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Research Article

Ageist Language in Doctor-Patient Interactions in Malaysia and Pakistan: A Comparative Qualitative Study

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Abstract

Much research on interactions between doctors and their older patients (Peck, 2011; Samra et al., 2015) has focused on patient attitudes or satisfaction. Previous research on older patients focused either on their healthcare needs (Shah et al., 2021) or their limited health literacy (Salim et al., 2022). Drawing upon qualitative comparative design and thematic analysis informed by Levy's (2009) age stereotype embodiment theory (SET), this study critically examines ageism in doctor-patient interactions in Malaysia and Pakistan. Thirty (30) participants (15 from Pakistan and 15 from Malaysia) selected through purposive sampling participated in this study and shared their responses. Findings reported that doctor-patient interactions were influenced by ageism, which manifested in some doctors employing ageist language, ridiculing older patients, emphasizing their perceived ineffectiveness, disregarding their opinions, patronizing, and infantilizing them. Moreover, cross-country differences in the use of ageist language were reported, and these differences included Malaysian doctors associating older persons with diseases and Pakistani doctors linking older persons with emotional vulnerability. Comparative, discourse-informed application of SET in Malaysia and Pakistan is a novel methodological contribution of this study. This study presents implications in relation to healthcare communication. While appropriate communication with patients is taught in some medical faculties, focus on communicating with older patients should also be incorporated in such courses.

Keywords: ageist language, doctors, interactions, older patients, Malaysia, Pakistan

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Malaysia and Pakistan are currently facing the prospect of an ageing population (Statista, 2022; 2024). Malaysia is officially considered an ageing country as the populace aged 65 years and above has almost reached 7.3% of the national population. In Pakistan, there are around 15 million people aged 60 or older, currently constituting 7% of its total population (HelpAge International, 2022). An ageing country, according to the United Nations (UN), is one in which people aged 65 years and above make up 7% of the total population. Accordingly, Pakistan will soon become an ageing country.

As an ageing nation, a country will normally experience an increase in life expectancy due to better healthcare services and higher living standards, as well as a decline in fertility rates. As older people are seen as a burden on national health resources (Cronshaw, 2012), ageism (discrimination based on age) tends to grow in a range of contexts. Ageism involves stereotypes of older and younger people in public discourse and on social media (World Health Organization, 2021). It seeps deep into our society, whether in law, policies, or healthcare practices, it segregates individuals based on their age (Mendez et al., 2022). Ageism also results in the use of ageist language that contains age stereotypes and negative ageist slurs against older people (Ali, Bakhsh, & David, 2025).

The growing population of older persons in Malaysia and Pakistan merits policymakers' attention because ageist stereotypes and discrimination against older adults can have a negative impact on the health and well-being of older citizens, creating potential barriers to health equality (Wyman, Shiovitz-Ezra, & Bengel, 2018). Among older people, ageism is associated with poorer physical and mental health, increased social isolation and loneliness, greater financial insecurity, and decreased quality of life. Ageism, or age discrimination, can be found across a range of sectors. Moreover, ageing poses social, economic, and cultural challenges (David, Ali, & Shah, 2022).

According to Stypinska and Nikander (2018), ageism prevails in the labor market where hiring managers discriminate against older workers. Discourse of ageism is also shaped by medical experts who negatively describe and explain the health problems of older persons (Wyman et al., 2018). In their comparative study, Marshall et al. (2022) discussed how discourses of technological innovation are entangled with those of ageing in the Netherlands, Spain, and Canada.

In this study, we focus on ageist language used against older Malaysian and Pakistani patients in doctor-patient interactions. The study is contextualized in Malaysian and Pakistani settings. We collected data from both countries and conducted a critical comparative analysis. This study also reports implications to encourage professional and age-inclusive language in healthcare settings.

Literature Review

There are relatively little research and information available on the comparison between doctor-patient interactions in Malaysia and Pakistan from the age-critical perspective. One exception is Rehman and Diah's (2020) cross-sectional comparative study of women's (doctors and patients) interactions in maternal healthcare centers in Malaysia and Pakistan. However, the study focuses not on ageism but on how doctors comply with Islamic values when interacting with their patients. Although there is a dearth of comparative studies on ageist interaction, numerous studies have independently examined doctor-patient interaction in both Malaysia and Pakistan.

In the context of healthcare communication in Malaysia, researchers have not focused on ageist discourse but on patients' satisfaction with doctor-patient interaction (Nordin et al., 2020), their positive and negative experiences of communications with doctors (Chin, 2021), and the impact of their gender and status on their communication with doctors (Mohajer & Endut, 2020). Moreover, Salim et al.'s (2023) qualitative study has explored the critical components of doctor-patient communication, including professionalism, good eye contact, and ensuring patient privacy and confidentiality. Yacoob and Yazid (2021) have discussed two types of doctor-patient interaction:

doctor-centered and patient-centered.

On the other hand, in Pakistan, researchers have not focused on ageist discourse. They have paid research attention to the positive and negative effects of doctor-patient communication on patients' quality of life (Jamil et al., 2022), patients' satisfaction with doctor-patient interaction (Jalil et al., 2017; Kanwel et al., 2024), language barriers and their impact on doctor-patient interaction (Mustafa et al., 2023), and medical students' attitudes to doctor-patient relationships. Afzaal et al.'s (2020) corpus-based study of doctor-patient interaction in Pakistan showed how the interaction lacked commonality, solidarity, and familiarity.

Ageism in Doctor-Patient Interaction

Researchers have identified age-related differences (Peck, 2011) and older patients' increased passivity (Greene et al., 1986) as key characteristics of ageist doctor-patient interactions that result in the violation of trust between a doctor and a patient (Ananchenkova, 2024). Such ageist interaction can make it more difficult for older patients to get equal access to medical care (World Health Organization [WHO], 2021).

