Social Development and Medical Education: A Gender-Based Policy Making in Iran

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Abstract: Confronted with the critical demands of human resource development in Iran after 1978,the authorities of medical education under the prohibitions or reinforcements of religion and ideology decided to implement a gender-based medical approach both in education and practice. Due to the regulations established in this field, there were chosen some female physicians to become specialists in each medical branch so that the women could refer to women specialists without any concern about opposite sex contact and touch imposed by religious perceptions. The referral system, defined as equal accessibility for women to female physicians, was based on separating sexes in medical institutes and health centers. In practice, some correlated difficulties appeared which lowered the confidence level for people. The first, lack of accessibility to female physicians in remote villages forced people to use by-pass directions to get medical treatment. Second, gender-based skills in medicine believed to be in favor of men, were platforms for women to choose the opposite sex physicians .The last but not the least, ignorance of abilities in finding higher positions could be a dual misstep in which competent men were deprived of access to specialty and low-competent women could be selected for the education they could not use in future. The continuous change in policy making to select competent candidates to bridge the gap in gender-based treatment took its poll on sustainability and social development in all aspects of life especially in rural areas. This paper analuses the negative attitudes brought about in gender-based medical education in Iran.

Keywords: Education, Female, Social development, Treatment, Urbanism

Introduction

Medicine and medical operations in Iran date back to about the dawn of civilization in Pars kingdom. The ancient Iranian medicine had inseparable ties with natural thoughts and some superstitions and later with Zoroastrianism as mentioned in Avesta. The only contemporary source from which we could expect information on Sassanid medicine or hospitals might be the Dinkard, an encyclopaedia of the Zoroastrian religion that comprises extensive quotes from materials thousands of years older, as well as from those of the Sassanid period [1]. According to some scholars the Dinkard was first composed under the reign of Khosrow I Anushirvan (531-579), but was destroyed during the Arab invasion and later, under the Abbasid Caliph al-Ma'mun (813-833),Azar Faranbagh, a Zoroastrian scholar, compiled it again from scattered sources [2]. According to some ancient Iranian myths, practicing medicine can be traced back to the era of Jamshid, the fourth mythical king of Iran and the oldest evidence of surgery demonstrates the trephination of a 13-year-old hydrocephalous girl performed 4850 years ago. The numerous health rules expressed in Avesta imply the importance of perfect and healthy life for ancient Iranians. Medicine in pre-Islamic era reached its zenith when the University of Jondishapoor was founded by the Sassanid in the south of Iran to be the center of medicine .It remained as one of the most important universities of the ancient civilized world for several centuries and attracted many scientists from all over the world who worked in different fields. The University of Jondishapoor contributed a lot to the progress of medicine in Western Europe around the seventh and eighth centuries and transferred medical knowledge through translation to Europe. Upon the rise of Islam and its expansion, writings of great Iranian physicians, especially in Arabic language, in the ninth and tenth centuries became the dominant works in the field of medicine in the world for many years. The tenth and eleventh centuries witnessed the blooming of two great Iranian learned men -Avicenna and Birooni- who are considered as turning points in the evolution of medicine in Iran, and in other parts of the world as well. The practice of medicine ,then ,merged with religious thoughts extracted from Islam .Practically, there appeared two traditional medicines; one in general practice which was conducted by men and no woman could step in and the second the medical affairs specified for women which could be done by midwifes. For years, medicine was practised in its traditional form based on using herbals as the main prescription for diseases.

Modern medicine flourished under the Qajar Dynasty after Amir Kabir, then prime minister, established Dar-ol-Fonoon School in 1851 in which medicine; pharmacology, mathematics, literature, fine arts were taught. Through employing foreign teachers, and sending a number of students abroad in 1858, the School came to play a key role in the development and education of modern medicine. Yet, the dominant role was played by men. In 1918, medicine was deleted from the syllabus of Dar-ol-Fonoon and started to be taught in a separate independent college named "College of Medicine" and in the same year, the first women's hospital was officially inaugurated. The introduction of females in medical education in Iran was based on a religious formation. Along with their religious duties, the missionaries in Iran initiated medical services for local residents and trained a small number of Iranian women in the care of the sick. The theories of the government were the spread of medicine in a limited form. The universities in Iran offered medical education to students without any consideration, although the traditional and religious affairs restricted the women`s attending the higher levels of medicine. The change in the structure of regiment in Iran witnessed a bizarre attitude towards the participation of women in medicine both in favour of and against the women. To defend and protect the religious personality of women, the segregation of gender was implemented in different levels of education which brought about contradictory reactions in Iranian society.

