

The Middle East

Health, Health Care, and Medical Education in the Arab World

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To clarify the scope of this chapter and also to sharpen the reader's "sense of the comparative" in medical sociology it should be noted that this chapter has a special feature. This chapter, on the Arab world, embraces a cultural-geographic region rather than a single nation, or an entire continent.

For this reason it is important to delineate "the Arab world." Here the author makes use of the Arabic language as the defining criterion of what makes a person an Arab and, by extension, the provenance of the Arab world. In making this choice, I follow in the path of many specialists in Arab studies. A leading example is the Hungarian scholar Raphael Patai. In explicating "the Arab mind," he wrote that an Arab is "one whose mother tongue is Arabic" (Patai 1976: 43). Patai shows that linguistic identity is the major basis for social solidarity and he traces out related historical, ethnic, cultural, and geographic features of the Arab world. Mansfield (1985) and Burton (1932) stress the linguistic criterion still more by arguing that Arabic as a spoken language has a special formative energy that blankets and infuses consciousness more strongly than other languages; Burton even likens the Arabic language, as a vehicle of expression, to the faithful wife who follows her husband's mind and gives birth to his conceptions or thoughts.

One can draw up a list of countries in which Arabic is the predominant language. These countries fall into two geographic clusters: countries in south-west Asia, and countries in North Africa. The countries in the first group are: Bahrain, Iraq, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, United Arab Emirates, and Yemen. The countries in the second group are: Algeria, Egypt, Libya, Mauritania, Morocco, The Sudan, and Tunisia.

The Arab world is centered in the Middle East, which is well known for being the cradle of the monotheistic religions of Judaism, Christianity, and Islam.

Measured by the number of adherents in the contemporary Middle East, Islam far exceeds Judaism and Christianity. However, it is a mistake to regard the Arab world as equivalent to the domain of Islam. This view, though widely held, is wrong on two counts. First, the majority of Muslims in the world are not Arab (i.e. Arabic-speaking). Turkey, Iran, Pakistan, and Indonesia all have populations that are predominantly to overwhelmingly Muslim but not Arab. Indeed, Arabs constitute much the smaller proportion – not more than one-quarter – of the world's Muslims. Second, some Arabs are not Muslims. Egypt, Lebanon, Iraq, and Jordan all have Christian minorities that have played an important part in earlier and recent history in the educational and professional development of the nation including its health services. Just as Europe is predominantly but not exclusively Christian, so the Arab world is predominantly but not exclusively Muslim. Even in the Saudi Arabia – the heartland of Islam – there are tribal groups that were historically Christian.

THE SOCIAL, DEMOGRAPHIC, AND HEALTH STATUS OF ARAB COUNTRIES

Aggregate and mean statistics that depict the health status of the Arab world as a whole would necessarily conceal sizable variations between nations and also within single nations. Despite their heterogeneity, it can nevertheless be stated that the nations of the Arab world are developing societies, not industrial societies. Even the Gulf Arab nations, stretching from Kuwait to Oman, although they enjoy what might be called an “industrial level” of wealth, are not industrial societies. They lack widespread industry and commerce; their wealth depends almost entirely on petroleum.

Tables 22.1 and 22.2 convey basic information on social, demographic, and health features of Algeria, Egypt, Lebanon, and Saudi Arabia. These nations occupy distinctive niches within the Arab world. With 66 million people, Egypt is the most populous Arab nation; Cairo, its capital, is one of the world's largest cities and presents all the problems of density and sprawl that beset metropolitan areas throughout the Third World. Algeria and Lebanon have, since the post-colonial epoch at the end of World War II, both liberated themselves from European-French domination; both have been rent by sectarian/religious violence jeopardizing the health and well-being of the population as well as economic and social progress. In addition to its wealth, Saudi Arabia sees itself as the titular leader of the Islamic world because the Muslim holy cities of Mecca and Medina are located in it.

Table 22.1 sets forth important social features of the four nations. Table 22.2 deals with demographic and health features. Over and above what the sheer numbers reveal, three general comments are in order.

