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Powerful Words: An Exploration of Linguistic Hierarchy in Moroccan Hospitals

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Powerful Words: an Exploration of Linguistic Hierarchy in Moroccan Hospitals

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ABSTRACT

Morocco is a country of distinct diversity, which exists as a result of the settling of multiple peoples and European colonization. As a result of this diversity, many languages are employed in different settings and spaces, and of these languages, French represents remnants of colonialism and continual elitism in the country. One of the spheres that French commands in Moroccan society is medicine, which creates a dichotomy between the educated health care providers and the underprivileged patients in public hospitals. The aim of this paper is to explore the effect of French on the doctor-patient relationship in urban, public Moroccan hospitals. Through secondary research and personal interviews, it will outline the understanding of the language situation in hospitals from the point of view of both the doctors and the patients, describe the effect of French on patients' understanding of healthcare, and explore the impact of French on patients' agency within the medical system. Ultimately, this paper aims to shed light on the intersections of culture, history, and medicine in order to explore avenues for process.

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INTRODUCTION

For as long as I can remember, I have had a keen interest in medicine. I was the precocious toddler who could never be found without her toy stethoscope, treating family members and fellow children alike. Similar to most children, I didn't think there was much to medicine other than science, and therefore dedicated the most effort to my STEM classes through high school. It was only after beginning college, and completing coursework in disciplines such as anthropology and sociology, that I began to develop a consciousness of the social aspect of healthcare. Since pursuing these disciplines, my interest in medicine has shifted away from that of hard sciences and towards a more holistic sense of well-being, which treats a patient instead of her symptoms. This overarching approach to healthcare incorporates concepts such as patient-related care and bedside manner, which help to ensure that the patient has the best possible interaction with the medical field. I was fortunate enough to find a connection between this field and Morocco before even stepping foot in the country; on the plane from Paris to Rabat, I read the first chapter of the book *Encountering Morocco*, which details ethnographic experiences in Morocco from a multiplicity of perspectives through different stories in every chapter. In this fateful first chapter, ethnographer Charlotte E. Van den Hout describes a scene in a psychiatric hospital where French and Darija, Morocco's dialect of Arabic, influence dynamics of power between doctors and patients. I had stumbled upon a uniquely Moroccan situation in healthcare that would continue to intrigue me as the semester passed, especially when I began to learn more about the country's colonial history and the presence of each language in society.

Morocco has always boasted a wide variety of cultures and languages. Currently, Modern Standard Arabic (Fus'ha) and Amazight, the language of the indigenous people, are the two

official tongues, while Darija, French, Spanish, and English are used to varying degrees and in different settings. Despite its official status, Amazight does not carry the same level of gravity and importance as Fus'ha or French; the latter two languages are employed in professional and elite spheres, demonstrating a sophisticated education and considerable privilege. Darija is in a similar category to Amazight in that it does not command importance or particular attention when spoken, as ordinary people conduct their ordinary lives in the language. French is the language of all higher education, including medical school, and consequently everything in the medical school is conducted in French regardless of a patient's level of understanding of the language. In an average day, a Moroccan doctor performs tens of consultations, writes hundreds of prescriptions, and confers with many other doctors entirely in French. However, there is a significant portion of the population who do not speak French, rendering the world of healthcare entirely foreign to them.

This study explores the effect of the language hierarchy that exists in Morocco, in part due to lingering colonial influences, on the doctor-patient relationship in Moroccan hospitals. If possible, it will provide an explanation of the linguistic hierarchy situation from the perspective of both doctors and patients to illuminate the current situation in Moroccan hospitals.

This paper will seek to address one question: how is the doctor-patient relationship impacted by the omnipresent use of French in urban Moroccan hospitals with non-French speaking patients? Does it affect the level of trust or comfort? Does it reinforce traditional hierarchical roles in the pairing?