Peck's study (2011) assesses whether doctors interact with older patients in a patient-centered manner and whether patient age moderates the relationship between interaction style and satisfaction, that is, whether older patients are generally satisfied with patient-centered medical encounters. Peck collected pre-and post-visit questionnaire data from 177 patients at a large family medicine clinic. The researcher audiotaped the encounters between doctors and patients. Patient-centered interaction style was measured by coding data from audiotapes of doctor-patient interactions. Patient satisfaction was measured using the Patient Satisfaction Questionnaire. Findings showed that physicians were more likely to have patient-centered encounters with patients aged 65 and older. It was also found that patient age moderated the association between interaction style and patient satisfaction: older patients were more satisfied with patient-centered encounters. The researcher concluded that patient age is associated with style of interaction, which is, in turn, associated with patient satisfaction. Understanding the factors and processes by which doctors and patients interact has the potential to improve many facets of health care delivery.

Wyman et al. (2018) address ageism at different levels of the health care setting with a review of empirical research and health care policy. At the micro (personal) level, manifestations of ageism include attitudes toward older adults by physicians, nurses, and other health care professionals. Ageist communication styles used with older patients, age-biased clinical decision-making regarding diagnostics and treatments, and self-directed ageism in older patients are also discussed. Macro-level (institutional or structural) aspects of ageism are then examined, as reflected in health care reimbursement structures, participation of older adults in clinical trials, institutional policies governing care, and the lack of emphasis on geriatric-specific training for health care professionals. The chapter closes with an integration of the findings and a discussion of the challenges in identifying and reducing ageism in this setting. Conclusions are drawn, and recommendations for future research and practice are made.

In another study, Mendez et al. (2022) evaluated the impact of an educational strategy on ageist attitudes against older adults among healthcare undergraduate students. A five-week intervention: Healthy environments and self-care for the older adults was implemented. To assess the impact of this strategy on ageist attitudes in participants, a simulated consultation with an older adult was conducted. Participants' perspectives on the experience were collected using an online survey. One hundred and thirty-eight undergraduate students from health programs were included. They highlighted growth in understanding of the normal aging process and the prejudices surrounding aging. During the role-play activity, participants identified communication, empathy, and professionalism as the abilities

developed with this strategy, and the need to show empathy and avoid prejudice against older adults in their clinical interactions. Educational interventions are a powerful tool for promoting cultural change and diminishing ageism-related prejudices and misconceptions among future healthcare professionals.

Attention has also been paid to the phenomenon of elderspeak. Elderspeak is often used when talking to older individuals and is characterized by slower/or louder speech, a patronizing tone, and other features (Schroyen et al., 2017). A part of the reason for such communication can be found in the actual context of a negative view of ageing (Ali et al., 2025). Schroyen et al.'s (2017) study on 40 healthcare professionals (physicians and medical students) records a podcast in which they must explain an endocrine therapy to two fictional patients (a 40-year-old and a 70-year-old). Results show that when participants explained the treatment to the older patient, they used shorter utterances and made more repetitions. In summary, physicians and medical students used elderspeak when they explained a treatment to older patients.

Theoretical Framework

This study uses Levy's (2009) age stereotype embodiment theory (SET) to explain how social beliefs about age and ageing are internalized over the life course, affecting older persons' cognition, behaviour, and health outcomes. The theory illustrates that age stereotypes operate through the internalization of age-related beliefs from early life, the unconscious activation of these stereotypes in later life, their self-relevance, their salience once individuals identify themselves as old, and multiple pathways of influence involving physiological, behavioural, and psychological mechanisms. Although SET has been widely applied in psychological and health research, its relevance to language and discourse, particularly in interaction, has only recently begun to be explored.

From a discourse-analytic viewpoint, age stereotypes are not just mental constructs. They are created, maintained, and strengthened through everyday interactions. In institutional settings like healthcare, stereotypes about older adults, such as beliefs about their dependency, cognitive decline, or inactivity, often show up in language choices. These include how people address each other, take turns in conversation, control topics, use simplification strategies, and frame evaluations. These interactional practices can serve as triggers that activate and reinforce age stereotypes in doctor-patient interactions. Integrating SET with discourse theory can allow age stereotypes to be viewed as discursively mediated phenomena. In doctor-patients interaction, doctors' control over epistemic authority, topic initiation, and turn-taking can frame older patients as less competent speakers, reinforcing socially embedded beliefs about age and ageing. Such discursive positioning reflects ageist ideology and contributes to the embodiment of older persons, who may internalize, align with, or resist these interactional cues. Through repeated exposure to such communicative patterns, age stereotypes become normalized within institutional discourse and incorporated into older persons' expectations of care and self-understandings. By extending Levy's Age Stereotype Embodiment Theory into the domain of clinical discourse, this study views ageist language as a key mechanism through which ageing is socially constructed and embodied. This integration enables a theoretically informed analysis of how ageism operates at the micro-level of interaction while remaining embedded within broader sociocultural and institutional structures.

None of the reviewed studies, to the best of our knowledge, have examined ageist doctor-patient interaction in a comparative context in Malaysia and Pakistan from Levy's (2009) perspective. This represents a significant research gap that our study aims to address. This study seeks to answer the following research questions: (1) How do ageist doctor-patient interactions manifest in Malaysia and Pakistan?; and (2)What are the similarities and differences in ageist communication patterns between doctors and older patients in Malaysia and Pakistan?

Methodology

A qualitative study design was used to compare how Malaysian and Pakistani doctors used ageist language in their interactions with older patients. Such a research design can help understand how ageism can affect interaction. Moreover, purposive sampling was employed to select older persons aged 60 or older. The participants were selected based on their experiences of ageism in doctor-patient interactions, which were determined through preliminary relevant questions posed to prospective participants. Participants were invited via email and WhatsApp messages, encouraging them to take part in the study. The participants who agreed to participate were recruited for interviews.