First, these are nations with relatively high fertility rates and high population growth rates. Their growth is almost entirely due to natural increase (the excess of births over deaths) rather than migration. Their present populations are youthful, with many children and adolescents, and relatively few elderly persons. However, as the figures on life expectancy presage, the elderly component will

Table 22.1 Social characteristics of four leading nations in the Arab world: Algeria, Egypt, Lebanon, Saudi Arabia

	<i>Total population in millions (1998)</i>	<i>Annual growth rate (1978–1998)</i>	<i>Gross National Product per capita (1995)</i>	<i>Average years of education *</i> (1990)		<i>Adult literacy rate (1995)</i>	<i>Dependency ratio ** (1998)</i>
				<i>Females</i>	<i>Males</i>		
Algeria	30.1	2.7%	\$1,600	1.9	3.8	62%	70
Egypt	66.0	2.3%	\$790	2.3	5.0	51%	68
Lebanon	3.2	0.8%	\$2,660	–	–	79%	64
Saudi Arabia	20.2	4.4%	\$7,040	–	–	63%	78
The World	5,885	1.6%	–	4.5	6.6	–	59

Notes: *refers to adult population (aged 25+); **ratio of population ages 0–14 and 65+ to population 15–64.

Source: adapted from *The World Health Report* for 1998 and 1999, Geneva, Switzerland: WHO.

Table 22.2 Demographic/health characteristics for four leading nations in the Arab World: Algeria, Egypt, Lebanon, Saudi Arabia

	<i>Infant mortality rate (1998)*</i>	<i>Maternal mortality rate (1990)**</i>	<i>Total fertility rate (1998)***</i>	<i>Life expectancy (1998) (years)</i>		<i>Total health expenditures as a percentage of GDP (1995)</i>	<i>Public sector health expenditures as a percentage of total (1995)</i>
				<i>Females</i>	<i>Males</i>		
Algeria	44	160	5.4	70	68	4.6	73
Egypt	51	170	3.4	68	65	3.7	43
Lebanon	29	300	2.7	72	68	5.3	39
Saudi Arabia	23	130	5.8	73	70	3.1	–
The World	57	430	2.7	69	65	5.2	48

Notes: *per 1,000 live births; **per 100,000 live births; ***average number of children born to a woman of reproduction age.

Source: adapted from *The World Health Report* for 1998 and 1999, Geneva, Switzerland: WHO.

increase rapidly in decades to come. As in other developing nations (Gallagher et al. 2000) the fertility rate, though still high by western standards, has dropped considerably within the past 20 years. Longevity is increasing substantially for the middle-aged and elderly. These four nations, along with the Arab world in general have moved a considerable distance along the path of the “epidemiologic transition.” As first enunciated by Omran, this transition is the massive demographic change that nations typically undergo in the process of industrialization; they move from the earlier combination of high birth and death rates to the “mature” phase of low birth and death rates (Omran 1971). In the earlier phase, life expectancy is low (in the thirties to forties); in the latter phase, it is high, reaching into the seventies and eighties.

Second, these four Arab nations stand low in education by comparison with the world population. Further, the “female shortfall” – the deficiency of education among women compared with men – is large. The nations with greater financial resources, such as Saudi Arabia, have made rapid strides in education in recent years. The opportunities for females are not far behind those available to males in primary and secondary education, but lag behind at the postsecondary level (more will be said below about the status of women in Arab society). In the poorer Arab countries such as Yemen and Egypt, educational opportunity is limited at all levels, especially for females. Lack of schooling of course shows up later on in the form of low adult literacy.

Third, some notion of health care outlays in the four countries can be obtained from table 22.2. A rough guide to the average expenditure per person can be obtained by multiplying the per capita income (table 22.1 – Gross National Product per capita) by the percentage of national income (approximated by the gross domestic product) devoted to health expenditures (table 22.2 – Total health expenditures as a percentage of GDP). This simple arithmetic reveals that the average annual health expenditure for an Algerian is \$74; for an Egyptian, \$29; for a Lebanese, \$141; and for a Saudi, \$218. All four nations have a skewed distribution of income in which there are small proportions of well-to-do persons and many poor persons. However, Saudi Arabia is unique in that its ruling family (the house of Al Saud) is both large, with some 8,000 adult members, and immensely rich; however, the lower end of the Saudi spectrum is comparatively better off than the low end in Algeria, Egypt, and Lebanon, with corresponding favorable implications for health services and health status in the Saudi case.