This paper will be structured in the chronological order I experienced this research. It will first provide a historical and social context for the research I will be conducting. Then, it will explain the hypothesis I have developed based on secondary research. Next, it will explain the

methodology behind the fieldwork portion of the study. It will then organize and discuss the findings to address the research questions, and finish with an analysis of the findings.

This paper is written through an autobiographical lens to emphasize the growth I experienced over the course of this study. This research has been a course of discovery for me, the author, regarding the dynamics of language in Morocco, the politics of healthcare, and the intersection between the two, and my findings have inevitably been shaped by my own perspective. I want to be able to explain the evolution of my understanding of the subject and provide an analysis with my unique bias in mind, and therefore this paper is a demonstration of my journey of research and synthesis of information.

LITERATURE REVIEW

History of Morocco

Morocco is a country of incredible linguistic diversity, owing to its rich history of varied inhabitants combined with the force of European colonialism. The original inhabitants of the region, the Berber people, were conquered by the Arabs around 700 AD, who subsequently converted the indigenous population to Islam. Ultimately, the Berber population was able to surmount this conquest through a series of dynasties from the 11th to 16th centuries, bringing Morocco to the height of its power. Midway through the millennium, the region was transferred into the power of successive Arab dynasties collectively known as the Sharifian dynasties. The most recent of these, the Alaouite dynasty, continues to occupy the throne today: Alaouite is the name of the current royal family¹.

In the early 20th century, Morocco experienced its first taste of European colonialism in response to political instability in the region. European tension in the region was already quite

high, and with the French conquest of Algeria already complete, the colonial power was keen to gain further influence in northern Africa. The Crisis of Agadir in 1911, a rebellion against the sultan Abdelhafid in Fez, prompted the intervention of French, Spanish, and German troops to the region; this overflow of European influence was subdued by the Treaty of Fez, signed in 1912, that officially designated Morocco as a French Protectorateⁱⁱ. During this era, Morocco remained a sovereign state for all legal purposes; however, the sultan became a figurehead, taking a backseat to the new colonial government. France chose to employ a different approach to the Moroccan Protectorate than the occupation in Algeria in hopes of better integration into the Moroccan public. This approach consisted of identifying the Moroccan elite class as fit to rule, and garnered their approval by offering the upper class French education opportunities for their childrenⁱⁱⁱ. Colonial rule in Morocco came to an end in 1956, when King Mohammed V signed the French-Moroccan agreement to transform the government into a constitutional monarchy free of European control.

Now, more than half a century after the establishment of Moroccan independence, traces of colonial influence still linger throughout society. Nowhere is this seen more clearly than in the prominence of the French language, which permeates businesses and government alike. The language has no official status in Moroccan society, as it is not included in the same category as Fus'ha and Amazight, but nevertheless command of French is imperative for upward mobility in Moroccan society, and is spoken in some capacity by approximately 66% of the population^{iv}. This is at least in part due to the fact that all tertiary education in Morocco occurs in French, and has been so for decades; even during a bout of Arabization post-independence, universities continued to instruct in French, potentially due to a lack of qualified teachers^v. This includes, most topically, medicine; a strong command of French is often correlated with professional

competency^{vi}. This phenomenon becomes problematic when we consider the dichotomy that occurs in primary and secondary schools across the country: public schools teach in Arabic, while private schools generally either instruct in French or introduce the language to students much earlier than in public school. As a result, private-school educated children generally fare better in university owing to their superior proficiency in French, allowing them to graduate and prosper^{vii}. This process, then, becomes cyclical, and serves to stratify society separately from the parameters of class divides. The government has acknowledged this disparity, and in February 2016 addressed it by mandating the gradual transition from Fus'ha back to French as the language of instruction in public high schools^{viii}. However, this is of little help to current products of the public school system, who suffer due to their lack of French proficiency.

