Teaching at the Margins: Experiences of Anthropology and Medicine in a Middle Eastern Setting

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For the last four years I have been teaching the Social Preventive Medicine (SPM) course to first year medical students at the American University of Beirut (AUB) in Lebanon. Around eighty students attend this core course, which is part of the teaching of public health within the medical curriculum. During the course of these years I have attempted to use the SPM as a platform to introduce theories and methods in medical anthropology to medical students. As both a medical doctor trained in Iraq – and an anthropologist – trained in the United States – this task has presented me with many challenges, as well as, offered me insights into tensions between the two fields. These experiences are the subject of this essay, which attempts to explore teaching at the margins of anthropology and medicine in a Middle Eastern setting. While situated at different margins, I reflect on how this course became an interesting site for exploring the complex task of teaching medical anthropology in a non-western context, while, at the same time, raising a set of paradoxes that are particular to teaching medical anthropology in a post-colonial setting. My attempt here is not to generalize my experiences or to reify the dichotomy of East and West; rather, it is to situate them within their socio-political, economic and historical realities.

For many years now, medical anthropology has developed quite a respectable presence within and around the medical sciences in North America. Many medical schools include anthropological scholarship as part of their curriculum. Themes such as global health, alternative healing, cultural competence, and illness narratives have become part of the realities of medical education in many schools, especially in the context of the management of migrant communities and native populations and the implementation of local, as well as, international, research and policy

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agendas. These themes, even with their limitations and problematic theorizations, have opened the door for an interesting dialogue between medical and social scientists. With the aim of directing this growing field of knowledge towards health practitioners, much of this liaison is currently found in departments of social medicine, public health and other interdisciplinary units and programs. The relative popularity of such interdisciplinary interests has also benefited from the increase in number of medical doctors who are trained in anthropology, as well as other fields in the social sciences and humanities. Medical anthropologists/physicians, such as Paul Farmer, with strong followings within the medical establishment, have managed to take these connections to a new level by attempting to highlight the political and the economical when interpreting the various inequalities and causalities of illness and disease, while at the same time showing its practical relevance to a critically oriented medical practice. As the relationship between the two fields is being redefined, medical anthropologists still face a lot of difficulties outreaching, not to mention, bridging differences within a positivist field of knowledge such as medicine.

With maybe some exceptions, medical anthropology's marginal role in medical teaching in non-western settings presents similar, yet at the same time, a whole different set of issues and challenges. In a way, it implies two obvious margins, both teaching within a positivist approach of medical or public health faculties, as well as, teaching in a non-western setting. This double marginality conjures paradoxes, which highlight certain "post-colonial" anxieties pertinent to the position of both medicine and anthropology in such places. By post-colonial anxieties, I refer to dilemmas of engagement arising from the complex position of these two fields at the borderlines of metropolises and post-colonies, empire and the nation-state, and immigration and return. To explore further the cartography of these different margins and anxieties, let me first give a short trajectory of my own personal journey, as I think it will shed light on some of the pertinent issues I am addressing in this essay.

Exile

I studied medicine at the University of Baghdad in the 1990s, the same period during which international sanctions were imposed on Iraq after the invasion of Kuwait. During my medical training and practice I witnessed the various social and economic impacts of the sanctions on the country's medical system and the health of the people. Infectious diseases and cancer rates were skyrocketing as massive bombings using depleted uranium during the 1991 war took its toll on social services and the environment in Iraq. Meanwhile, deteriorating economic conditions were prominently visible amongst the vulnerable. As an example, there was an epidemic of fresh cases of child malnutrition, a condition rarely seen prior to the sanctions, and which was attributed largely to the collapse of the country's economy. With a lack of medication, medical supplies and the deterioration of the entire health system during the sanctions, day-to-day medical practice was dramatically affected, putting doctors and the general health professionals under a lot of strain. Practicing medicine in such conditions rendered medical textbooks obsolete, as improvisation with whatever one had at hand became the rule. When the economic inflation hit its highest point, salaries for medical doctors ranged between 2-5$/month. Moreover, as government employees, doctors were banned from traveling outside Iraq. Thus, young medical professionals started