ARAB VALUES AND THE SICK ROLE

Sociologists and anthropologists have frequently observed that, in developing societies, social relationships are suffused by a yearning for emotional warmth and interpersonal affiliation. Many sociological frameworks that contrast modern civilization and traditional society recognize this feature. In Talcott Parsons’ (1951) well-known scheme of pattern variables, social relationships in traditional societies are particularistic, ascriptive, affective, and diffuse. These quali-

ties enhance the sense of trust, mutual concern, and reliability within a relationship.

Nowhere in the developing world is the striving for personal bonds, for affiliation, and the glow of intimacy stronger than in Arab society. A well-known Arab rhyming aphorism goes: "Jarr qabla darr w rafeeq qabla tareeq." It translates into "[Choose] your neighbor before your house and [choose] your companion before your journey." While it cannot be taken literally, it probes into the personalistic, personalizing nature of the Arab culture that spawned it. This quality of social relationships has implications for medical care, as will be seen below.

A second characteristic of Arab society with great relevance for medical care is the high value it places upon helper roles and helping activities. Of course, all societies would cease to exist if parents did not nurture their children – nurture as a radical form of helping is vital. Yet more than in most other societies, Arab society weaves helping activities into the social fabric, so that the giving of help becomes a constitutive or basic cultural value and not merely a source of benefit to the person who is helped.

These two characteristics of Arab culture coalesce to form another strong cultural formation: a high tolerance for dependency in the sick role. Medical sociologists will recall Parsons' formulation whereby the sick person is relieved of their usual social responsibilities in proportion to the discomforts and disabilities imposed by the illness and also the requirements of treatment.

It is not within the scope of this chapter to engage in a full exploration of the sick role. However a basic question for medical sociology can be raised: should the sick role be understood as a universal, impervious to cultural modification – or is it significantly shaped into variant forms by cultural values (Gallagher and Subedi 1992)? This question has obvious import for the theory of the sick role, for medical sociology more generally, and for the delivery of culturally sensitive medical care. The view of the author is that the sick role is indeed universal within broad limits; but it is nevertheless important here to discern the nuances that impinge upon it in Arab culture.

Arab culture is notably indulgent toward sick-role dependency. Here are three case-examples that would be difficult to duplicate in American society.

1 An example of "feeding dependency" comes from the observations of an American physician who spent several years as a personal physician to the royal family, Al Saud, in Saudi Arabia. He reports the following episode (Gray 1983: 45). The patient was a 60-year-old cousin of King Khalid. He was hospitalized for ulcer distress:

Since an ulcer diet was an important part of the treatment, the next step was to devise a diet that the prince would be willing to follow. I consulted with the dietician and recommended rice, yogurt, and camel's or goat's milk to start with. These were among the prince's favorite foods. He seemed content, provided his servant prepared the food and fed him spoonful by spoonful. I watched this nursery scene for a few moments and then left.

2 A 50-year-old female bedouin patient received hemodialysis at a tertiary care hospital in the Negev desert of southern Israel. She was married and, like most of the seminomadic Arab bedu, of low socioeconomic status. Because of vascular damage from diabetes (which was also the cause of her renal failure), her right leg was amputated. Following that, she was provided with a prosthesis, crutches, and a wheelchair. Hospital staff noted, however, that she rarely used her prosthesis or crutches; instead, her sons and grandsons regularly carried her or pushed her in the wheelchair. The patient's dependence upon kinsmen for mobility is consistent with the more general observation made by the staff (Lewando-Hunt et al. 1980: 10):

There is a specific cultural attitude amongst the Bedouin toward the chronically sick and the handicapped which both gives them support but also encourages them to be dependent on their family. One's family is expected to adjust to one's limited functioning. They have no expectations of rehabilitation. The blind are assumed to be unable to undertake any physical activity without guidance. The deaf are not expected to know how to lip-read. Their relatives and friends learn how to communicate by gesture. In the case of the dialysis patients, there is a readiness to care for them, even unnecessarily.

3 The third example is a female adolescent patient in Kuwait who was born with severe congenital anomaly known as spina bifida. With prompt, and continuing, medical and surgical treatment she survived (Gallagher 1998). As she grew, her physical development was arrested and she resorted to a wheelchair for mobility. Also she was incontinent of urine. She and her family, who were wealthy, were instructed that she should urinate through a device known as a Foley catheter, inserted in her vagina and re-inserted every day or two. This was uncomfortable for her (as it is for many similar patients). Despite medical admonitions, her family gave in to her complaints and allowed her to urinate freely into diapers. She began to suffer an intermittent urinary/kidney infection. This led over time to chronic renal failure and necessitated her being started on hemodialysis three times weekly.