French and Darija

It is important to note briefly the significance of Darija in Moroccan society. It is not an official language of Morocco, as to be considered a part of the Arab world, each country must designate Fus'ha as its official language as opposed to its own dialect, but is the vernacular of most ordinary Moroccans. Most interactions, from bargaining in the souk to conversations in the home, take place in this *lingua franca*^{ix}, which is spoken by 96% of the urban population^x. The use of French in a conversation where the default language would normally be Darija would be met with confusion, as French is not intended for this informal sphere.

Doctor-patient dynamic

The world of Western medicine is a very particular one. The biomedical approach to medicine is relatively new to the healthcare scene in comparison to the thousands of years of traditional healing methods; it has only gained significant traction in the past few centuries. However, its commanding presence is both undeniable and ubiquitous, a sentiment echoed by

book reviewer Arnold Relman: “Few other professions conduct their affairs with so much autonomy and receive in return such generous economic benefits. In a country [the United States] historically suspicious of privilege and authority doctors have enjoyed a large measure of both...”^{xi}. Healthcare providers also enjoy an extraordinary amount of power that accompanies the complete monopolization of the medical field, as they control both the supply and demand for medical products and services.^{xii} This, understandably, gives doctors an exceptionally favoured position in society: a highly educated individual with unilateral authority regarding her patients’ well-being wields considerable power. Author Paul Starr explains that “power, at the most rudimentary personal level, originates in dependence, and the power of the professions primarily originates in dependence upon their knowledge and competence,” and thus the nature of the doctor-patient relationship often results in a certain power dynamic that favours the healthcare provider^{xiii}. This dynamic can be likened to a concept such as paternalism, where, the doctor possesses the knowledge and authority on the issue, gives orders and expects patients to reply, and can reprimand the patient if she fails to follow orders^{xiv}. Although patient-centred care is beginning to gain traction, most medicine is still practiced in this traditional, hierarchical sense.

Patients, to their credit, are not oblivious to the nature of this situation, and in fact perceive quite acutely the gap between themselves and their caregivers. One patient in a study pointedly described the phenomenon of doctors being “up there” and “us patients being down here”, highlighting the clear sense of hierarchy in the relationship. Another patient said that “years ago, the doctor was God and if he told you to, you know, stand on your head in a corner, you probably would.”^{xv} The power possessed by the doctors, and in turn perceived by the patients, has the potential to negatively impact patient care if the doctor allows this hierarchy to

impact her relationship with her patients. Multiple studies have demonstrated that higher rates of problem resolution are achieved when doctors and patients share a perspective, implying the employment of teamwork in a diagnosis or treatment. Therefore, a lack of trust and agreement between the doctor and patient can conversely negatively impact these processes. A study in Canada explained that “providers who think they are especially good at communicating with their patients are not necessarily seen that way by their patients”, sometimes even despite the doctor’s belief that she is communicating effectively with her patient^{xvi}. Despite a doctor’s best intentions, she might not be adequately bridging the gap between herself and her patients to provide them with the best possible care.

HYPOTHESIS

The literature review discusses in detail both the presence of the French language in Morocco and the nature of the doctor-patient relationship. This relationship, in Western medicine, is ubiquitously hierarchical in nature, due to a multiplicity of factors: an elite, coveted education, the unilateral transfer of knowledge and expertise, and the influence on the entire medical field are only some among the many that contribute to this power dynamic. In Morocco, as aforementioned, French is the language of the elite, and stratifies the population as it permeates society. When French, in the Moroccan context, meets the situation of the doctor-patient relationship, Charlotte E. Van den Hout hypothesizes that among other factors, the employment of French is a marker of status within the hospital walls^{xvii}. From all the information I have synthesized above, I predict that the use of French by doctors in Moroccan hospitals only further separates the doctors and patients, exacerbating the power dynamic that is inherent in the doctor-patient relationship. I am curious as to how Moroccan patients perceive this circumstance, and will be seeking to address this throughout the course of this paper.