METHODOLOGY

To find the effects of gender-segregation in medical education, two phases were examined. The first period is related to Pre-Islamic period in which no specific issue was considered for medical education. All the doors were apparently open to women to continue their education. Social divisions were the most important factor for women to enter the higher degrees of medical education. The second phase, which is our focus, included a thirty –year period in which the most drastic changes in medical education happened. Information and data on the involvement of women working in medical section and the process of empowerment of these women were mainly collected through participatory observation and autobiographical interviews with women physicians who were involved in the project. These interviews were conducted by the authors with the women and their patients in different periods. The interpretation of the interviews was aimed at identifying professional changes caused by the women's involvement in medical practice. The interpretation model was distilled from the interviews on the basis of how the interviewee described herself and her relations with the patients .In contrast, the patients who were visited by female and male physicians were asked to express their opinions about the treatment and interaction. In all cases, the written consensus was taken to use the data anonymously. The publications of health ministry of Iran were the main sources of statistical data.

Islamic Revolution -1979

In 1980, the total number of practicing physicians in Iran was about 15,000. This number has almost exceeded 60,000 in the recent years. Meanwhile, in 1980 there was one physician practicing for an average of 2,500 people. During the following years probably due to emigration and other social factors this ratio even worsened and hit the rock bottom of 1 physician per 3,000 people. But less than 10 years, Iran's health system was enjoying a third world ideal of 1 physician for 1,000 people. Besides, there were about 6,000 foreign physicians employed by the government for medical practice in Iran in 1978 but nowadays, this figure is almost zero. The academic infrastructure has also expanded during the recent decade. The number of medical schools was 7 in 1970 and 14 in 1979. This number rose to 28 and 56 in 1990 and 2004, respectively .For medicine-related fields, the situation is almost the same [3].

Schools of pharmacy and dentistry were 3 in 1970. In 1996, 9 pharmacy and 12 dentistry schools were functioning in Iran and increased to 20 and 30 in 2006, respectively. Before 1978, Iran had less than seven research centers active in medical fields in the country; nowadays this figure has passed 100. Apparently, most of the resources and intellectual manpower in the country has shifted to the health and medical care to improve health infrastructure. This shift has led to improve health standards in Iran and the profile of disease and health has changed from that resembling a third world nation to that of an industrialized society. There can be found a lot of patients from the neighbour countries coming to Iran to use medical services .The common belief is that war and globalization were two important factors which helped to improve the level of health standards in Iran. On the other hand, profound differences and changes in medical education along with national health plans in Iran brought about an outstanding status for Iran in the region.