Although the cause of her kidney failure cannot be attributed solely to the family's indulgence of her discomfort with the catheter, this factor did contribute to her renal failure. In the first two case-examples, the patient's condition was not worsened by the latitude of their support system. In the case of the adolescent girl, whose medical plight was worse from the outset, it contributed to a severe yet necessary outcome, namely, hemodialysis.

ENVIRONMENTAL AND CULTURAL FACTORS CONTRIBUTING TO ILL HEALTH

The Arab world lies substantially in tropical latitudes. It has environmental and climatic conditions favorable to the spread of parasitic diseases such as malaria, schistosomiasis (spread by snails exposed to human feces), and leishmaniasis (spread by sandflies). These occur especially in regions that lack safe

drinking water and sanitation. Other common parasitic diseases are onchocerciasis (leading often to “river blindness”) and helminthiasis (i.e. tapeworm infestation).

Cultural-sanctioned practices may also pose a health risk. Consanguineous marriage – marriage between close relatives such as first or second cousins, or uncle/niece – increases the probability of genetic disease or disability. Consanguineous marriage – “inbreeding” – is widespread in developing societies (Bittles et al. 1991) and in tradition-oriented segments of industrial societies such as the Amish sect in the United States (McKusick et al. 1964). It raises the likelihood of genetically-determined diseases and conditions that would be rarer if marital or mating partners were drawn from a wider, more “public” pool of breeding candidates.

A Saudi study of 9,061 households conducted in 1987–8 showed that 34 percent of marriages of females in urban areas were with first cousins, 24 percent were with other relatives, and 42 percent were with non-relatives (Al-Mazrou et al. 1995). This is a high rate compared with western industrialized countries; it reflects basic features of Arab society. An individual’s family status and family connections are more completely determinative of his/her life-chances than in the West. In particular, opportunities for individualized careers, occupational differentiation, and cultural participation are limited, and much more limited for females than for males. The stronger role of family influence and the more restricted role of non-familial influences have many implications for choice of one’s marital partner.

The notion of marriage based upon love is certainly known and to some extent idealized in Arab society. However, there are few social opportunities for men and women to meet apart from situations arising from family circumstances. Although Arab life is intensely “social,” virtually all the sociability and social interaction are family-based or based upon same-sex relationships. Although the experience of the large extended family living under one roof is less widespread than formerly, the smaller nuclear families retain geographic contiguity and emotional closeness with each other. One’s individual life is densely filled with a round of religious feast-days and family events such as births, circumcisions, marital engagements, weddings, and funerals. Even in Arab metropolises such as Baghdad, Cairo, and Beirut, there is much less detached or alienated individualism than in New York or Paris.

Given this social pattern, it is not surprising that most Arab marriages are arranged by the parents or other older relatives of the marital partners. Though adverse genetic consequences of such arranged “close-in” pairings may occur, there are arguably at the same time several social advantages. Wealth and social status can be retained within the extended family. The bride and groom have the security of knowing a good deal about each other’s family of origination. Guidance and support can flow more easily from a shared cohort of older relatives.

If the negative genetic consequences of consanguinity could be weighed in a scale against the foregoing positive social consequences, in the light of full, objective information, many people would opt against the prevailing marriage pattern and hope for some other ways of providing guidance to young married

couples. Not surprisingly, laypersons do not figure in this manner. A study conducted in Saudi Arabia in 1988 found that, among a group of 36 families with children with metabolic and neurological disorders, many parents did not understand or accept probabilistic genetic explanations. They argued that if consanguinity were the culprit, then why were not all of their children afflicted (Panter-Brick 1991)? Many of them adhered to beliefs, such as the evil eye, that could allow for a particularized explanation why the afflicted child was different from his siblings.

THE ALLOCATION OF HEALTH RESOURCES

The Arab world faces critical dilemmas concerning the distribution of health resources for the present and projected future needs of the population. In confronting such issues, it is not distinctively different from other developing regions of the world. Indeed the industrialized nations face similar issues. One basic question is: what is the role of the physician in the overall delivery of health care, *vis-à-vis* the role of other health professionals? A related question concerns the balance between generalists and specialists within the medical profession. A further question concerns the place of the hospital in the health care delivery system.

