Ethics and Saudi Arabia

To the editor:

Dr. David Rhine's article[1] in April's *CJEM* presents a perfect opportunity to discuss the ethics of working in Saudi Arabia, or in other countries that systematically discriminate against or repress half of their populations. In his article, Dr. Rhine describes how women must always be accompanied by men, and must have their husband's approval prior to gynecological examinations. Commenting on this, he states, "Germaine Greer is unknown [in Saudi Arabia]." I'm sure he is not implying that this is a good thing; however, many Canadian physicians seem quite accepting of the systematic repression of women. In fact, choosing to work in Saudi for reasons of travel, money or social life could be considered tacit endorsement of this repression.

Many would argue that this is religious expression — something we have no right to interfere with. The problem is, such practices are forced on entire nations of women. Women born in Saudi cannot drive on their own, nor make their own medical decisions, nor choose another life. In other countries, female circumcision (mutilation) is still considered a religious practice. But where do we draw the line? If any other group was subjected to the same treatment as women, would we be so complacent? If, for example, all light-skinned people were forced to wear defined uniforms, prohibited from driving, and allowed out with only in the company of their "masters," would we be so complacent about the situation? The sad truth is, we might.

Ironically, in the same issue, Dr. Merril Pauls suggests that the Canadian Association of Emergency Physicians (CAEP) should establish an ethics committee.[2] I wholeheartedly endorse this proposal and suggest that we debate the ethics of participating in financial arrangements with groups who systematically segregate and repress defined elements of their society.

In this respect, the history of physicians is not a proud one. We have participated in human segregation, experimentation and in torture. Surely CAEP as an organization, and *CJEM* as our proposed singular journal, can do better than this!

M.S. Moser, MD
Vancouver General Hospital
Vancouver, BC

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1. Rhine DJ. Emergency medicine in Saudi Arabia: an expatriate's perspective. CJEM 2000;2(2):125-8.
2. Pauls M. Should CAEP establish an ethics committee? CJEM 2000;2(2):130.

[Dr. Rhine responds:]

Dr. Moser suggests that physicians should not work in Saudi Arabia because it systematically represses women. She writes, "many would argue that this [repression] is religious expression — something we have no right to interfere with. The problem is, such practices are forced on entire nations of women."

The truth is, modern women in Saudi Arabia are a powerful group. They are well educated, hold respected positions in the labour force and are remunerated fairly. If you asked the majority of Saudi women if they are "repressed," they would answer "No!" Wearing an *abaya* and not driving are religious constraints, and are perceived as inconveniences, not repressive societal barriers.

As stated in my article,[1] Saudi Arabia is the heart of Islam. The religion guides, drives and shapes every facet of life in the country for a Saudi citizen. Expatriates working in the country must live and adapt to these cultural differences or leave.

Living with these differences is not tantamount to full acceptance or condoning what might be perceived as repressive behaviour. When I lived and practised in Canada I had to acknowledge poverty, alcohol and drug abuse, child, spousal and elder abuse, criminal behaviour, personal and religious discrimination and other repressive behaviours. Recognizing these behaviours and living in a society where they exist does not constitute a tacit acceptance of these practices in Canada, nor does it in Saudi Arabia. Just as in Canada, Saudi Arabia has programs for dealing with abuse, addiction, poverty and criminal activity. So there are ways and means to deal with many of these concerns.

However, when it comes to matters of behaviour based on Islamic religion, expatriates are powerless to effect change and, indeed, have no right to do so.

Therefore, the choice for an expatriate living in Saudi Arabia is this: adjust, or leave. Or, if these cultural differences are viewed as "repressive," then one can choose to not go at all!

D.J. Rhine, MD
Riyadh
Saudi Arabia

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1. Rhine DJ. Emergency medicine in Saudi Arabia: an expatriate's perspective. CJEM 2000;2(2):125-8.

Wondering in Winnipeg

To the editor:

A Canadian Association of Emergency Physicians (CAEP) representative recently asked me if I had any thoughts on why the organization has attracted so few members in Manitoba. This is a difficult question to answer. Partly, it is a "Catch-

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22." Membership promotes discussion, enhances profile and spawns new membership, but there just isn't a "critical mass" in Manitoba yet. This will gradually improve; our EM residents are joining up more frequently now.

It also reflects CAEP's low profile in the region and the fact that most of our EPs are still GPs. The medical community here retains a strong local focus and is more likely to affiliate with the local bargaining group (battling for financial respect) than with CAEP, which is often seen as a "down-East" organization with little local impact.

To penetrate this market, CAEP must aggressively advertise and promote. The CAEP Roadshows, which appear periodically, are a good start, but we need more. Perhaps local opinion leaders would increase CAEP awareness and membership. Can CAEP help us in the political and academic arenas? And when CAEP solves overcrowding and bed shortages, we will undoubtedly beat a path to its door.

Robert Sweetland, MD
Department of Emergency Medicine
Health Sciences Centre
Winnipeg, Man.
rsweet@cc.umanitoba.ca

Welcome to the Third World: yet another opinion

To the editor:

The recent letter[1] by Dr. MacDonald missed the point of your editorial.[2] I applaud the personal-experience slant that your editorial put on the downsizing of our nation's health care system.

Winnipeg has also felt the growing gap between what we know to be optimal care and what we are able to offer on a day-by-day basis. The pressure to "push the envelope" by refusing patient transfers and the constant hovering over potential discharges to get another bed has left many of us tired and frustrated.

By the way, chairspace has become just as important as bedspace.

I also enjoy the humour and subtleties present in your other articles, because they provoke reflection on what we stand for as emergency physicians. To paraphrase an old tune:

Don't change a hair for us,
Not if you care for us.

Lisa M. Bryski, MD
Director, CCFP (EM)
Section of Emergency Medicine
Department of Family Medicine
University of Manitoba
Winnipeg, Man.

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