An After Life

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Until the sea-scimming missile (beloved of the tabloid press) streaked into the *USS Stark*, it had become quite tempting to imagine that the Gulf Region had replaced Frinton-on-Sea as the retirement Mecca for a generation of RAMC Officers.

The author, in less than a year in Saudi Arabia, has met former Corps surgeons, physicians, anaesthetists, paediatricians, an obstetrician, two administrative officers and two former ladies of the QARANC, all working in different hospitals throughout the Kingdom. Other serving and former members of the Corps have come and gone, most often as locums, a few with the intent of prospecting for a new career, most driven by an urgent financial commitment to top up either mortgage or university fees. Of those who take a job in the Gulf, a little over two and a half years appears as the average duration of tenure, seemingly giving the lie to the adage "two years for need, two for greed". One medical officer was repatriated at his own request after less than a week into his job, but others have remained to become Chief of their specialty, and two, both surgeons, to become hospital directors. Very senior former members of the Corps have been appointed *ab initio* as hospital directors to the larger more prestigious military units.

That some knowledge relating to the Arab world still exists within the Corps is not in question. It is now, however, restricted to a very few who served in Egypt prior to 1952 (and briefly in 1956), in Aden prior to 1967, in Amman during Operation Shoveller in 1968, in Libya before the advent of Colonel Gaddafi in 1968, and in Bahrain before independence in 1971.

The author's exposure to Arabia prior to 1985 was as a member of one of the many Field Surgical Teams supporting the Sultan of Oman's Forces during Operation Storm (the Dhofar Campaign), and to African Islam during a protracted Parachute Brigade Battle Group Exercise in the Sudan. It would be fair comment to observe that a lifetime spent on the North German Plain will prove of little value in helping the newly expatriate medical officer to come to terms with either the climate, political and meteorological, or the culture of the Arabian Peninsula.

How then does the reality of the post oil-boom Arabic world of the late 1980's relate to that knowledge? Do the blandishments of the recruiting agencies, their wares displayed on whole page adverts in the *British Medical Journal* and elsewhere resemble the date palm in that they do not always bear fruit? Or does the lengthy parade of digits formed up after the pounds sterling symbol in the advert resemble the sands of the empty

quarter during a storm – sufficient to blind the unwary traveller?

Arabia's unbelievable income from the 1973 quadruple increase in crude oil prices reversed the peninsula's former relationship with the West; in the span of a very few months the Gulf region became a land of milk and honey, whilst the industrialised West began to resemble an ever-encroaching desert, as national economies, and Governments, fell in the wake of huge increases in unit costs and massive unemployment, both brought about by the seemingly endless rises in energy costs. The Gulf States of 1986 have emerged from a golden decade into a significantly harsher world of political and fiscal realism.

In addition to changes in the economic climate of the region, any medical officer contemplating a career in the Gulf would be well advised to consider the volatile and sometimes violent political realities to be found there, and their far-reaching international repercussions.

Such major political considerations notwithstanding, what other factors are relevant in the decision-making process before a medical officer finalises a commitment to the Gulf? Professional satisfaction, remuneration, leave, living conditions and career prospects are those which spring most readily to mind.

Salaries in Saudi Arabia have, to date, been more generous than elsewhere in the Gulf Region. The silent explanation for this is that expatriates have found it more difficult to live within the rigidity of Saudi Islam than in the more *laissez-faire* Emirates or in the more westernised Oman and Bahrain. This apparent generosity on the part of Saudi Arabia has been cut back sharply by up to a third when compared to salaries on offer in 1984.

Then, a retiring Colonel, a Consultant of fifteen or more years standing, could confidently expect to receive (often in cash) a salary in excess of £60,000 per annum. This was the salary for a Ministry of Health appointment. In addition to this were added education allowance, a thirteenth month's salary and terminal gratuity (often 20% of a year's salary) after two or sometimes three years. In April 1986, however, the dual appointment of Hospital Director and Senior Surgeon warranted a salary of £42,000 per annum without any school fees or other fringe benefits as part of the salary package. The Sultanate of Oman is prepared to pay up to £32,000 per annum for Consultants together with the intangible benefits of access to commercially prepared alcohol and the perhaps dubious privilege of allowing one's wife to drive. These expatriate salaries may be