Many health planners and public health authorities believe that there has been, worldwide, an overemphasis upon the production of physicians and the building of hospitals. This view has been clearly articulated by the World Health Organization (WHO) and expressed in its program, "Health for All by the Year 2000," frequently abbreviated to HFA/2000 (World Health Organization 1981). This program was first enunciated in 1978 in a WHO conference at Alma-Ata in the former Soviet Union.

The central official health authority in virtually every Arab nation has endorsed HFA/2000. By itself, this endorsement does not necessarily mean that there will be a major reorientation of health care priorities. While in no way degrading the strategic position of the medical profession in the delivery of health care overall, the WHO initiative aims to promote primary health care, much of which can be delivered by non-physician health professionals. It also endorses ambulatory and community care conducted outside of hospitals; additionally, WHO urges the establishment of national referral systems through which, when hospitalization is necessary, patients can be directed to the most appropriate level of care/treatment. This embraces the creation of local or district hospitals, provincial or secondary-level hospitals, and central or highly specialized tertiary-level hospitals (Barnum and Kutzin 1993). Decisions for the establishment of the foregoing, "rational," or planned scheme of health care would be made in the political or governmental domain.

In every country there is a division between health services that are politically or governmentally financed and administered, and those that are in the private sector, where market or economic forces prevail. Many countries that are currently characterized as poor and developing have a relatively small private sector; though often woefully underfinanced, the public sector is larger.

Table 22.2 gives a rough estimate of the public/private balance in Arab countries. It shows that, as a percentage of total health expenditures, the amount spent by the government (the public sector) is 73 percent in Algeria, 43 percent in Egypt, and 39 percent in Lebanon. The case of Egypt is of particular interest because of its status as the most populous Arab nation. If the balance between public/private is 43/57, this roughly implies that governmental decisions cannot reach beyond 43 percent of total health outlays and correspondingly that the bulk of spending and provision lies in the private sector. This sector includes the services of private physicians, the large majority of whom in Egypt are specialists. It includes also the services of dentists and pharmacists, the latter being exceedingly important within the overall mix of health services in Arab countries. It includes as well private hospitals. In Egypt many private hospitals are relatively small, 10–20 bed hospitals owned by private physicians who also provide most or all of the medical services to their patients.

Another critical phenomenon in the Egyptian private sector is that Islamic organizations, also organized as political parties, have an extensive network of lay and professionally-trained persons who provide free health and medical services throughout the country, in both urban and rural areas. They are of particular importance in impoverished, underserved sections of cities. A newspaper account states: “Militants provide funds to the destitute, run clinics, mediate disputes and patrol against common crime” (Hedges 1992). Because the Islamic groups are private, voluntary organizations there are no reliable official statistics about the volume of services they deliver, in comparison with public and with private-market provision. It seems clear however that their contribution is substantial.

The Islamic-based organizations are not politically neutral providers of professional and technical services. On the contrary, they make partisan claims and wield political influence. Beyond the value of the clinical services they put forth, they seek to gain political–religious allegiance and to stir enthusiasm within the Egyptian populace. They argue that, in failing to offer effective health services, the national government is impotent, inefficient, and corrupt; they hold forth their own offerings as a demonstration of what can be accomplished through religious and cultural dedication (it is not clear, however, that they are themselves free of the faults which they see in the government). In Egypt they present an unusual model of “health service in the name of politics”; on a lesser scale, similar organizations and political–religious dynamics can be found in other Arab countries and in the West Bank (Greenberg 1992).

MEDICAL SCHOOLS IN THE ARAB WORLD

The eighteen countries comprising the “Arab world” (listed above) have among them, in 1999, 63 medical schools (also referred to as “medical faculties”). This figure is approximate and may be low by two or three schools. It comes from a WHO report published in 1988 (WHO 1988), supplemented by fragmentary information available to the author on schools more recently established. The report was based on a WHO questionnaire survey of all UN Member States.

