

Afghanistan and Oman

Personal reflections on a profound contrast

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أفغانستان وعمان
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To the Editor

Unable to return to Afghanistan initially after 9/11, I worked for five months in Yemen and found myself constantly drawing parallels between the two countries. Recently, during a visit to Oman I found myself constantly remarking on the stark contrasts with both Yemen and Afghanistan. Not surprisingly, the direction my reflections took was influenced in large part by my recent master's thesis research which focused on the role of epistemology in surgical training in Afghanistan.¹ The casual observer might latch on to the most obvious difference in relation to the two countries' ministries of health, namely availability of finances. Alshishtawy's article in this issue highlights a difference more important than quantity of finances; namely, quality.² By that I mean the quality of decision making in relation to finances. For the foreseeable future, Afghanistan's government is dependent on donor funding because clearly it will be a long time before taxes can fund health care. Even if there were technocrats in the Afghan Ministry of Health (MOH) who saw the need to allow cost recovery in the public system, the parliament seems set against allowing such pragmatism. When I recently asked a senior technocrat in the MOH in Kabul what form plans are taking for financing of health care 10 years from now he was not aware of anyone addressing this question. Clearly, it is not just the absence of conflict or the size of GDP that make Oman's health care such a remarkable success, but rather such elements as systematic analysis, practical planning and effective leadership in implementing plans.

The analytical framework used for my master's research I derived from the foundational document which led to the establishment of the modern research university. Von Humboldt's classic 1810 paper listed four conditions for developing the modern research university which I believe apply to the development of any knowledge derived profession: 1. Providing the Organizational Context; 2. Collaborative arousing of passion; 3. Challenging closure ("*...science and scholarship do not consist of closed bodies of permanently settled truths.*"); 4. Seeking feedback.³ The condition that I have found most obviously lacking in Afghanistan was the one so visible for its successful application in Oman; namely the first condition, that "... the state must supply the organizational framework and the resources necessary for the practice of science and scholarship..." The remarkable success of the past few decades in developing Oman's education and health infrastructure is outstanding. It goes without saying that Afghanistan's chronic continuing civil conflict accounts for a large part of the difference between the two countries' health care systems. However, a number of questions arose during my visit which I believe have broader relevance to the culture of training for the health professions.

Who gets into Medical School?

This question parallels an issue we have in Afghanistan. Both countries base selection of medical school candidates solely on examination performance. Hearing of a large majority of female medical students in Sohar, Oman leads me to wonder what effect this will have on health care delivery if many of them go on to work only part time in order to have a family. Some have openly admitted no interest in practising medicine. In the Afghan system one's post-secondary career path is assigned on the basis of ranking in the nationwide "concours" examination unless one asks to be switched to a lower ranked faculty. With top-scoring candidates assigned to medicine and lowest scoring to nursing it is no surprise that Afghan doctors often end up leaving the profession when they can be better paid as English-Dari translators for foreign organisations and that nursing as a profession shows clear signs of being undervalued. In both countries there appears to be a significant element of socially motivated career choice at the expense of decision-making based on suitability of personal aptitudes and enjoyments. Perhaps in both contexts a significant part of the blame is to be laid on the society at large and how it has developed; not just on the higher education system alone.³ Any rapidly changing society is likely to have elements of disequilibrium between traditional ideas about health and the epistemology that constitutes the foundation of professional expertise. In Afghanistan, I see almost weekly a case of severe morbidity from treatment at the hands of traditional bone-setters and yet I have also seen doctors who have taken their own family members to traditional healers. Clearly society's relationship to both the traditional and modern medicine communities is a strong determinant of health care delivery. Selection of candidates for the profession and selection of the professional to treat a given patient are key determinants of this relationship

What to think versus how to think

One of the observations that stands out in Oman by way of contrast with Afghanistan is the large majority of expatriate doctors in Oman. A recent study showed the figure to be 75%.¹ For most of my time in Afghanistan, I have to my knowledge been the only non-Afghan working in the national hospital system. The few foreign doctors have been for the most part in non-governmental organisation (NGO) programme management. This difference of course reflects the capacity of Oman to pay generous salaries to attract foreign personnel. In turn, this raises the question of indigenisation of medical expertise. Clearly, progress is being made in this regard in Oman. Is it then appropriate to raise the concerns that have been raised more generally about graduate education in the region?⁴ The general focus of these concerns can be characterised by an emphasis on content or skill-set transmission to the trainee without adequate attention to the capacity for critical thinking. In a world increasingly 'opportunity-flat'⁵ because of the internet, the capacity to negotiate the torrent of information for what is actually relevant and true requires more than ever before in history the capacity of critical thinking.