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compared with that of a serving Brigadier Consultant's pre-tax income of £40,000, or with that of an established NHS Consultant with Merit Award and private practice. Given such a comparison, salaries in the Gulf Region are no longer intrinsically high, but they retain their attractiveness solely because they are not subject to direct taxation and that residence in the Gulf provides an opportunity for off-shore investment. Some hospitals in Saudi currently deduct "hypothetical income tax" from their expatriate employees, and there is now reason to suppose that the imposition of a form of Income Tax is to be launched in 1988 on all wage earners within the Kingdom. In February 1987 the Saudi Government withdrew totally its previously generous pension scheme for expatriates; a twenty year expatriate, having paid 5% of his annual salary (and his employer 8%) to the pension fund, now finds himself without a pension and without any clear idea as to whether or not he will receive his contributions as a "lump sum".

The majority of expatriate medical officers sign an initial annual contract with a hospital management company, most of which are American based. Provision for a review of salary and fringe benefits on completion of the year is normal. Renewals are currently taking place, however, without an increase in either basic salary or benefits. An annual review in one hospital has come to mean that the salary revision occurs after eighteen months with implementation of the award, if any, at some point thereafter. Such unilateral interpretation of what was considered to be a legally binding contract, signed in England, has generated considerable ill-will amongst those expatriates in possession of that contract. Many 'expensive' western doctors are being replaced in hospitals throughout the Kingdom by 'cheaper' Indian, Pakistani and Arab graduates, particularly Palestinians. The non-renewal of his contract was the fate which overtook an ex-Corps Physician recently; he wished to complete a third year in a Government hospital but was rejected in favour of an Indian who accepted less than half the salary paid to the St Thomas's graduate.

Whilst the internationalism of expatriate medicine may at first appear as one of its more attractive facets for some, the retention of the social and professional mores to which they have become accustomed during their years of service is not always easy. The author's professional colleagues range from a Finnish tax exile from Helsinki to a South African Boer evading the racial policies of his homeland. A few isolated pockets of active American medicine remain within the Kingdom. A significant proportion of American doctors practising in Arabia are themselves ex-military and enjoy, on average, a salary twice that of a British expatriate; this together with their remarkably generous pension schemes permits them an extremely high standard of living. Most of these doctors will readily admit their considerable reluctance to tangle with the miasma of

malpractice litigation and peer review committees which permeate medicine in the USA and which now loom darkly over the Hippocratic ethos of medical practice in the United Kingdom. Nonetheless, American medical practice continues to be a major influence in Saudi Arabia and is the yardstick by which all comparisons are made, eg super-specialist teams from the United States are flown into the Kingdom to demonstrate new technologies and operative methods.

A further example of the Americanization of Saudi medical care is seen in the increasingly aggressive financial and marketing techniques developed by the US hospital management groups, more especially so by those in the Government sector. To remain competitive the smaller privately owned hospitals are tending to form consortia in which each member attempts to offer a super-specialist area of expertise. As an example of the "new order", a Consultant Anaesthetist, an Egyptian-American, was recently "advised" by the hospital accountant to complete the preparation for and induction of anaesthesia for elective coronary artery surgery (arterial line, internal jugular line, two peripheral lines and a Swan-Ganz pulmonary catheter) to teach a junior anaesthetist and to correct a hypotension and subsequent dysrhythmias within minutes. The management rationale for this "advice" was that, to take more than a quarter of an hour per case was potentially to deprive the hospital of an additional income of \$100,000 per month. It is worth commenting that all "real money" calculations in the Gulf are measured against the US dollar.

Professional challenge and job satisfaction are widely available in Arabia, but both, sadly, are quite capable of evading the expatriate medical officer. Job satisfaction *per se* can be reduced by the apparently idiosyncratic attitudes of the patients to their diseases, to their immediate treatment, and by their approach to those who are attempting to provide that treatment. In obstetric practice, the absolute refusal of a husband to permit his child to be born by Caesarian section is an everyday occurrence, regardless of the indications for and urgency of operation. In medicine, it is virtually impossible to treat hypertension with beta blockers because of their reputation for causing impotence there are no old men in Arabia. A Saudi father refused operation for his 11 year old son for an obvious acute appendicitis, preferring to put his trust in the tribal medicine man, only to return to the hospital five days later with the boy in septicæmic shock. An adequate explanation for this behaviour is difficult to pin-point given the unending stream of health campaigns organised by the Government and the television exposure of the population to western medicine, both as information and (more regrettably) as entertainment. Such behaviour may be either a reflection of a credibility gap between medicine and the Arab perception of "illness", or a cultural phenomenon implicit in the Islamic tenet that all things are the will of Allah.