Data Collection

In this study, data were collected through semi-structured interviews with older persons in Pakistan and Malaysia, using WhatsApp voice notes and audio calls, which were selected to facilitate comfort, mobility, and accessibility. An interview guide was developed to elicit participants' experiences of doctor-patient interactions, with a focus on interactional dynamics, linguistic treatment, forms of address, and explanatory practices in clinical encounters. Moreover, the semi-structured format enabled flexibility, allowing thematic consistency across interviews. Interviews were conducted via WhatsApp calls and voice notes in participants' preferred language(s) (Sindhi/Urdu in Pakistan and English and Malay in Malaysia). Translations of the interviews were manually conducted and verified by translation experts. Relevant notes were taken manually during and immediately after interviews, and the notes were discussed with participants for validation, which helped capture participants' illustrative phrases, contextual observations, and responses. Across both national contexts, a standardized data collection protocol was followed. Before data collection, participants were informed of the study's aims, ethical considerations, and their right to withdraw at any time.

Interviews (Shaikh & Parrish, 2023) were conducted with participants over a 3-month period (from December 2022 to February 2023). Smartphones were used to send interview questions to participants' WhatsApp numbers. Smartphones enable researchers to collect data remotely (Beneito-Montagut, Begueria, & Cassián, 2017). Since participants lived in Malaysia and Pakistan, online ways of collecting data (WhatsApp) were helpful in easily accessing the participants. The participants shared their stories regarding the ageist language used against them in their interactions with doctors. Each participant provided their responses about the use of ageist language in doctor-patient interactions. In total, 30 interviews were conducted via WhatsApp, with an average length of 40 minutes. The questions were designed to encourage the participants to share their answers. Data collection continued until data saturation (Lowe et al., 2018) was achieved (no new ideas emerged from the interviews).

Participants

This study used purposive sampling to select older persons (at least 60 years old) with prior experience interacting with doctors in healthcare settings. In total, 30 participants were interviewed via semi-structured interviews, comprising 30 from Malaysia and 30 from Pakistan. To reduce gender bias and ensure gender balance, the sample contained an equal number of female and male participants (n = 15 each). Participants were selected based on three criteria: being linguistically and cognitively able to reflect on their interactional experiences; being at least 60 years old; and having attended at least one medical session in the previous year. The sample was designed to facilitate cross-contextual analysis of ageist language practices within two socio-culturally different but postcolonial healthcare settings.

The total number of participants was 30. Fifteen (15) participants were from Malaysia, and 15 from Pakistan. All the participants lived in different areas in Malaysia and Pakistan. The average age of the participants was 66 years, and they were all retired professionals who had served in various

sectors. At present, they are not employed. WhatsApp messages and emails calling for participation in this study were sent to 40 older persons living in Malaysia and Pakistan. Thirty participants (15 male and 15 female) agreed to participate in this study, and all were subsequently contacted via WhatsApp. The selected participants were guaranteed that their identities would remain confidential. Ethical approval (Harvey, 2023) was also gained from the participants to ensure research ethical protocols were followed. In accordance with the ethical protocol (NiiLaryeafio & Ogbewe, 2023), participants' identities were kept confidential.

Data Analysis

Data were analyzed using thematic analysis. According to Berg and Latin (2008), thematic analysis includes coding data, examining meaning within data, and generating themes and categories via participants' shared experiences. Coding plays an important role in qualitative analysis (Vaismoradi et al., 2016). In this study, manual coding was conducted by identifying keywords and concepts relevant to the study's aim. The authors discussed and reached consensus regarding the codified data. Codes were grouped into categories, and similar categories were integrated to develop themes.

The thematic analysis followed a systematic process. Firstly, data were read and re-read for familiarization and identification of preliminary thematic patterns. Initially, codes were generated inductively from the data, focusing on recurring meanings and salient features in relation to the objectives of this study. These codes were then reviewed, compared, and redesigned through critical discussions among the authors to ensure consistency and analytical rigor. To validate the analysis, themes were cross-checked against the original dataset to ensure they accurately reflected participants' experiences. Disconnections in coding or theme development were addressed through discussion until consensus was achieved, thereby demonstrating credibility and trustworthiness of the findings (Daniel, 2019).

Rigor

Daniel's (2019) TACT (trustworthiness, auditability, credibility, and transferability) framework was used to increase the rigor of this study. Trustworthiness was achieved through data analysis and by comparing participants' responses to their experiences. The researchers reflected on and developed theoretical memos from the raw data, and compared their perceptions of the interviews. Moreover, auditability was maintained by providing clear, detailed descriptions of the study design and transparent explanations of the decision-making process. Thick descriptions of the data and peer debriefing were used to ensure credibility (the validity of the study). Finally, detailed descriptions of the study design and its characteristics were given to ensure transferability. Ethical protocols were carefully followed throughout the study. Participants were provided information about the purpose of the study and their right to withdraw at any stage. Institutional ethics approval was not obtained because participants were interviewed in their personal capacity outside healthcare settings. Prior to data collection, informed consent was obtained, and anonymity and confidentiality were maintained.

Results and Discussion

Five themes reflecting older persons' experiences of ageism in doctor-patient interactions were identified. These themes were important for understanding how older patients in two different countries experienced ageism in doctor-patient interaction.

Ageist Terms Used against Older Patients

The age of the patients determines how they are to be treated by their doctors. According to Peck (2011), if a patient is young, there is a greater chance that they will be respectfully treated by their doctor. If a patient is aged 60 or over, he or she may not be treated with respect (Table 1).

