

Re: Afghanistan and Oman Personal reflections on a profound contrast

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مؤنس الششتاوي

To the Editor,

The letter to the editor by Ken Foster "Afghanistan and Oman: Personal reflections on a profound contrast" published in the April 2010 issue of SQU MJ¹ presents an interesting review of some differences between Oman and Afghanistan in relation to the two countries' health care systems highlighting political stability, availability of finances, and the quality of decision making as enabling factors in favour of Oman.

Indeed, Dr Foster's letter has provided also a well articulated discussion of a number of questions that are related to the culture of health professions' training in both Oman and Afghanistan. Hearing of a large majority of female medical students enrolled in the private medical school in Sohar, Oman,¹ Ken Foster really raised the concern regarding "who gets into medical schools?" blaming society much more than the higher education system itself. Actually, this provides a good opportunity to reveal the whole picture for SQU MJ readers. Data of 2008 from Ministry of Health (MOH), which is the main provider of health services in Oman,² showed that 59.6% of the Ministry's Omani manpower forces were females.³ Indeed women outnumbered men in all medical and health categories [Table 1], with the exception of medical specialists/consultants whose numbers were more or less equal (208 males and 203 females).³ In 2008/09, the number of enrolled and graduated female students (Bachelor's degree level) in governmental, private medical/health sciences universities and colleges in Oman and abroad, and in basic and post-basic diploma studies in MOH training institutes also outnumbered male students with the exception of students studying medicine (Bachelor's degree) at Sultan Qaboos University [Table 2].^{3,4} The same bias towards the female side was also true as regards medical residents of Oman Medical Specialty Board (OMSB) sponsored by MOH [Table 2].^{3,4} This very clear "feminisation" of the medical/health sciences professions in Oman has reversed the male dominance of past years. Worldwide, a similar picture also exists. Back in the 1970s, only 10% of American doctors were women compared to one-third of the physician workforce today. In medical schools, they make up half the class.⁵

Foster¹ and others^{6,7} assume that female medical doctors are more likely to work part-time in order to have a family, leading to staffing problems. Even those who disagree with that opinion acknowledge that women doctors in the U.S. work less—47 hours per week on average, versus 53 for men. They also see about 10% fewer patients.⁵ Women are also less likely to take part in training or research,⁷ and are far more likely to choose specialties where they have "set" hours.⁶ To some extent, that is true in the case of Oman. Because working full-time is the routine for MOH doctors, 2008 statistics revealed an under-representation of female residents in specialties such as medicine, surgery, accident & emergency, anaesthesia and ear, nose & throat surgery,³ the ones that usually require being on-call most of the time. The problem is clearer in the nursing profession where more than 88% of Omani nurses working in MOH health institutes are females [Table 1]. The Omanisation ratio in the profession is increasing year on year, reaching 90% in some regions

Table 1: Omani manpower employed by Ministry of Health in 2008

Categories	Total	% Female
Doctors (General practitioners)	623	61.5
Doctors (Specialists/Consultants)	411	49.4
Dentists	100	55.0
Pharmacists	120	75.8
Nurses	6,014	88.3
Physiotherapists	101	60.4
Radiographers	316	60.8
Laboratory Technicians	618	70.7
Assistant Pharmacists/Dispensers	583	66.7
Dental Technicians	195	55.9
Dieticians	127	81.1
Health educators	134	99.3
Teachers/Tutors in MOH training institutes	87	71.3
Medical Orderlies	2482	67.5

with an average of 66% in 2009.⁸ Omani nurses prefer to work in institutions located near to their homes and tend to take more time off early in their careers. Within a year or two of entering practice, married nurses usually take several maternity and morbidity leaves. Subsequently, they often ask for more flexible hours, or morning only work, so other staff (mostly expatriate females who have left their families in their original countries) has to cover up the slack often creating bitterness and resentment. These circumstances threaten the delivery of high-quality care for MOH clients.