Medical education in Islamic government

Socialization is, no doubt, an influential factor in creating gender disparities in the choice of fields of study, as it channels males and females into gender-specific majors in college and horizontal sex segregation situates male and female students in different learning and social environments. This trend can affect the profile of health system in a country such as Iran in which women play a great role in social institutions [4]. In order to investigate the path of medical education in Iran, indicators of medical education can be searched from 1970 to 2006.Before that, the medical system was of centralized form and health facilities were concentrated in the towns and big cities. The medical universities were limited in the number and existed only in 10 big cities of Iran. Since 1978, there have been rises in the number of educational institutions to about 60 (there are many non-official institutions in Iran which are controlled by private sections), student admissions in the programmes of medical sciences from 1387 to 20000; medical student admissions from 600 to 5600; teaching staff from 1573 to 9900; and teaching-bed to student ratio from 1.05 to 3.08 [5]. The numbers of students in clinical specialty and MS degrees have increased, and various programmes in clinical sub-specialty and PhD degrees have been initiated. Even some collaborative projects have been implemented to increase the physicians` knowledge with advanced universities in Europe. The quality of medical education has improved with increasing field and ambulatory care training, with more emphasis on teaching preventive medicine and a significant rise in the research activities. Most qualitative and quantitative progress has been achieved following the establishment of a joint Ministry of Health and Medical Education in 1985. The results demonstrate the success of Iran in upgrading medical education by the unification of health services and medical education under one ministry [6]. The establishing of health centers in even remote areas with female and male physicians to regularize the referral system is considered to be a cornerstone in improvement of an access to the health system. The statistics of safe and perfect delivery in Iran shows a great success in birth health and maternal health under the supervision of trained physicians and skilled midwifes found in different parts of the country which had never seen any physicians previously. Training special physicians for villages and remote communities is the greatest achievement in medical system to upgrade the health standards and remove the hidden deaths caused by simple diseases [7]. One interesting change is the relative increase in the number of female students and graduates in country's medical system. Women comprise about 54% of the students in the health and medical fields. Although the female dominance is more pronounced in undergraduate and bachelor degree levels, a considerable proportion of students studying medicine, pharmacy and dentistry are women. This dominance is not restricted to large and industrialized cities; smaller cities may also show an even greater female to male student ratio. This is in line with the increasing literacy rate of women in Iran. The dual role and responsibility of the post-Revolutionary woman are clearly reflected in the Constitution of the Islamic Republic of Iran. The Constitution "considers women's employment and their social and economic activities to be very meaningful and conducive to social well-being" and at the same time emphasises the role of the woman "as a mother and her significance in maintaining strong family bonds and affectionate relationships" .During the war between Iran and Iraq ,the number of male candidates for higher education reduced and there appeared a suitable opportunity for women to have greater and wider social and academic participation. Iran was confronting a transition phase of socialization in which progress and women`s role taking in different aspects became the major theme of life. On top of all, the presence of women in medical system now underwent a great upheaval. The equal opportunity for women to be visited by the female physicians was the most important point which was emphasised by the government, theologians and health authorities. The only problem with medical education in Iran is related to gender segregation in two fields; education and practice. According to Islamic law, the coeducation is forbidden and girls and boys are to be separated in their education .This segregation is practically implemented from the elementary education. Educational choices traditionally figure among the major factors driving occupational/sectoral gender segregation on the medicine practice. What is the driving force behind the high degree of gender segregation in the fields of studies and how education policy can make a difference. The debate on coeducation and single-sex schooling is closely related to this issue. The effect of education segregation can imply the limitations and narrowing of job opportunities for some specific strata of society. The gradual segregation of the sexes in Iran means there are more opportunities for women to pursue more careers and especially medical careers, but that appears to be one of the few advantages. A prime objective of Iran's Islamic revolution in 1979 was to separate men and women in almost every aspect of their lives and to minimize their physical contact. After the revolution, no new male residents were accepted into the specialty in higher degrees of medical education, and the number of male gynecologists has been dwindling. The country has also begun introducing female- only hospitals that men are not permitted to enter. This gender segregation has had a major effect on medical education. To ensure that there are enough female physicians to treat the country's women and girls, Iran will be training thousands of new female physicians to examine the female patients. Ten years ago only 12.5% of Iranian medical students were women, and the government responded by setting a goal that half of new students would be female. Today, one-third of the 22 326 students in Iran's medical schools are women. To ensure that there are enough female specialists for women patients, another filter was added at the residency-selection stage. All the residency positions in obstetrics/ gynaecology were reserved for women, as were half of the positions in internal medicine, general surgery and cardiology. In many other specialties, including orthopaedic surgery, urology, neurosurgery, ophthalmology and psychiatry, women had to fill at least 25% of the residency position. These trends will guarantee the training of an adequate number of female physicians and fill the gap in medical practice, but they are raising many questions about the impact on medical education. Today, male medical students in Iran are not receiving sufficient training in obstetrics. This means that male physicians in rural and remote areas, where female physicians may be unavailable, may have trouble handling difficult deliveries. Likewise, female medical students are being deprived of education and training in male hospital wards. The changes in medical education in Iran raise several issues. There are concerns that they may rob Iranian women of their right to choose a male or female physician. There are applied some restrictions by health insurance companies to pay the medical costs when a woman is visited by male physician. For now, female patients have the right to choose their physicians whether male or female, but there are fears that eventually they will be obliged to seek physicians of the same sex. The three pillars of social status, participation and equality, have combined to ensure equal opportunities for women in access to medical schooling and access to female physicians, though shaped and circumscribed by the ideology of Islamization. All three components have played an important role in shaping the content and direction of medical education at all levels. In the current phase of reform, gender equality and women's empowerment are further emphasized, with education in particular viewed as the means to provide women more space to understand their rights and strive for them independently. Allocating spaces for women in different levels of medical education which deal with people` life is anti- socialization in which women are given negative prestige and they are viewed as supported occupants in their job. In medicine it seems that women are experiencing Role Stagnation, a feeling of stagnation and lack of growth in the job because of few opportunities and because of segregation in health-care women receive less care and lower quality care compared to men. Access to informal sources of health information has also been found to be affected by segregation .Social networks provide health information that influence and support health behaviours of specific genders. Segregation may also impact individual's skills and knowledge needed to use health information, or their health literacy. Health literacy or the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions [8].