Table 1

Ageist Terms

Participant No.	Response	Country	Gender
1	A doctor said I had been weak and I needed rest only.	Pakistan	Male
2	Doctors who have treated me have often addressed me as a feeble person, someone who lacks vitality.	Malaysia	Male
3	It's like older persons may have health issues, and they are diseased.	Malaysia	Male
4	Weak, emotional, deaf and angry.	Pakistan	Male
5	We are seen as too sensitive and irritable.	Pakistan	Female
6	It's like we are useless to them.	Pakistan	Female
7	Old in every way.	Malaysia	Female

Responses in Table 1 show ageist terms used against older patients. Terms, such as "weak" (response 1), "feeble", "lacks vitality" (response 2), "diseased" (response 3), "emotional", "deaf", "angry" (response 4), "sensitive and irritable" (response 5), "useless", (response 6), and "old in every way" (response 7) used by doctors against their older patients show the former's attitude towards the latter. In doctor-centered interaction (Peck, 2011), these ageist terms negatively represent older persons (David et al., 2022). Associating weakness, disease, emotional breakdowns (anger), and irritability with older persons are some ways of ageist stereotyping (World Health Organization, 2021). Moreover, the ageist notion of older patients' uselessness in response 6 in Table 1 is based upon the misperception that older persons are seen as a burden on national health resources (Cronshaw, 2012). Furthermore, the use of an ageist phrase "old in every way" (response 7) can be conceptualized as an unprofessional way of addressing older patients because, according to Salim et al. (2023), professional ways of addressing recognize older persons' self-respect. Responses 1 and 2 demonstrate the physical weakness in older patients, while response 3 shows their weakened immunity and vulnerability to disease. According to Wyman et al. (2018), such ageist stereotypes are potential barriers to health equality. Instead of curing or reducing their medical problems, such ageist talk may increase their health problems and stigmatize their ageing process.

Responses 4 and 5 imply that older patients cannot suppress their anger and often give vent to their pent-up emotions. Ageism segregates individuals' personalities and capacities based on age (Mendez et al., 2022). Similarly, this study discusses how older persons are segregated due to their incapacity to control their emotions. Since older persons are assumed to be "old in every way" (response 7), they are considered by some ageist doctors as "useless" (response 6). Employing Levy's (2009) stereotype embodiment theory, the data in Table 1 demonstrate how ageist meanings are created, circulated, and internalized through clinical interactional discourse. Ageist labels such as "useless", "diseased", "feeble", "weak", and emotionally charged linguistic items like "angry" and "irritable" construct ageing through a decline and deficit vocabulary.

There is a difference in how ageist terms are conceptualized and used in doctor-patient interactions. For instance, a Malaysian participant (response 2) reported that weakness was viewed as the lack of vitality. In contrast, a Pakistani participant (response 1) stated that weakness was conceptualized as a need for rest. Another Malaysian participant (response 3) discussed that older persons were assumed to be diseased, whereas Pakistani participants (responses 4 and 5) mentioned that older age was linked with emotional vulnerability. In the context of Malaysia, the older way of life was seen as a general pattern in an older patient's social life. In contrast, older age was seen as a

consequence of older patients' uselessness to doctors in Pakistan.

Mocking Older Patients

Ageist language is used to make fun of older patients' appearance (Table 2).

Table 2

Ageism and Mockery

Participant No.	Response	Country	Gender
8	This medicine will refill youth in you. I am sure you will feel young.	Malaysia	Male
9	I am prescribing some anti-ageing tablets. Everybody likes to look young.	Pakistan	Female
10	You need to drink more water and take more vitamins because these will help you slow down the process of formation of the wrinkles around your eyes. I did not like that.	Malaysia	Male
11	A doctor once told me: "it's good to look young and healthy".	Pakistan	Female
12	I was complimented: "you are looking young and handsome today".	Malaysia	Male

Doctor-centered interaction with older patients can include linguistic items that mock them. This mockery manifests in the words/terms/utterances used by doctors in interactions with older patients. Terms such as "feel young" (response 8), "anti ageing tablets", "likes to look young" (response 9), "wrinkles" (response 10), "looking young and healthy" (response 11), and "looking young and handsome today" (response 12) are examples of how doctor-centered discourse is used by doctors with their older patients. These responses imply that being young is much better than being old. Youth is linked with health and handsomeness, while older age is associated with illness and perhaps ugliness.

The linguistic item "refill youth in you" (response 8 in Table 2) is an example of ageist mockery because older age has been implied as an empty cup/glass that needs to be refilled with youth. Conceptualizing older persons as empty cups/glasses reinforces the ageist notion that they are passive and receptive to doctors' discourse. According to Greene et al. (1986), doctors' ageist interaction with older patients results in the latter's increased passivity. Besides, the doctor seeks to dominate the older patient through his patronizing statement, "I'm sure you will feel young" (response 8 in Table 2). The doctor's patronizing statement, a kind of elderspeak (Schroyen et al., 2017), negatively represents older persons.

Response 9 in Table 2 demonstrates how ageist mockery has been used against older patients. The statement "I am prescribing…" is patronizing in its aims and meaning, and it links with the sentence "Everybody likes to look young," which makes fun of older patients because, according to the doctor, they want to look young. Such ageist mockery can violate trust, discouraging older patients from taking prescribed medicine (Avanchenkova, 2024). This can negatively impact the health and well-being of older persons (Wyman et al., 2018). Moreover, response 10 in Table 2 mockingly equates the ageing process with the formation of wrinkles around the older patient's eyes. In doctor-patient interactions, the use of mockery rather than respect for patients' privacy and confidentiality is an example of unprofessionalism (Salim et al., 2023). In responses 11 and 12 in Table 2, older age is

mocked, and youth is celebrated. This shows how ageist mockery has seeped deep into healthcare practices (Mendez et al., 2022) and how such mockery results in the negative description of older persons' health problems. In the words of Wyman et al. (2018), ageist doctors negatively describe older persons' health problems (Wyman et al., 2018).

Different forms of ageist mockery were used in doctor-patient interactions across the two countries. Response 8 demonstrated that the Malaysian doctor mocked the older patient using metaphorical language (refill youth), whereas response 9 manifested that the Pakistani doctor mocked the older patient using literal language. Furthermore, the Malaysian doctor was reported to explicitly mock older age by linking it with wrinkles (response 10), while the Pakistani doctor was mentioned to implicitly make fun of older age by associating youth with health.

Analyzed from Levy's (2009 perspective, the data reveals how age-based discrimination is conveyed and internalized via apparently positive, youth-centered clinical talk. Mentioning "anti-ageing tablets", "refilling youth", "looking young", and the prevention of wrinkles positions youthfulness as the desirable norm, whereas ageing is subtly created as a deficit requiring concealment and reversal. In the words of Levy (2009), these age stereotypes are slowly absorbed over the course of life and activated in the later phase of life. In this dataset shown in Table 2, medical advice and praise serve as implicit cues that prompt older people to evaluate themselves against youthfulness standards, leading to self-assessment of physical decline and dissatisfaction with natural ageing. Such discursive practices illustrate how apparently benign or complimentary language causes the embodiment of ageist beliefs, influencing older persons' self-perceptions of worth, health, and appearance within clinical interactional contexts.