Some countries (member states) gave incomplete responses. Each of the 18 nations has at least one medical school except for Qatar and Mauritania, which have none. Kuwait, Oman, and United Arab Emirates have one medical school each. At the other extreme, Iraq has six; Algeria, nine; and Egypt, nineteen. Among the oldest medical schools are: University of Baghdad (Iraq, founded in 1927); American University in Beirut (Lebanon, 1867); University of Khartoum (The Sudan, 1924); University of Damascus (Syria, 1919); and, in Egypt, University of Cairo (1827) and University of Alexandria (1942). Western colonial influence was strong in the Middle East and North Africa prior to World War II. The few medical schools started during this earlier period owe their establishment to western initiative. Later, under the recently decolonized national governments, many schools were begun in the fifties, sixties, and seventies. The most recently established is that in United Arab Emirates, which admitted its first class in 1986.

To study the dynamics of medical education in any developing country of the globe is to seize upon a particularly symbolic fulcrum for social change in that country. This is particularly true in the Arab world. Many countries in South America, Africa, and South Asia are undergoing struggles in the effort to modernize in the fast-paced era of economic and cultural globalization. Aside from industrial and commercial development, two pivotal features of modernization are the drive toward the implementation of scientific knowledge for human betterment and toward greater respect for the rights and the potential of the individual human being. Medicine and health care tie together these two objectives. Though increasingly assisted by other health professions, the physician remains the key actor. As proto-physicians, medical students are an especially strategic group for embodying national expectations and visions.

CULTURAL TENSIONS IN MEDICAL EDUCATION

Tension is felt in all developing societies between still powerful cultural traditions and the pull toward the future. Nowhere is the tension greater than in the Arab world. Medicine is seemingly a universally acclaimed and non-controversial ingredient in the formula for progress. Medical education of course goes along with medicine. What could be more solidly aligned with the future yet culturally impartial than the preparation of the next generation of doctors?

Yet there are within the structure of medical education in the Arab world several veins of controversy – features that call into question its Arab-Islamic legitimacy. These are: (1) the struggle to reappropriate the historic medieval Arab medical heritage as a contemporary guide in the medical school curriculum; (2) the use of western languages (especially English) with medical students as the “language of instruction”; and (3) the emancipatory pressure of medical learning and activity upon the traditional proprieties of gender.

These features of controversy will be dealt with serially below.

1 In the history of western culture it is an accepted truth that in the long interval between the end of Roman imperial culture and the western Renaissance, Arab scholars studied, translated into Arabic, and promulgated classical

Greek and Roman thought. Along with astronomy and mathematics, medical taxonomy, discovery, and application were particularly important (Khairallah 1946). Especially illustrious were Ibn Sina (or Avicenna: 980–1037), Al Zahrawi (936–1035), and Ibn Rushd (or Averroes: 1126–1198) (Ahmad 1991). Many Arab–Muslim physicians and medical educators, both in the Arab world and in the West, desire that these “forgotten” names and their accomplishments be celebrated so that current medical students will identify with a heritage that rapidly lost its vigor about five centuries ago. However, the general temper of medical education nowadays, whether in North America, Europe, the Middle East, or Asia, leaves little room for concern with the history of medicine (except as a specialized scholarly discipline). The desire of medical educators for revival seems at best nostalgic; it has not worked its way into medical curricula in the Arab world.

In contrast, the prospects for fresh interest in what might be called “traditional health care, Middle Eastern style” and its incorporation into medical education seem brighter (Pillsbury 1978). Belief in the evil eye, the practice of cauterization (touching afflicted portions of the body with hot irons), and potions to reverse female infertility would not find favor in medical schools. However much of the knowledge and technique possessed by community herbalists and midwives is of interest to medical educators. Just as so-called alternative medicine is being selectively adopted into western medical schools, so the equivalent process has favorable potential in the Arab world.

2 The issue concerning the use of Arabic as the language of instruction in medical education has a cultural dynamic similar to that concerning the history of Arab medicine. In both instances, it appears that an integral feature of Arabic–Muslim tradition has yielded to western cultural hegemony. In the WHO survey of medical schools, most schools list English as the language of instruction while those in former French-dominated regions – Tunisia, Morocco, Algeria, Syria, and Lebanon – list French. Some schools permit some lecturing in Arabic but virtually all written materials – textbooks, lab manuals, syllabi, teaching outlines, lecture handouts – are presented in English (or French).