Nonetheless, a therapeutic mishap or surgical misadventure can rapidly precipitate either substantial financial reparations to the patient's family (blood money), a prison sentence, or deportation, or all three for the medical officers involved in the case. Three month's unpaid work, a month in prison and deportation was the sequence of events which overtook a retired Royal Navy Surgeon in the very recent past. Deportation normally takes place after the findings of an "investigation" are made public. Such "investigations" are invariably performed in secret by the religious authorities of the region; impartial medical input to the investigation is rare and takes the form of a review of the case notes by a member of the regional university. The doctors involved in the incident are neither present nor represented and there is no right of appeal against these findings. The infallibility of Sharia Law and its prescribed punishments, together with the all-pervasive layers of Government authority, engender a sensation of constant apprehension in many expatriates; amongst medical officers this promotes both defensive medicine and an even more defensive lifestyle.

The epidemiology of the disease patterns of the Arabian Peninsula is an admixture of the familiar (diabetes, hypertension and ischaemic heart disease) and the relatively unfamiliar (schistosomiasis, hydatid disease, extensive brucellosis and a variety of haemoglobinopathies). In obstetric practice, grand multiparity is the norm, and the principal problem in obstetrics is to try to persuade the Saudi patients to accept anti-natal care. Diarrhoeal disease in the first months of life represents a significant cause of infant mortality. For the surgeon, road traffic accidents provide the single most frequent challenge. Gunshot wounds received during feuds are not uncommon in the more remote areas where the Bedouin lifestyle persists. There is little doubt that significant shifts in disease patterns have occurred during the Gulf's "Golden Decade"; one example is in dental caries. Deep waterwells, for generations the sole source of water, were over-rich in fluoride, and produced brown-stained but rock hard teeth. Desalinated sea water is now piped through the Kingdom. As it is devoid of fluoride ion, the teeth of the nation's children are beginning to reflect this deficiency, aided, no doubt, by the ubiquitous cola and candy bars.

Diagnostic, laboratory and therapeutic hardware is invariably culled from the upper realms of European or American technology and most hospitals can only be described as lavishly equipped. Little serious thought would seem to have been given to the necessity of purchasing some of the hi-tech facilities. The author recently visited a 150 bed military hospital replete with a CAT scanner, and two more such instruments were *in situ* in other hospitals in the town which boasted, at best, a population of 60,000. Problems in supply and training occasionally limit the effectiveness of some of this

equipment however. Biomedical units of measurement are the once familiar milli-equivalents and milligrams percent, a reflection of the failure of the SI units to cross the Atlantic.

Living conditions for medical officers within different hospitals vary considerably. The spectrum viewed by the author whilst visiting former members of the Corps ranged from a two-roomed flat in an asbestos-roofed breeze-block hut (the home of a former Consultant Adviser whose knowledge of entomology enabled him to identify his nocturnal companions) to a three-bedroom, house-boy included apartment in the capital city. Recreational facilities within hospitals vary in a similar manner from virtually none to one hospital which, in addition to tennis, squash, olympic pools, a yacht club and weight training rooms, is able to boast three sets of sauna baths.

The international hotel chains quite frequently include sports complexes within their facilities and annual membership fees for these range from £100 to £250. Jogging is popular with expatriates of all nationalities; whether this is a manifestation of a wish to remain physically fit or an escape route for inner frustrations is uncertain. Ten kilometre, half marathon and, indeed, marathon road races are held in the cooler weather. The Saudi Arabs themselves, for historical reasons, do not have a sporting tradition, although football is increasing steadily in popularity (the 1986 Mexico World Cup was carried live by most TV stations in the Gulf) and cricket is popular in the Emirates.