Assuming that Older Patients have Nothing to Contribute

Ageist doctors deny older patients' role in the contribution to society (Table 3).

Table 3

Ageism and Social Contribution

Participant No.	Response	Country	Gender
13	Old fashioned and unable to understand their and others' health problems.	Malaysia	Female
14	It's like we are useless and cannot contribute anything to society.	Pakistan	Female
15	They see us as a source of their income.	Pakistan	Male
16	I remember a doctor telling me that older age comes with many diseases.	Malaysia	Male

Responses in Table 3 also show how doctors have negatively interacted with their older patients, denying the latter's social importance. Ageist terms such as "old-fashioned" and "unable to understand health problems" (response 13) suggest that older patients' approach to their health is old-fashioned, outdated, and that they cannot understand their health problems. This ageist response implies that older persons cannot contribute to society (see also response 14). Such ageist responses in doctor-patient interactions that lack solidarity with older patients (Afzaal et al., 2020) are based on the mistaken notion that older patients are a burden on national health resources (Cronshaw, 2012). Moreover, doctor-patient interaction that does not recognize the social importance of older persons/patients is doctor-centered (Yacoob & Yazid, 2021).

Another way of denying the social significance of older patients in doctor-patient interaction is to see them as "a source of…income" (response 15). Instead of developing familiarity with older patients' social issues and solidarity with their health problems, doctors prioritize pecuniary interest in their older patients. According to Afzaal et al. (2020), the lack of familiarity, commonality, and solidarity in doctor-patient interaction can centralize the agency of doctors while decentralizing patients' agency. Decentralizing older patients' agency in doctor-patient interaction can, in the words of Greene et al. (1986), increase their passivity. Older patients' increased passivity can make them receptive towards ageist stereotypes (see response 16), which, as reported by the World Health Organization (2021), are found in healthcare communication targeted at older persons.

The ageist doctor-patient interaction regarding older patients' social insignificance was handled differently in Malaysia and Pakistan. In the context of Malaysia, the discourse of older patients being old-fashioned and unable to understand their health problems was used to highlight their social insignificance (response 13). Contrastingly, the discourse of commercial gains was used to degrade older patients in Pakistan because they were only seen as a source of income (response 15).

Data in Table 3, from Levy's (2009) perspective, demonstrates how instrumental and deficit-based age stereotypes are conveyed and internalized through medical interactions. Responses in Table 3 construct ageing as an inevitable state of decline and cognitive incompetence. Repeated exposure to such representations can cause older persons to embody beliefs of dependency and incompetence.

Excluding or Ignoring Older Patients' Opinions

Excluding older patients' opinions from doctor-patient interaction is yet another form of ageist discrimination. The examples of such discrimination are shown in Table 4.

Table 4

Ageism and Exclusion of Older Persons

Participant No.	Response	Country	Gender
17	They sometimes show no empathy. I remember one day I was in a physician's clinic, they assumed I must be a blood pressure patient.	Pakistan	Male
18	*Doctor*: I know how you feel. I will prescribe the medicine, and you will get well. *Patient*: But I have taken this medicine… *Doctor*: Yes, take more and it will show its effects.	Pakistan	Male
19	Patients talk a little while doctors talk so much and sometimes, they may talk you down.	Malaysia	Male
20	A doctor may take it for granted that his/her opinion is the final opinion in all the heath related matters.	Pakistan	Female
21	For instance, they don't like their patients asking too many questions, and this shows that they are authoritative in their interaction.	Pakistan	Male

Elderspeak is a kind of patronizing speech used against older patients (Schroyen et al., 2017). Responses in Table 4 show how elderspeak is used against older patients. A patronizing tone in doctor-patient interactions can reflect arrogance, exclude older patients' opinions, and lead to doctor interruptions. Showing no empathy towards older patients and linking a disease (blood pressure)

with them (response 17) demonstrates how ageist opinions are foregrounded in doctor-patient interaction and how older patients' opinions are excluded. According to Afzaal et al. (2020), doctor-patient interaction does not contain solidarity towards older patients. In contrast, response 17 in Table 4 shows a lack of empathy and tenderness in ageist doctor-patient interactions. Response 18, "take more, and it will show its effects," shows a rude expert attitude towards the older patient. The doctor rudely commands the patient to take more medicine and seeks his (patient's) compliance. According to Wyman et al. (2018), ageist doctors negatively describe older persons' health problems. However, response 18 in Table 4 shows how ageist doctors can be rude by imposing their opinions and sidelining older patients' opinions, and how such rudeness results in the negative description of older patients' health problems.

Moreover, talking down to older patients (response 19), doctors' dominating behaviour (response 20), and a lack of tolerance for patients' questions (response 21) are all instances of arrogant behaviour and manifestations of elderspeak. The use of elderspeak in doctor-patient interaction is doctor-centered because it suppresses older patients' voices. Through such ageist discourse, doctors patronize their older patients and present themselves as more knowledgeable and authoritative. Both Malaysian doctors and Pakistani doctors were reported to talk down to their patients and rudely respond to their questions. In line with Levy's (2009) stereotype embodiment theory, data in Table 4 show how ageism operates through epistemic marginalization and interactional exclusion. Such age-based stereotypes are internalized and expressed in the later phase of life.

Treating Older Patients as Children

Treating older patients as if they were children is also an instance of ageism, and this is now discussed (Table 5).

