 11(1), 37-64. [Hebrew]
- Ong, L. M., DeHaes, J. C., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. *Social Science & Medicine*, 40, 903-918. [https://doi.org/10.1016/0277-9536\(94\)00155-M](https://doi.org/10.1016/0277-9536(94)00155-M)
- Prince, M. (2013). Religious women dealing with sexuality and body after marriage. Contemporary Feminist-Religious Discourse: A Selection of Lectures from the Sixth and Seventh International Conferences on Woman and Judaism, 2010. *Kotav*, 135-143. [Hebrew]
- Ram, A. (2005). *Israel's globalization: McWorld in Tel Aviv, Jihad in Jerusalem*. Rassling. [Hebrew]
- Ritzer, J. ([2000] 2006). *Modern sociological theories*. Open University Press. [Hebrew]
- Rosenbaum, T. (2013). 'I am merely a tool in his hand': The contribution of cultural messages to the self-perception of religious and ultra-Orthodox women in their private life. Contemporary Feminist-Religious Discourse: A Selection of Lectures from the Sixth and Seventh International Conferences on Woman and Judaism, 2010. *Kotav*, 113-121. [Hebrew]
- Roter, D. L. (1984). Patient question asking in physician-patient interaction. *Health Psychology*, 3(5), 395-409. <https://doi.org/10.1037/0278-6133.3.5.395>
- Rier, D. A., Schwartzbaum, A., & Heller, C. (2008). Methodological issues in studying an insular, traditional population: a women's health survey among Israeli haredi (ultra-Orthodox) Jews. *Women & Health*, 48(4), 363-381. <https://doi.org/10.1080/03630240802575054>
- Secunda, S. (2012). The construction, composition and idealization of the female body in rabbinic literature and parallel Iranian texts: Three excursuses. *Nashim: A Journal of Jewish Women Studies and Gender Issues*, 23, 60-86. <https://doi.org/10.2979/nashim.23.60>
- Sharvet, A. (2008). *Woman, Eve, man. Jewish femininity between development and tradition* (pp. 16-17). Reuven Mas Publishers. [Hebrew]
- Simchi, M. (2013). Healthy beliefs about the use of preventive medical services for infants are accepted in most ultra-Orthodox women (thesis for a master's degree in humanities and social sciences). Ben Gurion University of the Negev: Beer Sheva. [Hebrew]
- Tiefer, L. (2012). Medicalizations and Demedicalizations of Sexuality Therapies. *Journal of Sex Research*, 49(4), 311-318. <https://doi.org/10.1080/00224499.2012.678948>
- Trager, T. (2010). State education for healthy sexuality. *Echoes of Education*, 84(6), 50-54. [Hebrew]
- Weijts, W. (1994). Responsible health communication: Taking control of our lives. *American Behavioral Scientist*, 38(2), 257-270. <https://doi.org/10.1177/0002764294038002007>
- West, C. (1984). When the doctor is a "lady": power, status and gender in physician-patient encounters. *Symbolic interaction*, 7(1), 87-106. <https://doi.org/10.1525/si.1984.7.1.87>
- Wolfson, N., & Shakuri, C. (2011). *Distance, touch, the secret of intimacy - a Jewish look*. Miskal Publishing founded by Yedioth Ahronoth and Sifrei Hemed, 12-13. [Hebrew]
- Yanai, N., & Rapaport, T., (2001). Niddah and nationalism: The female body as text. In Y. Atzmon (Ed.), *Hear my voice: Representations of women in Israeli culture* (pp. 408-426). Am Oved. [Hebrew]