seeking alternative jobs to support their families or chose to escape the country in search of a better life abroad. Being part of this generation of medical professionals, feeling helpless and inapt to practice medicine in Iraq, I fled into exile in 1998 with the help of special traffickers specialized in smuggling medical doctors out of the country. For 3 years I lived in Lebanon, where, 8 years after the end of its civil war, the country was still struggling with the effects of a lack of organized health care. In Iraq health care was mostly nationalized, yet the effects of the sanctions on the totalitarian regime in Baghdad impacted its capacity to provide health services to its population. In Lebanon, however, even with the abundance of medical supplies and high-tech diagnostics, health inequalities dominated the provision of care. To the degree that the state's provision of health care to its population was inept, the private sector had "successfully" taken over the role of health provider. With a for-profit sector attempting to capitalize on the provision of health, the general population was left with no legal protection or an equitable plan. Working as an Iraqi medical doctor in Lebanon was itself a marginal experience. As a foreign doctor, I was not allowed to practice "legally." The requirement for licensure in Lebanon included passing a general written medical exam and paying 50,000$ to the medical association to be registered for practice in the country. I moonlighted in the emergency ward of a hospital that would still employ foreign doctors for relatively low and unstable monthly salaries. At this point, it became clear to me that one can never separate the practice of medicine from the social and political context. Frustrated with the potentials and disenchanted with clinical practice, I moved to the study of public health at AUB, seeking a wider engagement with various health questions. Studying and working in public health, I became more aware of the larger context of health and illness through examining these issues from the population's perspective. Still, even public health, with its focus predominantly on quantitative approaches, was not able to answer the crucial questions at the heart of these social phenomena. As my path crossed with anthropology, I realized that, as a critical discipline, it had an interesting way of navigating between the various levels of the personal, the social, the economic and of course the political. As I embarked on my graduate studies in anthropology at Harvard University, my insight into the role of social sciences in medicine was taking shape. It was clear to me that anthropology could provide an important critical lens into the practice of medicine and public health, much needed in many parts of the Middle East. Still being a medical doctor trained in the "developing world" was "not good enough" to allow me to practice medicine in North America, even if I were to have spent a lot of time and money preparing for exams and tests – an ordeal I opted not to pursue. Even though I am continuously presented in conferences, amongst colleagues and in many social settings, as a medical doctor/anthropologist, the experience I had gained was very different from that of colleagues who had been entirely trained in a North American system. My position as a medical doctor and anthropologist is something I am constantly trying to reckon with as I attempt to make sense of my career as an anthropologist and teacher of medical anthropology to medical students at the AUB.

Return

Established as the Syrian Protestant College in 1866, the AUB is considered one of the teaching institutions that played a key role in the production of knowledge and expertise in the region. A vibrant political campus, the AUB has been essential in the history of political movements by endorsing

ideological thoughts across the political spectrum. The medical school was originally established in 1867 and slowly grew to be one of the most important and prestigious schools in the training of medical doctors in the Middle East during the late 19th and 20th century. The medical school also attracts students from all around the Arab region. Yet, only the privileged can afford the high tuition fees, a hurdle for many students from lower income classes. Even though the school was essential in training doctors who took their place in the practice of medicine and politics in the region, it has been an important institution for the export of medical doctors to the West, especially to the United States. It is the dream of most of these young medical students to specialize in the West and for many to move there permanently – this is part of a general phenomenon amongst many young professionals and graduates in Lebanon.

In 2004 I returned to Beirut, invited by the American University to teach the Social Preventive Medicine course. My task was not straightforward. I was asked to teach a course to medical students, which would sensitize them to the importance of public health and its different domains. It was important for students to see health as a bigger concept, and that they, as future doctors, were just part of its workings rather than at its center. The SPM at AUB was originally designed during the 1970's as part of the teaching curriculum to introduce public health into the teaching of medicine. Throughout the years, the course was taught by a number of medical doctors who had, more or less, chosen "alternative" careers in medicine, working in public health and primary health care. Being taught to first year medical students, the course was intended to leave an impression on medical students as to the importance of a collective vision of health in their future medical practice. The course was also dreaded by many faculty members in public health who were overwhelmed with dealing with teaching concepts of public health to intense and competitive "biologically oriented" first year medical students. The SPM course was, indeed, located at the margins of medical education at AUB.

When I was asked to teach the SPM, I opted to modify the course material with an introduction to medical anthropology, all the while keeping the connections with public health and clinical medicine strongly pertinent. Choosing the material was very tricky since the majority of students came from pure scientific backgrounds. The education system at AUB simulated American university systems with 3-4 years of pre-med courses. This required students to take core courses in the humanities, which many underappreciated. In an attempt to make the course more relevant to the students, I focused the main themes of the course around questions of social suffering and inequality, hoping to use them to inject some anthropological perspective into the teaching of the course. The course attempted to start from the social context of the clinical encounter and expanded beyond to the interconnectedness of the social, political and economic dimensions of health. The course culminated in the final assignment, a "mini-ethnography," which the students conducted either individually or in pairs. The assignment entailed an interview with a person suffering from a chronic health condition or a member of their family. The assignment pushed the students to take a long social history of the condition, attempting to explore the narrative of illness, its social and cultural contexts, as well as how it features within the general health system of the country. These were not in-depth anthropological accounts, yet still some of the papers were surprising with their insights. For many of the students this was a daunting task as this was their first "patient" interview. Each year students handed in their assignment about various conditions and their takes on the health system in the country. Even though