Table 5

Degradation of Older Persons

Participant No.	Response	Country	Gender
22	Older patients' minds are like children. My doctor once said that to me.	Malaysia	Male
23	*Grandpa, your minds runs like a child's mind. I did not like it.*	Malaysia	Male
24	Often, doctors tell me that older persons are like children as they cannot deal with their health problems on their own. He meant to say we rely on caregivers.	Malaysia	Female
25	Conversation is short as if he is addressing a little child.	Pakistan	Male
26	A doctor said: "Older persons like children ask so many questions".	Pakistan	Male

Older patients are treated as people who are like children (see responses in Table 5). Doctors assume that older patients think as children do (see responses 22 and 23) and rely on caregivers to solve their problems (response 24). Denying older persons' many years of experience and comparing their thought processes with those of inexperienced children's cognitive processes is an ageist way of degrading older patients. This degradation of older patients is a key feature of doctor-centered interaction (Peck, 2011) because it places doctors at the center of interaction while dismissing older patients as childish. When older patients want more information about their health issues and ask doctors questions, this irritates doctors (response 26) who want to make conversation with older

patients as short as possible (response 25). Striking short conversations with older patients can be seen as an example of elderspeak, in which older people are spoken to as if they were children. Doctors should not be irritated; rather, they should patiently listen to their older patients and provide them with detailed answers to help them understand their health problems. In this way, doctors can make their interactions patient-centered and avoid what Wyman et al. (2018) call misunderstandings of older patients' health problems.

Denying older persons' right to ask questions, their dignity, or autonomy is also an example of ageist language. In doctor-patient interactions, doctors dominate the conversation and give their older patients limited time to describe their health issues. According to Levy (2009), such ageist stereotypes are internalized over the course of life and activated in the later phase of life. Older age should not be stigmatized, and healthy ageing should be encouraged.

In the context of Malaysia, older patients were reported to share psychological similarity with children, and they were accordingly treated like children (responses 22 and 23). However, in the context of Pakistan, older patients were shown to have verbal and behavioral resemblance with children as they asked many questions (response 26). These examples demonstrated how older patients were treated like children in doctor-patient interactions in the two countries, though there were differences in the treatment approaches.

It is evident that doctors, as reported by participants, in Malaysia and Pakistan, use ageist language in interaction with their older patients. Such doctors were reported to employ ageist language, ridicule older patients, emphasize their perceived ineffectiveness, disregard their opinions, and adopt a patronizing approach that infantilizes them. These multiple ways of misrepresenting older patients reinforce doctor-centered interaction and go beyond Afzaal et al.'s (2020) description of doctor-patient interaction that lacks familiarity, solidarity, and commonality. Participants in this study were negatively described in ageist terms. For example, ageist terms, such as "weak, diseased, and emotional," were used to refer to older patients. In contrast to a study by David et al. (2022), which examined a specific context in Pakistan's Sindh province, this study explored cross-country responses to examine how ageist perceptions of weakness in doctor-patient interaction varied across two settings. For example, a Malaysian doctor conceptualized weakness as the lack of vitality (response 2), while a Pakistani doctor viewed weakness as a need for rest (response 1).

Doctor-centered interaction mocks older patients by providing a positive view of youth and a negative view of older age (responses 9, 10, 11, and 12). As this study has illustrated, many doctors in Malaysia and Pakistan use metaphorical (response 8) and literal language to make fun of their older patients. That said, the very fact that these doctors are mocking and disrespecting their older patients means that they are implicitly discouraging patient-centered interaction. Focusing on these ageist dimensions in doctor-patient interaction provides insights into how older patients are treated in healthcare communication. While no older patients in this study reported their desires of "like to look young" in the ageist sense of the term (idolizing youth and mocking older age), critical scholars of doctor-patient interaction like Ananchenkova (2024) remind us that such definitions of "like to look young" can violate the trust between doctors and patients. A critical view of ageist mockery in doctor-patient interaction that extends beyond Ananchenkova's (2024) idea of a violation of trust is older patients' perception of detesting mockery (response 10), as it can enable them to question doctors' mockery and navigate ageist systems. Sometimes this ageist mockery targets physical changes (e.g., wrinkles), while at other times it equates older age with unhealthiness (response 11). This dynamic nature of ageist mockery reflects, to some extent, what scholars may refer to as doctor-centered interaction (Peck, 2011; Yacoob & Yazid, 2021). To have their healthcare needs met, older patients rely on doctors who mockingly view them as a burden on national healthcare resources.

Doctors' perception of older patients as socially ineffective emerged as another dominant theme in our study. In other words, older patients were seen as futile/useless. In doctor-patient interactions, patients are not at the center. They are mostly at the receiving end of the interaction. Doctors showing irritation or anger at the questions older patients ask is also a sign of ageism. Demonstrating patience when addressing/interacting with older persons is important because angry behavior can hurt the feelings of older patients. Although doctors may make a handsome income by treating older patients, they continue to use ageist language against older persons. For instance, they claim that older people are not able to look after their health and cannot protect themselves against diseases. Associating immunity deficit with older patients is also a sign of ageism, and such negative views of older patients are commonly found in doctor-centered interaction (Peck, 2011).

Doctors use a different way (elderese) to address or interact with older people. Participant 1 mentioned that doctors prefer a 'different' method of speaking with older patients. This different speech may categorize older persons as diseased, weak, and unhealthy. According to participant 2, doctors presuppose that older persons tend to have serious health issues. These responses are in line with Schroyen et al.'s (2017) idea of how doctors use elderspeak to patronize and dominate interaction with older patients. Such verbal and behavioral patterns (patronization and domination) are ageist because some doctors selectively use these in their interactions with older patients.

Not giving due respect to older patients and treating them as though they were children is yet another kind of ageism. Information provided by older patients to their doctors is not taken seriously,, and doctors tend to impose their views on them. Moreover, doctors showing pity to their older patients is also a form of ageism. Such degradation of older patients takes away their right to speak/respond to their doctors. It adversely affects the dignity and autonomy of older patients. Unlike Afzaal et al.'s (2020) study on the lack of familiarity, commonality, and solidarity as key components of doctor-patient interaction, this study discusses how denying older patients their rights, harming their dignity, and challenging their willpower are key components of doctor-patient interaction. These ageist and dehumanizing speech acts should be replaced by the use of inclusive and polite language. Care should be taken when interacting with older patients.