Realising personal potential

What motivated the women in Iran to base their choice for physicians on expertise and not on the gender? There are considered many reasons to justify the issue. The most important thing is that the spread of social networks and self-awareness are endowment Iranian women are experiencing which helps them to tackle a burning issue in their lives. The statistics of patients women who refer to specialists in medical affairs and surgeries show that social development can be a significant factor to return the right to choose the physicians to women [9].

CONCLUSION

Women's Health is devoted to facilitating the preservation of wellness and prevention of illness in women and includes screening, diagnosis and management of conditions which are unique to women, are more common or more serious in women, or have manifestations, risk factors or interventions which are different in women. Women's Health is necessarily interdisciplinary, holistic and woman-centered. It recognizes the importance of the study of gender differences, recognizes multidisciplinary team approaches, includes the values and knowledge of women and their own experience of health and illness, recognizes the diversity of women's health needs over the life cycle, and how these needs reflect differences in class, ethnicity, culture, sexual preference, levels of education and access to medical care. Women's health includes empowerment of women, as for all patients, to be informed participants in their own health care. These considerations have affected the medical education in many countries [10]. Despite significant achievements in female schooling and considerable progress towards gender equality in Iranian education, the battle is not over yet. Quantitative and qualitative shortcomings continue to exist in the realm of education while the broader participation of women in society is far from ideal. In fact, the dramatic increase in the number of educated women in Iran is not reflected in their participation in political and economic life, although there has been some improvement in recent years. Since gender equality in education is part of gender equality in society at large, it is important to view the educational status of women within the broader framework of female participation in the social, political, and economic arenas [11]. The active presence of women at all levels of public life, especially at higher levels of planning, politics, and administration where they are most visible will act as an incentive for younger women to seek further education. To the extent that gender bias in medical education exists, it raises concerns not only about inequities or injustices. Gender bias calls into question the quality of the base of medical education evidence, and it is this base from which female physicians are increasingly expected to practice. While providing role models of both genders in education and practice must be of main concern in medical education, imposing the rules for women to take some positions in treatment can violate the humans` right to choose the best for their disease. The implementation of gender segregation in medical education demands involvement of the most talented women – including recruitment and/or up skilling of appropriate physicians, to sit on suitable curriculum. Gender issues affect communication with female and male patients and the development of communication skills appropriate to each sex. The cultural expectations of women, including between cultures and between sexes in a single culture, and the implications of these expectations for health must be considered seriously.

REFERENCES

[1] Fichtner H. (2000). On the notion of Good Measure (paymân) and other related philosophical concepts from the Dênkard III, Third International Congress Proceedings (6th to 9th January 2000), K. R. Cama Oriental Institute, Mumbai 278-86.

[2] Gutas,D.(1998). Greek Thought, Arabic Culture: The Graeco-Arabic Translation Movement in Baghdad and Early as Society (2nd-4th/8th-10th centuries)(London and New York: Routledge.

[3] Ministry of Health and Medical Education (MHME). (1998). A Comparative Statistics of the Functioning of the Ministry of Health and Medical Education since 1979-1998. The Bureau of Statistics of the MHME.

[4] Avison, W. R & Kunkel, J.H. (1996). Socialization in Teevan. James J . Teevan, Jr. (ed.). Introduction to sociology: A Canadian Focus. 5th ed. (Toronto: Prentice-Hall Canada).

[5] Azizi, F. (2003). The reform of medical education in Iran. Medical Education. 1997; 31: 159.

[6] Marandi A. The integration of medical education and health care system in the Islamic Republic of Iran: a historical overview.Iran J Med Edu. 2001; 1: 8 – 11

[7] Khosravi A,. Taylor,. R, Naghavi M,& Lopez, AD.(2007). Mortality in the Islamic Republic of Iran, 1964 – 2004. Bull World Health Organ.; 85: 607 – 614.

[8] Bakken, L. L., Sheridan, J., & Carnes, M. (2003). "Gender differences among physician scientists in self-assessed abilities to perform clinical research", Academic Medicine, vol.78, no. 12, pp. 1281-1286.

[9] haya,F.T.,Yan,X.,&Farshid,M.,etal.(2010).Social networks in cardiovascular disease management .Expert Review of Pharmaco economics and Outcomes Research, 10(6),701–705.

[10] Bright, C. M., Duefield, C. A., & Stone, V. E. (1998). Perceived barriers and biases in the medical education experience by gender and race, Journal of the National Medical Association, vol. 90, no. 11, pp. 681-688.

[11] Borghans, L.,& Groot, L. (1999). Educational presorting and occupational segregation. Labour E