

SUDAN'S WOMEN DOCTORS IN 'NINJA MASKS': PRACTICING MEDICINE BEHIND A VEIL COVERING THEM FROM TOES TO FACE

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Abstract

Islam is religion of around two thirds of the Sudan population, and plays an important role in their lives. In this review we discuss the increasing trend among a sector of Sudanese women doctors to wear *niqab* which is an Islamic dress that covers a woman from toes to face, with only a small slit to allow her to see. For the benefit of non-Muslim readers, we forwarded our review with a detailed description of Islamic viewpoint of dress and its different version throughout the Islamic World. We also gave in detail the English meanings of the Islamic Arabic words (written in *italic*).

Wearing *niqab* carries serious impacts on the medical profession and medical education. The wearers tend to be isolated and less reactive or cooperative with colleagues and seniors. The process of communication with patients is expected to be adversely affected. There are fears of a trend to gender segregation at both health settings and medical schools.



Doctors' dress

Since the Hippocrates era doctors have been given advice on the way they should dress.¹ The basic function of a doctor's dress style is to favourably influence doctor-patient relationship, especially in aspects such as trust and confidence building. In general patients prefer that their doctors to dress in traditional way (i.e. a white coat and formal suit).² They feel that they would have more confidence in doctors with this dress style.² The least disliked outfit is tweed jacket and informal shirts and ties.³ In particular old patients and those in higher social classes prefer the traditional style.² For children and teenage patients the situation is different. In one study 43% of a teen sample stated that the dress of their doctor 'makes no difference for them', and only 25% said that they prefer them to wear a white coat.³ On the other hand, there is a view that there are more important attributes for a doctor than the way he or she dress such as availability, kindness and clinical competence.³ Also, some doctors believe that the new advances in medical practice have outgrown the need for using dress as means of impressing patients.³

Religion and medical care

Worldwide, there is an increasing interest on discussing the role of religion (and spirituality) in the medical care.^{4, 5, 6, 7} This shows the potential impact of religion (negative or positive) on health and disease. In one study, two thirds of participants feel that their physicians should be aware of their religious and spiritual beliefs.⁸ But, nevertheless, little attention is paid to study physicians' particular cultures and values that may influence the clinical encounter, especially in the way they relate and provide care to patients.⁹ This is best investigated by assessing 'intrinsic religiosity' which represents the extent to



which an individual embraces his religion as the “master motive” that guides and gives meaning to his life. ¹⁰ This can be measured by variable tools such as agreement or disagreement with the statement, “I try hard to carry my religious beliefs over into all my other dealings in life.” ¹⁰ In an American study including physicians from all religions, it was found that although they are likely to attend religious activities regularly, but less likely to consciously make efforts to apply their religious beliefs to other areas of life. ¹⁰ The same study suggests that physicians and patients differ in their reliance on God; while patients look to God for support and guidance, the physicians try to decide what to do without relying on God. ¹⁰ Some international studies that investigated the relationship between religiosity and clinical speciality had found that paediatricians and family physicians are the most religious, and psychiatrists the most secular. ^{11, 12}

Dress: Islamic viewpoint

Islam (Islamic religion) require that its followers to totally submit to teachings of Allah (the proper name of god in Arabic). For the faithful Muslim, Islam is supposed to control all aspect of his life. What should a Muslim wear is no exception. Muslim women who adhere to the tenements of Islam are required to follow a dress code called *hijab* (an Arabic word means veil, cover, shelter, screen) or *purdah*. ¹³ In the *hijab* or veil, the body is covered by a robe and parts of head and face are to be covered by a veil or headscarf. There two types of headscarves worn by Muslim women to ensure decency of her dress. The first one covers hair ears and neck and leaves face uncovered; it carries different names through the Islamic World such as *khimar*, *dupatta*, and *baknuk*. ¹³ It is usually worn by moderately religious woman Muslims. The second type of headscarves covers the entire head and face except for a slit (or netting) for eyes



to allow a woman to see; it carries different names such as *niqab*, and *burqa*. It is usually worn by fundamentalist Muslims, being the most extreme example of Islamic dress. In both types of veil, the woman is required to wear a loose, high-necked robe that covers the whole arms and legs and rest of the body (*Jilbab* in Arabic). The rationale of Islamic dress is that a godly Muslim woman should not draw sexual attention toward her by wearing this concealing clothing which also entails acts of respect and dignity. In private, and in presence of close relatives at home, rules of dress are relaxed. The term ‘veil’ or ‘purdah’, is perceived by some Muslims, as a social system of values and norms used to designate the practice of secluding women from contact with men outside the immediate family. In addition to wearing veil, this goal can be achieved making separate rooms for women at home, and by provision of segregated public facilities.¹³ Thus women are assumed to be weak and vulnerable and in need to be protected from their own sexual sensations or men’s sexual advances.¹³ The veil is not a class phenomenon. It is worn by women in all social classes, irrespective of their educational or professional backgrounds. The advocates of *hijab* claim that veiled women are recognized as individuals who are admired for their minds and personality and not for their beauty or lack of it, or as sex objects.⁵ (Mustafa). On the other side, the critics of *hijab* claim that it is out of style, restricts the women’s chances in many professions and that in some instances they are enforced to wear it (by state or a male family member).