This analysis is a snapshot in time and context of the doctor-patient interactions. Future research can examine how ageist doctor-patient interactions are shaped by socio-cultural factors across a range of contexts. Further, as a limitation, participants (older patients) were selected from two countries; other researchers can select participants from different contexts and include doctors' voices to provide a balanced view of doctor-patient interaction. Older patients are not simply recipients of medical/health care; they navigate their own independent pathways to feel respected, and they should be treated with respect.

The findings highlight the need for more age-inclusive interactional practices in clinical settings in Pakistan and Malaysia. Ageist language, demonstrated through assumptions of incapacity, dismissal of patients' opinions, infantilization, and ridicule, can undermine older persons' willingness, trust, and dignity. The cross-country differences manifested in this study indicate that ageism can surface in distinct interactional forms. These insights underscore the importance of integrating geriatric communication training into ongoing professional development and medical curricula, with particular focus on recognizing and avoiding ageist discourse. Such training needs to emphasize shared decision-making, respectful dialogue, and the acknowledgement of older persons' lived reality, thus ameliorating doctor-patient rapport and healthcare outcomes.

Theoretically, this study extends Levy's (2009) age-stereotype embodiment theory by showing how age stereotypes are internalized by older persons and enacted and reinforced through institutional discourse, such as doctor-patient interactions. Contextualizing ageism within everyday clinical

interaction, the findings of this study demonstrate how clinical encounters work as key sites where ageist stereotypes are discursively created and normalized. The comparative dimension in this study helps enrich gerontolinguistic scholarship by illustrating that the embodiment of age stereotypes can vary across socio-cultural settings, shaping the tone and content of ageist language. Therefore, this study adds to ageism research by integrating stereotype embodiment theory with discursive analyses of healthcare interaction, providing a more comprehensive understanding of how macro-level age ideologies materialize in micro-level interactional practices.

Conclusion

This study focused on the use of ageist language in doctor-patient interactions in Malaysia and Pakistan. A comparative analysis of the data was provided, drawing on Levy's (2009) SET with a discourse lens. Analysis of interviews revealed how some doctors used ageist discourse against older persons in Malaysia and Pakistan. Comments and assumptions were made that excluded the opinions of the older patients, which, in the perceptions of the patients, reflected their being degraded and feeling that their right to speak was being denied. The study has implications related to language use in doctor-patient interactions in healthcare settings. It informs that ageist language used with patients in Pakistan and Malaysia creates hierarchical relationships between doctors and their older patients. Therefore, it is suggested that prejudice against older people must be reduced through training and workshops arranged for medical professionals, such as doctors. Such trainings and workshops can help doctors achieve age-critical consciousness and contest ageism in healthcare settings.

Although this research used a small sample of 30 participants across two settings, a much larger sample could be used, and more study sites could be included to report similar/different findings. Future research can thus help develop a more nuanced and holistic understanding of this problem, reducing ageism against older persons in a range of contexts. There is also a general tendency to recall the negatives when recalling an encounter. Therefore, in the next research article, we will seek permission to sit in on doctor-patient encounters so that we can investigate both sides of an interaction. Educational interventions are also a powerful tool for promoting cultural change, diminishing ageism-related prejudices and misconceptions in future healthcare, and reducing the use of ageist language.

Conflict of Interest Statement

We have no conflict of interest to declare.

AI Disclosure

Artificial Intelligence (AI) tools were not employed at any stage of the research process or manuscript development.

References

Afzaal, M., Khan, M., Bhatti, A. G., & Shahzadi, A. (2020). Discourse and corpus based analysis of doctor-patient conversation in the context of Pakistani hospitals. *European Journal of Social Sciences*, *8*(4), 732-752. https://tinyurl.com/yzdn7mjy

Ali, A., Bakhsh, I., & David, M. K. (2026). Integrating older persons' narratives of resistance with critical discourse analysis to counter ageist discourses. *Discourse & Society*, *37*(1), 22-43. https://doi.org/10.1177/09579265251341468

Ananchenkova, P. I. (2024). Ageism in the doctor-patient relationship. *Problems of Social Hygiene, Public Health and History of Medicine*, *32*, 1053-1056. https://doi.org/10.32687/0869-866X-2024-32-s2-1053-1056

Beneito-Montagut, R., Begueria, A., & Cassián, N. (2017). Doing digital team ethnography: Being there together and digital social data. *Qualitative Research*, *17*(6), 664-682. https://doi.org/10.1177/1468794117724500

Chin, Y. W. (2021). Impact of doctor-patient communication in health status of the Indigenous people in peninsular Malaysia. *Journal of Social Sciences and Humanities*, *18*(2), 29-39. https://tinyurl.com/8mrje3wr

Cronshaw, S. F. 2012. Aging workforce demographics in Canada: Occupational trends, work rates, and retirement projections. In W. C. Borman & J. W. Hedge (Eds.), *The Oxford handbook of work and aging* (pp. 99-114). Oxford University Press.

Daniel, B. K. (2019). Using the TACT framework to learn the principles of rigour in qualitative research. *Electronic Journal of Business Research Methods*, *17*(3), 118-129. https://doi.org/10.34190/JBRM.17.3.002

David, M. K., Ali, A., & Shah, S. A. (2022). Investigating older persons' perceptions of ageist language and its use: Focus on Sindh, Pakistan. *International Journal of Language Studies*, *16*(4), 157-177. https://tinyurl.com/2ydn49fk

Greene, M. G., Adelman, R., Charon, R., & Hoffman, S. (1986). Ageism in the medical encounter: An exploratory study of the doctor-elderly patient relationship. *Language & Communication*, *6*(1-2), 113-124. https://doi.org/10.1016/0271-5309(86)90010-8

Harvey, J. (2023). Gaining ethical approval. In J. Gourad (Ed.), *Educational research for early childhood studies projects* (pp. 44-56). Routledge. https://doi.org/10.4324/9780429350931

HelpAge International. (2022, October 24). Ageing population in Pakistan. *HelpAge Asia*. https://tinyurl.com/2s49w3u8