many were reluctant in the beginning, the assignment became one of the most fruitful experiences for the students during their first year medical training. One of the main challenges of this course was to make available material in medical anthropology relevant to student interests. Heavy-handed theory did not work very well, though some did really appreciate it. Reading bits and pieces of medical anthropology classics, such as Emily Martin's (1992) *The Women in the Body*, Arthur Kleinman's (1988) *The Illness Narrative* and Paul Farmer's (1999) *Infections and Inequalities*, the course tried to revisit the clinical relevance of such material within the context of the Middle East. Still, the reception of the material was fascinating to see. The sections on medical ethics attracted considerable debates in class. In addition to reading material on bioethics, we tried in class to build on case studies and examples from the day-to-day clinical encounters. I used examples from my own experiences in Iraq working under the sanctions and having to make difficult decisions under harsh circumstances. I tried to show that these decisions were not just clinically driven, but rather were subject to many other factors and variables, which controlled the daily medical practice. Guest speakers also shared their own experiences about dealing with patients and the health system in the country, while students also presented some of their own encounters with their interviewees. Still one of the most challenging aspects was getting the students (and sometimes the guest speakers) to appreciate that while there were clear "right" and "wrong" decisions, other decisions, which hinged on cultural moral reasoning, were ambiguous and carried no clear answers. The point was not to represent a relativistic point of view on health and illness, rather it was to initiate a debate and dissect these cases and the different moral and medical contingencies constantly emerging. It became clear to me that this was not the right place for teaching students anthropology or methodology, even though I think there is always the possibility of finding a few students who would be interested and would like to pursue that interest elsewhere. The kernel of the course was to get medical students to start questioning given facts that are handed to them in their medical education, as well as much of the social and cultural assumptions that are attached to health and illness. The course was, more or less, a lens-box, where different lenses were utilized to see the big picture with more sharpness and acuity.

Still, it was not an easy task to highlight the local relevance of such reflections given the lack of serious medical anthropological studies on the region. Focusing on the local setting was important as part of creating critically-minded doctors who would eventually make future changes in the practice of medicine and public health in the country and the region. One of the main points of contention of the course had to do with the career trajectory of these medical students at AUB. These were not students trained in a western setting where they will deal eventually with migrant communities or travel to a "third world" country for a semester. Many aimed at ending up in the United States for their specialization and/or to live. The fantasy of the American health system, as "the best medical system in the world" was disturbingly held with strong faith. I tried to undermine this fantasy by getting students to read articles about the problems in the American health system. I even organized a screening of Michael Moor's *Sicko*, which was received with shock and awe. Nevertheless, the paradox was that many times my attempts to teach about the specificities of the local context in the Middle East or other regions turned into students' curiosity about medical practice in the United States. I was asked constantly about how I got into Harvard and how come I managed to get a scholarship to study something other than clinical medicine. I constantly questioned myself as to whether I should encourage students to stay in

Lebanon and work or whether I should accept and probably support their desires to ride the immigration wave and the various possibilities of traveling and specializing in the US. As someone returning from the West, I didn't want to be hypocritical about the "value" of specializing in the West and its symbolic capital: The only reason I was standing in front of them teaching was attributed to my studies in the West. Ironically studying in the West also legitimated my training as a medical doctor; I was the doctor/anthropologist who would be the right person to teach medical students. These post-colonial anxieties reflected the position of medicine, as well as anthropology, at such margins as mostly dependant on metropolises and empires.

These experiences, as marginal as they are, represent an interesting site to think further about forging new relationships and networks with other programs, both at the local and international levels. In recent years, several universities in the Middle East have shown a genuine interest in including social science in the teachings of medicine. Medical schools in Lebanon, Syria and Egypt have been attempting to incorporate more "social science" within their medical curriculums, and medical anthropologists are called upon to aid in this process. This interest partly stems from the desire of many of these schools to be accredited in the West, as reviews of these schools are being done by western institutions. Even though the definition of what could be included or considered as social science is itself a point of contention, and despite the fact that western universities were not necessarily the right models to draw on in non-western settings, this opening has presented itself as an opportunity for medical anthropologists in the region to seek recognition within medical establishments and finally be heard. The direction that this new interest will take and its repercussions is something that remains to be seen. Yet, unless more collective and institutional efforts are made towards developing a localized perspective on social sciences and humanities within medical education, such experiences will remain somewhat sporadic.

Conclusion

In *Writing at the Margin* Arthur Kleinman (1995) characterizes anthropology and the anthropologist as being constantly at the margin of medicine. The margin is what allows the anthropologist to situate his/her critique onto the inequalities of health and power relations of medicine and medical practice. In the Middle East in general and in Lebanon in particular, teaching medical anthropology to medical students invokes a multitude of margins which lie at the crux of disciplines and post-colonialism. As I have shown, my own experience of teaching medical anthropology to medical students in Beirut was wrapped in a set of anxieties about immigration, professionalization in the West and the trajectory of medicine and anthropology within certain contexts. In other words, such experiences of teaching and practice, as well as engagement, cannot be dissociated from the socio-political, historical and economic realities of society. This tension between medicine, anthropology and the post-colonial setting is what makes teaching at these margins an exciting and challenging process, where medical anthropology will hopefully always work as a critical lens not only on medical practice and practitioners, but on their position within the borderlines of our own post-colonial anxieties.

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