METHODOLOGY

In embarking on this project, I quickly realized that my fleeting observations on French and healthcare in Moroccan society lacked considerable depth and context. I sought to rectify this problem by compiling resources for a literature review before collecting data to analyze, simply to garner a clearer picture of the issues I was looking to address throughout this study. As part of this research, I spoke with Dr. Yelins Mahtat, who is, among other things, a linguist at Mohammed V University in Rabat. He provided me with a slew of information regarding Morocco's tenuous relationship with its former colonizer and its impact on the Moroccan identity. With a more complete picture of the situation at hand, I felt comfortable collecting data to use for this study.

Since most medical facilities have an excessive amount of bureaucratic red tape to confront, and given my limited time frame, I wanted to solicit insider help in obtaining interview contacts. To do so, I contacted Dr. Mohammed Hassar, the doctor who presented about Moroccan health risks to our SIT group during orientation week. He put me in touch with one of his colleagues, who I went to meet at the hospital he worked at. From there, I was able to meet a few doctors who were willing to help me, and I began the authorization process to conduct research at this hospital. Once all the paperwork was complete, I was fully authorized to commence the data collection process.

I collected all the quantitative data presented in this study at one hospital, a public, specialized hospital located in Salé. Due to the difficulties I encountered in securing a site to observe doctors and interview patients, I did not have enough time to find and establish a new research site in the time allotted for ISP. I recognize that this might have had a considerable effect on the results of my research, a concern I will address later on.

The first method of research I employed was observation of the doctor-patient relationship. I spent approximately 16 hours observing doctor-patient consultations for various rheumatoid-related concerns. The shortest consultation I observed lasted 13 minutes, and the longest almost half an hour. The conversations with the patients took place almost entirely in Darija, so I was unable to understand most of the organic conversation, but the doctor often turned to me to explain what she had just said, and many patients made an effort to communicate with me, which I reciprocated to the best of my ability in my limited Darija.

In tandem with the observation of the doctor-patient interactions, I shadowed the doctors throughout their other activities, including consultations with other doctors and rounds to visit patients. This was to gain an understanding of the way the doctors interacted with the rest of the hospital patrons outside of the more intimate consultation setting.

The final method of data collection I used was interviews. These came in both structured and unstructured forms, mostly out of necessity; the doctors were so busy in the hospital that my only opportunity for interviewing them was in between patient consultations. These informal interviews consisted of questions about the consultation that had just concluded, or a continuation of a conversation that had occurred before the arrival of the last patient. I conducted six structured interviews with patients referred to me by one of the doctors I shadowed. All of the interviewees were middle-aged to elderly women, which was the principal demographic of the hospital. I would have preferred to interview both men and women for a more varied perspective, but women proved much more willing to participate in an interview and they outnumbered the men by a wide margin, so there was more opportunity to recruit women.

In the process of conducting this research, my positionality undoubtedly shaped some of the results I gathered. To begin, I chose to interview the doctors in French, as I do not speak Darija,

and used a translator to interview patients who only speak Darija. These considerable language barriers affected the quality of answers I received, seeing as nuances in conversation are lost with the use of a translator and the lack of words to describe ailments and feelings through different languages. I believe my status as a foreigner in Morocco also shaped the type of answers I received, as in my personal experience in Morocco foreigners are treated quite differently than other Moroccans. Some of my informants could have simply been telling me what they thought I would want to hear or was more accustomed to, and there is also the possibility that my informants sought to shed Morocco in a rosier light for the international attention being addressed towards them. Being a woman in Morocco also poses considerable challenges, one of which includes the constant catcalling and general street harassment. This different perspective on women is evident in their treatment, and I experienced this throughout my research.

These biases that I have identified in my informants also apply to my own point of view as a researcher. My female, Western, privileged lens influenced my perception of my interviews and participant information, and in turn could have guided the course of my conversations or my observations. Luckily, after three months of living in this country, most of the initial shock over differences from my familiar Canadian and American setting has subsided; factors such as the omnipresence of Islam and the treatment of women in the street no longer take me by surprise. I am therefore better equipped to undertake this project now than when I first arrived in Morocco, but there remains parts of my view that I cannot shed. Instead of trying to minimize this bias, which is near impossible, I acknowledge it here and attempt to use it to the best of my ability. This position gives me the advantage of having another culture and practice to reference, which allows me to reflect critically on my surroundings.