Throughout the Islamic World, there are varied versions of the Islamic dress. In Saudi Arabia women wear *abaya* (a loose robe) in addition to a veil as described above. A similar dress is worn in Sudan and Egypt. In Pakistan, Islamic dress is called *pakchadar* (a garment with a headscarf).¹³ In Afghanistan, women wear



the *chaddri* (a headscarf that extends into a pleated coat, covering everything but hands and feet).¹³ In some countries such as Saudi Arabia, Sudan and Iran wearing an Islamic dress is obligatory (if not worn a woman might be subjected to some form of punishment). It is no doubt that the Islamic regimes prevalent in these countries have brought with them a return to ultraconservative values. The increasing influence of fundamentalist Islamic organizations (as in Egypt, Afghanistan, for example) underlies the emergent spread of Islamic dress in these countries. Even among immigrant Muslim communities in Europe and North America wearing veil might be taken as a means of self-expression.¹⁴ Thus, in most of Muslim countries, whether governed by Islamic or secular regimes, numbers of veiled women is on the rise. As pointed out by an observer “it looks as if the veil is turning out to be a symbol of modernity and not of conservatism”.¹⁴

Historically, the first instances of women’s veiling are recorded in an Assyrian legal text from the thirteen century BC (but it was restricted to noble women).¹³ There are some opinions that Quraan (the holy book of Muslims) does not stipulate veiling or seclusion of women, but they are social habits been assimilated from the conquered Persian and Byzantine societies.^{15, 16} Even more some historians claim that the early generations of Muslims were somewhat flexible on the dress of their women.¹³ By time, laws and rules associated with dress become more severe and ostentatiously restrictive, perhaps as a sign of Islamic enthusiasm or piety.¹³ Until the twelfth century AD the Anglo-Saxon and then the Anglo-Norman women wore veils that cover parts of their heads and faces. At different times, the veils were worn by non-Muslim people at different occasions such as at times of funerals, mourning, weddings, on entering



a church. Almost the only instance of use of veil to hide face by men is among the men of Tuareg tribe in North Africa (but their women do not traditionally wear veil!).

Sudan's women doctors and niqab

The decade of the 1990s was marked by the major turning point in the pathway of medical education in the Sudan.¹⁷ In a few years the number of medical schools rose from three to more than twenty, and the annual intake of medical students increased from 300 to more than 1500. There was a dramatic increase in the intake of female students to medical school to as high as 60% in the academic year 1997-1998. Although we could not get a definite figure from the concerned authorities but, roughly, the women may constitute more than 60% of the registered medical students at the present time.¹⁷ With the increase of numbers of women graduates and migration of men, the total number of women doctors may reach two thirds or more of the total doctors in the coming few years.¹⁷ Officially, there is no a certain uniform in our medical schools, but every woman (outside home) is required to cover her hair and to wear long dress to cover her legs and arms, otherwise she might be barred from entering her school or workplace. But in the last few years there have been increasing numbers of students and practicing doctors who used to attend to their schools and hospitals wearing the *niqab* (that completely covers them from foot to face). This 'phenomenon' also occurs in similar rates in other university schools and work settings. As a teacher, I notice that these students are passive and too reluctant to actively participate in academic and training activities such as examining an adult male patient (even those with no venereal or urological problems). Even more, the veiled students have far limited contact with their



male colleagues (and sometimes even female ones). They are usually, themselves, members in a radical Islamic organization or from a family dominated by such fundamentalists.

Niqab: impact on medical care

Should a female Muslim doctor wear what she wants to? Apparently this simple question is no more than a common sense, but in reality it is a rich source of conflict between the physicians' individual right to self-expression and their duties to act in the interest of their patients, and also between religious affiliation and membership within the medical profession..¹⁸ For example, for a faithful Muslim woman doctor, a dress code prescribed by her religious affiliation determine what she wear, with no regard to any requirements set by administrators of hospitals or medical schools. Doctors in Sudan are a highly respectable social sector, being the most privileged and profitable. Usually, the society expects them to behave conservatively in most aspects of their lives, including their clothing. This conservatism, as I see it, should exclude an eccentric dress such as *niqab*, where the patient is has to sit to a black 'ghost' covered from foot to face (usually in black colour). Of course a minority might advocate wearing *niqab*, as it is no more than religious affiliation or fashion statement. Even in a liberal society like the American an eccentric behaviour such as body piercing was found to affect the patient's trust and judgment of physician competency. Even those persons who themselves are pierced view pierced physicians negatively.^{18, 19}

The *niqab* offers a great chance for cheating in examinations (both written and clinical). It happened once at Cairo University medical schools that practicing



male doctor used such a veil and entered the examination room to answer the written examination questions instead of his sister!