Most of the faculty in Arab medical schools are Arabs. Many find it difficult to use English (or French) even though they obtained their higher degrees in European or North American universities. If non-Arabic languages are a stumbling block for faculty, it is even more so for the students. Questions arise about students who fail academically: are they simply weak students who lack intellectual capacity to master medicine – or are they bright students who are trapped by an inadequate command of the non-Arabic language of instruction (Gallagher 1989)?

On the surface, the issue seems straightforward but nevertheless difficult to resolve: should students learn medicine in their native language or another, more metropolitan language? Beneath the surface but close to it are a host of other issues which make it so difficult to settle – the nature of medicine, the place of science in medical education, the role of the physician in society, and the tensions between Arab and western culture.

One obvious fact is that almost all students in Arab medical schools are born and raised in Arab culture, and they look forward to a career of practice with

Arab patients. Given this, English often appears to be an artificial imposition. They do, however, have increasing amounts of exposure to English through the mass media and through primary and secondary education. Whether this exposure is sufficient to establish a base for learning medicine in English is hotly debated among the faculties.

Another question is this: is the physician primarily a technician who has learned a series of algorithms and techniques for treating patients – or is the physician a scientist who knows and understands the deeper, and always evolving, scientific principles that underlie techniques? Although this question vexes faculty in medical schools everywhere, it has special resonance in the Arab medical schools as suggested by this additional question: can the Arabic language and Arab–Muslim culture become a vehicle for scientific knowledge and discovery?

3 Given the strength of religio–cultural tradition in the Arab–Muslim world, it is not surprising that basic expectations about gender find expression in medical education. Medical education is gender-segregated by administrative policy throughout most of the Arab world though its stringency varies. Thus, Saudi Arabia, the most stiffly orthodox Arab nation, has separate campuses for male and female medical students; less conservative, the United Arab Emirates has separate classes, separate labs, and separate library facilities, but all using the same faculty. In Kuwait, there is no segregation policy – the prevailing patterns of interaction between male and female students approximate those in the West.

Given the sequestered and restricted movement of females in Arab public space, there is a gigantic built-in need for female physicians. As in western countries many female patients prefer female doctors; additionally, the male guardians of females – husbands, brothers, fathers, sons – do not wish their clients to be dealt with by male physicians. Thus, in most Arab countries, females constitute 40–60 percent of the total of medical students; once trained and registered, this sizable contingent of female physicians then meet the health needs of children as well as females in their society. Another factor that draws female students to medicine is that it is one of the very few professions open to females, particularly in the more conservative Arab countries. Indeed, the narrowness of vocational opportunity probably means that some female students are more concerned to prove themselves intellectually and academically in a general sense than they are specifically interested in medicine (Gallagher 1993).

A concomitant development in Arab medical education and medical care is that there is currently a shortage of academically qualified males who aspire to medical training and practice. This is an important trend that is not well understood sociologically; it has to do with the occupational aspirations of males. Many expect to find employment in private businesses of their fathers or other older male relatives, or in the national civil service (a major employer throughout the Arab world); while they may seek a university education, many of them lean away from the intensive type of professional training that medicine requires.

The relatively small number of qualified male applicants has given rise to sensitive and contentious discussions among medical educators. It has led one of the Arab Gulf countries to adopt a type of “affirmative action” policy that openly favors male applicants over female; males can matriculate with lower

secondary school grades and lower entrance test scores than females. The rationale for this differential standard is not that males have been discriminated against in the past; it is, rather, that without the differential some 70–80 percent of practicing physicians would, in ten years' time, be female. There would not be enough male physicians to meet the needs of male patients. Female medical students and physicians are concerned about the “double standard” but appear to accept it as a policy necessity for the present.

One recalls that, in the United States, studies of medical student recruitment and socialization were, among other events, an important springboard for the emergence of medical sociology. The same would certainly be true for medical sociology in the Arab world. A good starting point would be precisely the aforementioned troublesome dearth of male applicants for medical school. By itself it is a highly specific and narrow problem-phenomenon in search of a sociological explanation. Its solution however would require a systematic study of student socialization and progress across the full six-year university curriculum, covering its premedical, preclinical, and clinical phases. It would also verge upon questions and concepts that lie as much in general sociology as in medical sociology, such as the life-course expectations and aspirations currently held by young Arabs in their diverse family and social milieux.

ARAB MEDICAL SOCIOLOGY

This chapter will conclude with a brief examination of the topic alluded to above, namely, what is the current status of medical sociology in the Arab world? Relatedly, what is the status of general sociology there?