Despite my best intentions in the completion of this study, I encountered many challenges. The time constraint of three weeks to complete the ISP was the most difficult to address, as it greatly limited the amount of fieldwork I was able to conduct. To do this research justice, I would have preferred weeks, or even months, of participant observation, and dozens of interviews from doctors at various stages of their careers. Of course, I could not extend the length of the ISP period, but I capitalized on my shadowing opportunities by spending as much of the day as possible following and learning from the doctor. In addition to this challenge, finding doctors to talk to also proved to be difficult due to the seemingly impenetrable nature of the hospital system in Rabat. The bureaucratic system made it impossible to walk into a hospital and find a doctor to talk to, so I was instead pressed to explore other avenues. Contacting doctors I already knew to get my foot in the door proved to be the most effective method to combat this issue. Finally, as aforementioned, only gathering data at one hospital could have serious limitations on my research and prevent the generalization of these findings to all of urban Morocco. However, I believe this specimen could be considered a fairly representative one. First of all, the hospital is public, which ensures a certain level of standardization due to government oversight. In addition, the hospital serves a diverse demographic from both Rabat and Salé, allowing for a plurality in mentality and opinion. With these considerations in mind, there is some merit to these results, which can at least be applied to other public hospitals who serve similar demographics.

In completing this study, I was also pressed to consider the ethical dilemmas I could perpetuate with my research. In addition to the typical concerns with research of human subjects, one of the cruxes of Western medicine is doctor-patient confidentiality, and by shadowing doctors in their interactions with patients, I would be breaching this relationship. To make my

informants more comfortable, doctors and patients alike, I explained with the aid of a consent form that none of the information I collected would be linked to their identities in any way, and if they became uncomfortable at any point they were welcome to end their participation in the study and withdraw their information. They were also permitted to retract any specific piece of information they did not wish to be included as part of the study. In the remainder of this paper, no names will be used, and participants will instead be numbered to protect this confidentiality.

FINDINGS

As demonstrated in my hypothesis, based on the literature I had gathered to compose the literature review, I expected the use of French in Moroccan hospitals to cause further rifts in the doctor-patient relationship, even if it is not the cause of the disconnect that could exist between doctors and patients. I will present my findings here in a chronological order; over the course of my research I first shadowed and talked to doctors, and then interviewed patients, broadening the perspective of my results, as the two entities had contrasting interpretations of the interactions and operations of the hospital they both occupied.

It is first important to note the conditions of the hospital and the consultations I witnessed. The waiting room in the hospital filled to capacity every day well before 9:00 AM, but consultations did not start until between 9:30 AM and 10:00 AM, as the doctors were presumably otherwise occupied until then. Two or three doctors shared the same consultation room, talking with patients at different desks in the corners of the rooms. There was one examination table, which doctors rotated through with their respective patients. For the consultations, the patients first entered the room and handed the doctor files including their medical history, any relevant scans, and laboratory results. If it was the doctor's first time meeting the patient, she took a brief history of the patient, including age, place of residence, and

basic information related to the ailment that brought the patient to the hospital in the first place. More detailed information could be found in the green dossier every patient possessed, which every doctor who saw the patient would write in. The doctor examined the patient, looked at any X-rays the patient brought, and occasionally consulted with another doctor or a superior to determine the cause of the ailment. Finally, the doctor would either write a prescription for medication, a referral to another specialist, or both. During my observations, I did not witness any clear-cut diagnoses of a patient's condition. The doctor then scheduled a follow-up appointment herself, without the aid of a secretary or administrator, and sent the patient on her way. Despite the abundance of patients waiting to be seen, the consultations were not brief; the doctors allotted a significant amount of time to each patient, and allowed the patients to adequately express the problem they wished to address.