Others, including myself, look at the picture more positively. Dr McKinstry,⁷ researcher at the University of Edinburgh, noticed that, like in Oman, women are willing to take on "family friendly" specialties shunned by male doctors, such as primary care, pediatrics, and very recently obstetrics.³ Another defender, Professor Jane Dacre, at the University College London,⁷ said: "there is quite a developing evidence base that female doctors are not inferior to male doctors, but in fact are doing better in terms of getting into medical school

and in their exams". She added: "rather than worrying about having too many female doctors, there should be more focus on ensuring equal opportunities for medics throughout their careers". Like these experts, I think that society and the higher education system should not shoulder the blame. Although the recent rise in female medical/health sciences students and graduates is worrying, Oman should continue choosing the best candidates regardless of gender. However, flexible hours, on-site child care and part-time training/work options are needed to ensure female staff has equal career opportunities and time for their families. One should not forget that part-time work or a lighter workload also has its advantages. Many studies show that doctors who work fewer hours experience less burnout; moreover, a strong association has been proved between long working hours and medical errors.⁵

Another important concern raised by Ken Foster is about graduate education in the region and the emphasis on content or skill-set transmission to the trainee without adequate attention to the capacity for critical thinking.¹ I fully agree to that and assure that critical thinking simply means good thinking. Critical thinking skills enable the students to compare, analyze and critique information. Especially when the information content of a discipline is huge, it becomes even more vital to spend time to understand and evaluate this information, not just to learn more information. The result of evaluation can range from positive to negative, from acceptance to rejection or anything in-between.⁹

Thus, critical thinking is not necessarily being "critical". To some extent, the word 'critical' has a negative implication.¹⁰ In fact, a much more appropriate descriptive term to be used instead of "critical thinking", is "evaluative thinking". Evaluative thinking is based on reflective thinking that is focused on interpreting, analyzing, and evaluating information, arguments and experiences with a set of reflective attitudes, skills, and abilities to guide thoughts, beliefs and actions.¹¹ Using "evaluative thinking", an individual makes a decision or solves the problem of judging what to believe or what to do, but does so in a reflective way. In problem solving situations, students learn to generate ideas (by creativity) and evaluate ideas (by criticality). Although creativity occurs first in the process, it's best to begin with a foundation of critical thinking because wise evaluation, in evaluative "critical" thinking, can prevent "creativity plus enthusiasm" from converting questionable ideas into unwise action.⁹

A third concern raised in Foster's letter¹ was about the importance for clinical departments in all Omani

Table 2: Medicine/health sciences training and education activities, Oman 2008

Activities	Total (Omanis)	% female
Students studying medicine (Bachelor's degree) Sultan Qaboos University in 2008/09*	353	45.0
Students studying nursing (Bachelor's degree) Sultan Qaboos University in 2008/09*	291	59.0
Sultan Qaboos University graduates (Bachelor's degree in Medicine) in 2008/09*	108	62.0
Sultan Qaboos University graduates (Bachelor's degree in Nursing) in 2008/09*	42	76.0
Students studying (Bachelor's degree) in private universities & colleges in Oman 2008/09*:		
Oman Medical College	141	72.3
Oman Dental College	13	76.9
Graduates (Bachelor's degree) from private universities & colleges in Oman 2007/08*:		
Oman Medical College (Medicine)	9	88.9
Oman Medical College (Pharmacology)	4	75.0
Students studying Medicine (Bachelor's degree) in universities abroad in 2008/09*	74	56.8
Residents (doctors) sponsored by MOH and registered with Oman Medical Specialty Board (OMSB) #	276	59.8
Students enrolled in Basic Diploma education at MOH training institutes#	2,107	70.6
Graduates from Basic Diploma at MOH training institutes#	658	75.8
Students enrolled in Post-Basic Diploma in MOH training institutes#	185	90.8

Legend: * = Reference 4; # = Reference 3; MOH = Ministry of Health

health institutions throughout the country to rely on "Medline" searches to get answers to clinically relevant questions. Ken Foster is quite right to highlight the gap between research-based best clinical practice and what doctors actually do. Traditionally, the medical profession has behaved as if the dissemination of research findings in peer-reviewed journals would eliminate this gap. However, according to Grimshaw *et al.*,¹² physicians typically have less than one hour per week to read and have not necessarily been trained to appraise published research. Physicians interested in improving their practice also encounter organisational, peer group, and individual barriers in addition to information overload and patient expectations.

Web-based information has had a significant impact on biomedicine by dramatically improving ease of distribution and access. The success of web-based information arises from ease of use, platform independent client-server software, wide availability of inexpensive web-based information browser applications, and its support of distributed hypertext and multimedia. Ongoing innovative encryption-based technologies also facilitate the creation of secure wide-area access to clinical information systems. The information obtained should help physicians rein in inappropriate costs. Healy adds another powerful benefit that will accrue to population research itself: computerized information on individuals that can be compiled, searched, shared, and analysed. However, she emphasizes the responsibility of the physician under oath to protect confidentiality and so assure medical privacy.¹³

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