The veiled women (as patients or medical students) usually do not feel comfort on attending health settings and medical schools attended by both sexes. They are rather at ease in female-only environments, even on other aspects of life such as markets and places of entertainment. In particular, I notice that veiled women refrain from consulting male doctors on issues of family planning and gynaecological problems. A European doctor who had worked in a rural area in Afghanistan had observed the impact of subordinated status of women on a minor issue such as visiting her doctor.²⁰ A male doctor can not examine a woman below her waist and he has to question (to obtain medical history) the man who accompany her to the clinic and not the woman herself.²⁰ In the early 1980s the Iranian strong leader Ayatollah Elkhomini issued a religious opinion (*fatwa*) that examination of a woman by a male gynaecologist violated religious rules.²¹ The situation is worse among families of fundamentalist Muslims (even in countries ruled by secular governments) who prohibit their women from visiting male physicians even in non-gynaecological problems, and even if a female physician is not available. These variable patterns of gender segregation might affect training of medical students. Male students will not receive enough (if any) training in clinical problems of obstetrics and gynaecology, and likewise, female students will not receive proper training in male urology.²¹ This may adversely affect the situation of health services in most Islamic countries (already dominated by deficit in manpower).



Effective communication between the doctor and his patient is a critical component of quality health care. A ‘good’ doctor-patient relationship (rapport) can be defined as having an easy and comfortable relationship, and it include warmth, respect, interest and enthusiasm for serving the patient.²² There are profound effects of the way a doctor communicates with his patient. The more informative and supportive the physician, the more his patient is satisfied with care, better understanding of his health condition and actively involved in diagnostic and therapeutic decisions.²³ There several factors that can affect doctor-patient relationship; of these are the characteristics of individual physician such as his sex, age, and appearance. For example, a large scale study found that female physicians are more engaged in more positive talks, more partnership-building, question-asking and information-giving.²⁴ But the question, here, is what about the situation for the woman Muslim doctor that wears the *niqab*? . *Niqab* is not only a piece of cloth or a dress fashion. It is one component of an Islamic religious practice aiming at baring a woman from contacting any man apart from her husband and immediate family. This practice in its orthodox version views a man (apart from close relatives) as an evil or a source of all the sin in the world. Therefore, a godly woman should not see or talk to a man or let a man see or talk to her. It is quite clear that there is no a real chance for a doctor in *niqab* to make an effective communication with her male patients (who are obliged to deal with a ‘ghost’ that totally covers ‘its’ face (and also his feelings and expressions!). Some children might be frightened by this *Ninja-masked* creature that is supposed to speak and examine him. Some extremists consider that even the mere voice of women as *aawra* (a thing that is undesired to be heard or seen by the others). In their etiquette, the Sudanese welcome each other by hand greeting, followed by some informal comments on



health, but, for the veiled women, hand greeting is considered as *haram* (an act that is strictly forbidden by god). Refusal of hand greeting or welcoming a male patient with a brief head nodding is the first ‘shock’ who might immediately refrain from been seen by this ‘estranged’ doctor. There is a doubt if veiled doctors could engage themselves ‘sensitive’ issues such as sexual or urological problems with their male patients.

At the present time, women doctors who wear *niqab* are obliged to see male patients at health settings, or have their undergraduate studies with their male colleagues. At medical schools, they tend to keep contact with male students to the minimum. They usually choose to work at obstetrical and paediatric and other units away from adult male patients. They hope that over time and increase spread of veil wearing there will be a gradual social acceptance of *niqab* and other types of veils. At different times, during 1990s, there were some failing trials to segregate male and female students at classes and practical sessions, but they only succeed in imposing a moderate version of *hijab* (a headscarf covering hair and neck, and a long dress to cover arms and legs), otherwise would not be allowed to enter a school or a work place. Of course veiled doctors dream that the concerned authorities, at some time, will perform total gender segregation at both health settings and medical schools. At the present time, of the 26 medical schools there are only two of them with female-only intake (one of them is part from a secular university established to secure enough chances for women in high education, and the other is an Islamic university).



Conclusions

Enthusiastic Muslims believe that women should be isolated from physical contact with people outside her immediate family. Wearing *niqab* fulfil this requirement by preventing other people to see her. The women doctors, in spite of any professional requirements, are not exempted from wearing *niqab*. As we saw above, wearing *niqab* is associated with some adverse effects on medical care. Some opinions view that *niqab* is worn by only a small minority as a way of expression of their religiosity, and we should consider values of tolerance and not to contribute to marginalize people with different views. On the other hand some view that the efficient doctor-patient relationship which is essence of the professional role of doctors (adversely affected by *niqab*) requires some compromise (as any other relationship). We hope that women doctors should weigh their own right to wear *niqab* against the profound adverse effects on interaction with their patients. We believe that the individual personal preference is not the only consideration. In this regard one can advocate policies forbidding women doctors from wearing the headscarf (*niqab*). It is easier to change a doctor's dress style than, for example, than to change his bedside manners. So they should dress in a way that inspires confidence of his patients.

On the other hand, there is a need to assess the attitudes of patients toward the eccentric dress styles of their doctors (*niqab* is an example). In addition, we need to try to establish if patients think that the way their doctor dresses affects his or her effectiveness as a doctor (that is whether it makes them more likely to follow his advice). The *niqab* wearer (doctors and students), as well, can be a subject of investigation in regard to issues such as academic and professional difficulties facing them, and their relations with senior and junior colleagues.



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