Jalil, A., Zakar, R., Zakar, M. Z., & Fischer, F. (2017). Patient satisfaction with doctor-patient interactions: a mixed methods study among diabetes mellitus patients in Pakistan. *BMC Health Services Research*, *17*(1). https://doi.org/10.1186/s12913-017-2094-6

Jamil, S., Sattar, T., Ullah, M. I., & Kafait, A. (2022). Doctor-patient communication and its effects on patients' quality of life in public hospitals of Multan city, Pakistan. *Rawal Medical Journal*, *47*(4), 1022-1025. https://tinyurl.com/49bbasyf

Kanwel, S., Ma, Z., Li, M., Hussain, A., Erum, N., & Ahmad, S. (2024). The influence of hospital services on patient satisfaction in OPDs: Evidence from the transition to a digital system in south Punjab, Pakistan. *Health Research Policy and Systems*, *22*(1). https://doi.org/10.1186/s12961-024-01178-8

Lowe, A., Norris, A. C., Farris, A. J., & Babbage, D. R. (2018). Quantifying thematic saturation in qualitative data analysis. *Field Methods*, *30*(3), 191-207. https://doi.org/10.1177/1525822X17749386

Marshall, B. L., Dalmer, N. K., Katz, S., Loos, E., López Gómez, D., & Peine, A. (2022). Digitization of aging-in-Place: An international comparison of the value-framing of new technologies. *Societies*, *12*(2), 35. https://doi.org/10.3390/soc12020035

Mohajer, L., & Endut, N. (2020). The role of gender and status in communication between doctors and patients in Malaysian contexts. *Kajian Malaysia*, *38(Supp.1)*, 89-108. https://doi.org/10.21315/km2020.38.s1.6

Mustafa, R., Mahboob, U., Khan, R. A., & Anjum, A. (2023). Impact of language barriers in doctor – Patient relationship: A qualitative study. *Pakistan Journal of Medical Sciences*, *39*(1). https://doi.org/10.12669/pjms.39.1.5805

NiiLaryeafio, M., & Ogbewe, O. C. (2023). Ethical consideration dilemma: Systematic review of ethics in qualitative data collection through interviews. *Journal of Ethics in Entrepreneurship and Technology*, *3*(2), 94-110. https://doi.org/10.1108/JEET-09-2022-0014

Nordin, N., MohdHairon, S., Yaacob, N. M., Abdul Hamid, A., & Hassan, N. (2020). Effects of family doctor concept and doctor-patient interaction satisfaction on Glycaemic control among type 2 diabetes mellitus patients in the Northeast Region of peninsular Malaysia. *International Journal of Environmental Research and Public Health*, *17*(5), 1765. https://doi.org/10.3390/ijerph17051765

Peck, B. M. (2011). Age-related differences in doctor-patient interaction and patient satisfaction. *Current Gerontology and Geriatrics Research*, *2011*, 1-10. https://doi.org/10.1155/2011/137492

Rehman, A., & Diah, N. M. (2020). Managing Women's Matter: A cross-cultural study of doctor-patient relationship in Pakistan and Malaysia. *Intellectual Discourse*, *28*(2).

Salim, H., Young, I., Lee, P. Y., Shariff-Ghazali, S., & Pinnock, H. (2022). Insights into how Malaysian adults with limited health literacy self-manage and live with asthma: A photovoice qualitative study. *Health Expectations*, *25*(1), 163-176. https://doi.org/10.1111/hex.13360

Samra, R., Griffiths, A., Cox, T., Conroy, S., Gordon, A., & Gladman, J. R. (2015). Medical students' and doctors' attitudes towards older patients and their care in hospital settings: A conceptualisation. *Age and Ageing*, *44*(5), 776-783. https://doi.org/10.1093/ageing/afv082

Schroyen, S., Adam, S., Marquet, M., Jerusalem, G., Thiel, S., Giraudet, A., & Missotten, P. (2017). Communication of healthcare professionals: Is there ageism? *European Journal of Cancer Care*, *27*(1), e12780. https://doi.org/10.1111/ecc.12780

Shah, S. A., Safian, N., Ahmad, S., Nurumal, S. R., Mohammad, Z., Mansor, J., Wan Ibadullah, W. A., Shobugawa, Y., & Rosenberg, M. (2021). Unmet healthcare needs among elderly malaysians.

Journal of Multidisciplinary Healthcare, *14*, 2931-2940. https://doi.org/10.2147/jmdh.s326209

Shaikh, G., & Parrish, A. (2023). *A quick guide to research methods for dissertations in Education*. https://tinyurl.com/hpyyaspx

Statista. (2023, August 29). *Malaysia: Aging population 2022*. https://tinyurl.com/4ekkj76z

Statista. (2024, May 30). *Pakistan - Age structure 2022 | Statista*. https://tinyurl.com/4kkbs4cj

Stypinska, J., & Nikander, P. (2018). Ageism and age discrimination in the labour market: A macro-structural perspective. In L. Avalon & C. Tesch-Romer (Eds.), *Contemporary perspectives on ageism: International perspectives on aging* (vol. 19, pp. 91-108). Springer. https://doi.org.10.1007/978-3-319-73820-8_6

United Nations [UN]. (2025). *Property articles by Og*. https://tinyurl.com/3wv8x2v7

World Health Organization [WHO]. (2021). *Ageism*. World Health Organization (WHO). https://tinyurl.com/3vczd3at

Mendez, A., Lopez, M., Rodriguez-Quintanilla, K., & Carrion, B. (2022). Ageist no more: Interprofessional training for undergraduate healthcare students. *Geriatrics*, *7*(1), 17. https://doi.org/10.3390/geriatrics7010017

Wyman, M. F., Shiovitz-Ezra, S., & Bengel, J. (2018). Ageism in the health caresystem: Providers, patients, and systems. In L. Ayalon & C. Tesch-Romer (Eds.), *Contemporary perspectives on ageism: International Perspectives on Aging*. Springer. https://doi.org/10.1007/978-3-319-73820-8_13