Part 1: Relationships

DOCTOR POINT OF VIEW

The following findings were obtained from the shadowing of doctors and brief interviews. A description of the research approach can be found in the methodology section.

1. Apparent absence of spoken French

All of the previously collected data indicated that French would be the language of choice of the doctors, due to both its hierarchical implications and for the comfort of the doctors immersed in the language during their medical training. Indeed, all the doctors I spoke to had a perfect command of French, and spoke to me with extreme ease. However, my conversations with doctors and other hospital staff marked the relatively few occasions I heard the language spoken out loud. Every consultation I witnessed took place exclusively in Darija, even if a patient was

able to speak French. The conversations between doctors took place in a fluid mixture of the two languages, where French was employed to describe medical terms and possible causes of illnesses, while Darija took precedence for greetings and other conversation. French was only used a handful of times as the principal language in a conversation: to examine a sub-Saharan prisoner who did not speak Darija, and in a brief meeting with a pharmaceutical representative bringing samples from her company. The representatives all speak French in the hospital setting, as it is mandated by the companies they work for. Otherwise, the language was used out of necessity or precedent, and not in a way that purposefully marginalized or alienated a patient. In fact, the only times I felt uncomfortable with the way the language was being deployed was when the doctors attempted to explain the consultation to me in French or English while a patient was still present, and the patients could not understand what was being said about them.

2. Doctors as cultural interpreters

One of the characteristics of Moroccan healthcare, where the language of medicine differs from that of the people, is that patients often do not have the vocabulary to describe their ailments. In Darija specifically, many medical terms used in French simply do not exist. Therefore, the patients are driven to become creative in their descriptions. One patient, during a consultation, said his throat felt like a *tinine*, or dragon, in his attempt to describe the symptoms of a sore throat. One of the doctors I shadowed used different expressions or animals to understand the sensation the patient was experiencing. She asked her patients, “Does it feel like ants crawling on your skin? Or an electric shock? What about fire?”, when they expressed signs of certain kinds of pain. After gathering this information, she translated the descriptions into illnesses she could put a French name on, allowing her to understand the ailment in the terms coined by Western medicine. This cultural translation was not unidirectional; after this

transaction of information occurred, the doctors would offer explanations and instructions in a palatable register: everyday Darija. In this way, the doctors act as the bridge between French and Darija, facilitating both a literal and a cultural transfer of information.

The gap caused by the language dichotomy did not only exist in descriptions of illnesses, but also in the understanding of medication. The names of most medications are in French, and besides over-the-counter varieties, most bottles do not provide an Arabic translation. Although some patients could recall their medication when prompted by the doctor, many more could not name the medication they take every day. To familiarize the doctor with the medications they were currently taking, the patients would either bring their bottles with them to the hospital, or, in a much more difficult process, the doctors would attempt to guess the name of the medication by describing several varieties of a generic brand by colour and shape until the patient could pinpoint which medication they did in fact take. In this case, again, the doctors make the effort to bridge a gap caused by the use of French in a public Moroccan hospital.

At this point in my data collection, the research seemed to indicate that the usage of French in this hospital does not have a large impact on the doctor-patient relationship. The doctors I observed made considerable efforts to help their patients navigate the health system in a foreign language, and their efforts seemed to be producing results; patient level of interaction with spoken French is minimal, and written French plays no significant role in the life of an ordinary patient in Morocco. Even despite the question of language, the power dynamic in the doctor-patient relationship was more muted than I had expected from the literature. All of the doctors had cordial, if not warm, relationships with their patients, and some were so well-liked that they couldn't walk down a hospital corridor without a "*Lebes? Hamdulilah!*" and a kiss on each cheek from a patient or two. Despite the seeming overflow of the patient waiting area, the

consultations did not feel rushed, and patients had the chance to express all of their concerns to the doctor without pressure. One woman even cried out of frustration over her mysterious illness, and was consequently consoled, right in the middle of a consultation. This first segment of research left me with a rosier picture of the Moroccan hospital system than I was expecting, both surprising and pleasing me. I would encounter a different perspective, however, from the individuals on the other side of the consultation table.