Sociology made its first appearance in the Arab world in Egyptian universities in the 1920s (Zayed 1997). Since then, it established itself in many other Arab universities. However, although it has achieved some breadth, its depth and cultural impact, along with that of the other social sciences, has not been substantial. Its influence has not been strong either in the universities or in general public discourse. In his account of Arab sociology, Bagader (1997) sees several reasons for this condition. One is the language barrier. Most sociology has been written in English, French, or German and has yet to be translated into Arabic. However, once translated or adapted, sociological material then appears to be “obscure and alien” – a second reason for the low impact of sociology. The few sociology textbooks written in Arabic are “based on American textbooks . . . which enforced the notion that sociology is totally a Western discipline that does not have anything to offer to Arab society and culture” (Bagader 1997: 68–9).

Probably the status of sociology will rise as the Arab world makes further progress toward democratic political institutions and toward a culture of open public discourse. It is possible meanwhile to draw a more encouraging picture of medical sociology. As in the United States and many European countries, medical sociology has grown and prospered by the adoption of sociological concepts and perspectives into the curricula of medical and other health professional schools (Cockerham 2000). Medical schools in Oman, Kuwait, United Arab

Emirates, and Saudi Arabia have in various ways drawn upon sociology as an important source of content, and upon sociologists to teach it. Typically the sociological content is conveyed within an interdisciplinary framework – in courses dealing for example with the biopsychosocial model of disease, or with medical interviewing. As in the West, the departmental sponsorship of “interdisciplinary medical sociology” varies widely and sometimes multiplies within the same medical faculty – departments of psychiatry, family medicine, behavioral sciences, community medicine, and preventive medicine are the major sponsors but occasionally sociological content and personnel are found also in clinical departments such as pediatrics and obstetrics.

A 1986 survey of research in Arab sociology by Sabagh and Ghazella (1986) reveals virtually no work that falls clearly within the domain of medical sociology. Since that time, three foci of research activity have emerged that deserve mention here, as follows:

1 Problems that nurses in Jordan confront have been investigated by Professor Muhanna Haddad in Jordan (Haddad 1988). He finds that many nurses felt disrespected and unappreciated in their work; they had difficult working conditions, and hospital administration ignored their complaints. Moreover those who were widows were “easily suspected of immorality and sexual deviance in a traditional society” (Haddad 1988: 3).

2 The Dubai Community Psychiatric Survey, conducted by Professor Rafia Ghubash (Ghubash et al. 1994), examined the effects of rapid and massive social change on the mental health of female nationals in the metropolis of Dubai, United Arab Emirates. On the basis of data gathered in her household survey, Ghubash found: “The overall rate of psychiatric disorder in Dubai . . . is high in international terms and this is consonant with the hypothesis that the rapidly changing culture of Dubai is stressful to its citizens . . . retaining some traditional values in the face of social change does not necessarily imply an increased risk of affective and neurotic forms of psychiatric morbidity . . . on the contrary, insofar as it represents a choice, it may be a prudent course of action” (Ghubash et al. 1994: 131).

3 In Saudi Arabia, Professor Zohair Sebai, in the Department of Family Medicine at the King Faisal Medical Faculty at Dammam, has studied the beliefs of rural Saudi bedouin groups concerning disease causation, family planning, and medical care (1985). Sebai found, with regard to birth control, that many bedouin women had a passive, accepting attitude toward future pregnancies, while approximately one-quarter said they wanted no more pregnancies. Bedouin men, in contrast, “don’t accept contraception . . . They always want more children, since children are a symbol of wealth, strength and vitality. They reason that it does not cost much, if anything to have one more child, as he or she will be raised with other children in the household” (Sebai 1985: 460).

The foregoing examples of research demonstrate the range of investigations being carried out by Arab investigators. For sociologists trained in the West, the Arab world offers a prodigious and intense arena of topics for research, most of them connected with processes of social change. It is not surprising, however, that there are difficult problems of access that hamper investigators coming into Arab societies as strangers. For this reason, we as medical sociologists must turn

to our Arab colleagues. We hope that research training and facilitation will increase among Arab sociologists (and other social scientists) and that future accounts will report steady progress toward increasing our understanding of health and health care in the Arab world.

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