Segregation of the sexes is a major aspect of Islamic life, more so in Saudi Arabia than in some other Gulf States. The extent to which this doctrine is applied to the expatriate community in different areas of the Kingdom occasionally seems haphazard, and is quite capable of overnight change. At one hospital in the restricted military zone close to the Jordanian border, all female employees are kept literally under lock and key to prevent them being seen in public. They are bussed from their accommodation the few tens of metres to the hospital main entrance, but, once inside, they are free to walk, talk and dine with whomsoever they may choose. Muslim/non-Muslim and male/female separation in hospital cafeterias is common. Mixed bathing in hotel pools is prohibited. Even to stay in a hotel, a married woman is required to produce her passport, her husband his work permit, and the requisite Government documentation permitting him to travel within the Kingdom. This paperwork is routinely scrutinised by hotel reception staff to ensure that an adulterous relationship does not exist between the guests. In the case of a Saudi woman, the punishment for such a relationship is to be stoned to death; expatriates may expect jail and deportation. Expatriate women may offend the religious authorities by not covering their arms or ankles when appearing in public. To avoid this, many women wear the all-enveloping formless black dress, or *habiyah*, but even this deference to Islam may

means of a direct dial satellite link is simple and costs £2.00 per minute from Arabia and £1.50 per minute from UK. Postal services are essentially good, but prone to the vagaries of the region. Air travel between Europe and Arabia suffers from a relative over-capacity of aircraft seats, and significant discounts (in excess of 50% of IATA advertised prices) are available. The Bahrain Causeway offers access to airlines which do not have landing rights in Saudi Arabia, such as Qantas.

Consumer durables and luxury items abound throughout the region and at present there is no direct taxation on these items. Food, flowers and fashion goods are all expensive, but petrol costs 30p per gallon. Japanese cars are less costly than they are in the UK, but are rising in price as the yen continues to rise against the dollar. Korean automobiles are now increasingly seen in the Gulf, as are Korean electronic products; both undercut the yen. The road system in Arabia is excellent but the standard of driving is universally appalling. Many expatriates simply refuse to drive, thereby eliminating the chance of visiting jail as either a participant in or a witness to a high speed motor vehicle accident or tyre blow-out.

Rumours of impending social and political change abound in Saudi; one such rumour suggests that Saudi women, now better educated than ever before, may be encouraged to play a larger role in National life and to reduce the country's dependance on expatriate labour in some service areas; nursing would be an example.

Despite this, the *British Medical Journal* and *Lancet* still advertise on behalf of hospitals in the Gulf for most medical specialists and for nurses – particularly for midwives. Since most developed countries in the West have made it far from easy for foreign medical graduates to gain postgraduate clinical experience within their hospitals, it may be assumed that the Gulf will continue to have a need for expatriate medical expertise at consultant levels for perhaps another decade, or until such time as their own graduates build a medical system comparable with or better than that of the West. Training within the Eastern bloc, which is common for many countries in Africa and Asia, is not particularly acceptable at the moment to the absolute monarchies of the region. The majority of pre-clinical and clinical teachers in the medical colleges of Saudi Arabia are expatriates, frequently African, who are enjoying a financially rewarding sabbatical of one or two years in the region. English is still the language of medical education, but this will change to Arabic when sufficient indigenous academics are in post. At present, expatriate academics who are annually graded as less than either outstanding or excellent have their contracts terminated. To be graded good, is bad. The teaching staff do not grade students.

There can be little doubt that many clinicians in the Royal Army Medical Corps who have practised medicine over a wider geographical area than many doctors, are well qualified to assist the professional

aspirations of newly qualified Gulf graduates. This highly personalised view of Arabia has attempted to cast some light on several less well known aspects of life and medical practice in the region. Any medical officer who

is considering a delay in taking his place in God's waiting room at Frinton-on-Sea should remember that, just as a droplet of spilt crude oil glisters in the Middle Eastern sun, all that glisters is not gold.

THE SYNTEX AWARD

In 1982 Syntex Pharmaceuticals instituted an award for projects submitted by RAMC General Practice Vocational Trainees. The Annual Prize is £100 and is administered by the RAMC Prize Fund through a nominated Syntex Award Committee.

The 1986 Syntex Award was won by Captain R G W Anderson with a paper entitled "Uptake of Measles Vaccine in an Army Group Practice". He is seen here being presented with cheque and bound copy of his

paper by DGAMS, Lt Gen Sir Cameron Moffat. Mr Barry Turner, the Syntex representative, is also in attendance.

Captains T D Manners and P E Sharples were runners-up in the competition and received book-token prizes from Syntex for a paper on the audit of a Paediatric Surveillance Programme in an Army Group Practice.