The NGO for which I work in Afghanistan has been focusing lately on strengths: Richard Koch's 80/20 Principle.⁶ This approach is very useful as far as maximising a given individual's contribution when there are other players to choose from. However, when one is the only option to meet a particular urgent need, as is often the case in health care, then one should also incorporate a focus on analysing one's weaknesses. This principle of focusing on weaknesses should be even truer of whole systems. In the professional realm, it is this tension between focusing on strengths (often oriented toward keeping everyone happy) and focusing on weaknesses (to cut out inefficiency and error) that informs much of the cultural divide between 'East' and 'West'. Victor Davis Hanson has highlighted this difference perhaps more effectively than anyone else by looking at the history of the military profession. In his book *Carnage & Culture* he looks at nine military campaigns over the last 2,500 years and concludes that 'the West' has dominated militarily because it has built on the foundations of 1) freedom of individual expression (and maybe also rights) and 2) the centrality of rational enquiry/reflective analysis.⁷ This difference led to the inability of the hero on horseback with superior individual power to overcome the disciplined coordinated systematic defences of a phalanx of Greek infantry, for example at the Battle of Marathon in 490 BCE. Perhaps the cultural parallels of lessons

drawn from the military profession are more clearly highlighted in the battle of Midway in 1942 in which overconfidence, focus on blaming rather than analysing bad outcomes, suppression of questioning from junior officers, following traditional tactics, resistance to initiative, honour motivated planning (the best pilots earned the right to go kamikaze, leaving behind a less experienced pool of trainers) played a role in producing failure analogous to the dynamics in the operating room that I am familiar with as a surgeon. Recently there has been interest in applying the lessons from aviation in the operating room environment. These have also highlighted the central role of reflective analysis of how we function as a community or as a system rather than just asking what piece of equipment or individual skill-set is lacking. This systems approach is becoming increasingly accepted as the preferred approach to preventing medical error. However, it can also be the prime force for improving the use of limited human resources – whether limited by quantity or quality.

Whose learning comes first – The Profession's or the Professional's?

As a surgeon doing primarily upper extremity surgery in Afghanistan's main orthopaedic hospital I am constantly faced with examples illustrating a failure of the above two principles of reflective analysis and individual expression. I have no doubt that the single largest source of loss of hand function in Afghanistan is not the injury per se but iatrogenic joint and tendon stiffness that could have been prevented with a little bit of knowledge and modest effort – but certainly not requiring expensive or complex technology. Repeated attempts to introduce change in this regard have been without significant effect, despite the absence of any clearly identifiable resistance. Without doubt a large part of the reason for this inertia is the simple absence of a systematic habit of looking for new ideas and then evaluating them before incorporating them into working practice. In other words, when reflective analysis and freedom of expression are suppressed the threshold for change becomes too high and impedes progress. It often happened that an individual would be convinced of the benefit of some new development, but there was little mechanism for dissemination of the new idea throughout the department unless it was instigated from the top of the hierarchy. By contrast Dr C.Thomas' description of how new ideas become adopted in the Khoula Hospital plastic surgery department seemed to approach the ideal in terms of openness to exchange of ideas. Despite the large difference between the two countries in how their medical communities function, it is safe to say that for each country the road to success is paved with the same stones. These include critical self-assessment and openness to new ideas. Two of the best measures of reflective analysis in a medical community are well conducted departmental morbidity and mortality rounds. In this day and age a good measure of the presence of the other foundational principle, individual expression, could be openness to new ideas. In a hierarchical honour/shame society a good measure of this openness might be the promotion of young members of the department on the basis of merit rather than connectedness. Nowadays it probably also correlates closely with how much the department relies on Medline searches for the answers to clinically relevant questions. Development of both of these aspects of the profession is sorely needed in Afghanistan. How much they could be further developed in Oman I cannot say, but the question is worth addressing in relation to the profession throughout the country and not just in the academic centres.

An answer to the Geography Challenge?

This leads me to conclude with the one parallel challenge that both countries share. Each faces the challenge of delivering health care to sparsely populated mountainous and arid regions that have been traditionally rather isolated from the outside world. Many of our patients in Afghanistan take four or more days of travel to reach Kabul and when they do they tend to find it an inimical environment where they quickly go into debt to pay for their family member's care. Although the trip from Nizwa to Muscat has shrunk in a generation from a week long camel trip to a one and a half hour motorway trip, there still seems to be sufficient paucity of specialist medical care outside of the main urban centres to pose a relative barrier to care. I sense this may

be the case notwithstanding the truly remarkable achievement of, for example, virtually all cleft lip patients being registered within a week or two of birth for surgery at three months. I say this in part because in my own country of Canada, with a much longer history of developed health care, there are still challenges in providing specialty services at a distance from the large urban centres. Two solutions seem to offer the most help in meeting this challenge: 1) an internet based program for onsite professional development using PubMed literature searching to promote an evidence-based approach to practice combined with video conferencing to provide specialist input on difficult cases 2) targeted provision of resources and training to handle the most common conditions amenable to a non-specialist type of surgical “generalist”. Thus competencies such as bowel resection, hernia repair, C-section, care of modest burn injury and common fractures could be combined with improvement in the early management of trauma and prevention of complications such as joint stiffness and compartment syndrome – all combined in a surgical generalist role for small towns. It could be tailored to the specific professional resources in a given town and evolve with the health care system while improving access for the rural population. These two keys constitute my dream for Afghanistan, and I feel that some aspects of this approach would have relevance to any country with a geographically challenging distribution of its population such as Canada, Australia and at this stage in its development of its medical profession, Oman.

Kudos to Oman’s great progress to date! May Omanis soon comprise the majority of their own health care team.

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