PATIENT POINT OF VIEW

These findings were collected via observation of consultations and interviews with patients. For further information on these methods, kindly refer to the methodology section.

The participants in this section of the research added another dimension to the data collected by observation and interaction with doctors. This perspective did not align well with this previous data, suggesting that the doctors are less aware of the circumstances faced by the patients and how their lack of knowledge of French can still indirectly strain the doctor-patient relationship. None of the patients who participated in this research spoke French, and therefore provided an important perspective in this research. The semi-structured interviews were conducted through a translator, and the responses of patients in this conversations have been organized and detailed below.

1. Medications

Every patient I spoke to claimed to know the exact name of the medication they had been prescribed, even if she chose not to demonstrate that ability during the interview. Most could identify the medications they took in one form or another, and were creative in their methods for doing so without the use of language. One woman, who could not read her prescription as it was

in French, went to the pharmacy to fill her prescription, and had the pharmacist teach her how to say the name of the medication. Others memorized the colours and shapes of their different medications, and followed directions to take, for instance, the white pill twice a day and the blue one before going to bed. Most informants made the effort to memorize the name of their medications, even though they could not speak French.

2. Files

Of the many documents that Moroccans are responsible for carrying with them to each one of their medical providers, the most important is arguably the green *Dossier de Santé*, which contains a patient's entire history related to the illness she currently suffers from, and is bringing her to the doctor today. One doctor told me that the files are inconsequential for patients, as they are simply used for doctors to communicate with each other, but in reality they contain much more information than currently prescribed medicine and a rough description of the illness. No patient, however, was able to read her file; most did not even know what the file contained. This practice has evidently been normalized, as none of the patients I talked to seemed bothered by this fact.

3. Arabic and French

As I had already observed, all the patients reported that the doctors spoke to them exclusively in Arabic. However, the use of French in the hospital system seems to have had a much larger effect on the patients than the doctors suspected. Every patient I interviewed was unhappy with the prevalence of French in the healthcare system, even when it was only employed among the doctors and hospital staff. Patient 2 said that since not everyone had the opportunity to study French, the doctors should speak Arabic instead of French, and added, "if they spoke Arabic, I

would feel closer to them than I do”. Patient 6 was also unhappy with the phenomenon, but saw little way around it, explaining that the patients are unable to stop the doctors from speaking French, but she would much rather they speak in Arabic. Patient 4 echoed this sentiment, stating “whatever language they want to speak they can”, implying that this higher authority is able to do as they please without fear of repercussion. Patient 3 took this one step further by explaining that regardless of language, she must do whatever the doctor thinks is best. The questions regarding the use of Arabic and French in the hospital shed significant light on the hierarchical nature of the doctor-patient relationships in a Moroccan hospital, and the role French plays in straining these relationships.

4. Hospital environment

Despite the answers I received to questions about the use of French and Arabic in the hospital, which demonstrated some signs of disdain among the patients, the attitude towards the hospital itself was quite *laissez-faire*. One woman, Patient 4, explained that she was going to visit a different hospital because this one had not solved her health issues after over two years, but the other patients seemed quite complacent with the state of the hospital itself. Patient 4 expressed that the state of the hospitals wasn't great, but they have nothing else, so they must deal with it. Patient 3 said, “God blessed us with this hospital, and it's not great; we ask for more, but it's okay.” Finally, Patient 6 took me surprise by expressing that the hospital is great, as there is healthcare, and they take care of the patients.

I was unprepared for the last answer that Patient 6 offered, because it seemed to differ from my literature sources, observations, and other interviews. This was important to note, because throughout the course of the interviews, I felt a certain lack of connection to my interviewees. Part of this can be attributed to the language barrier, which I had to overcome with

the use of a translator, but not all of it. My identity as a Canadian person and an American student created wariness on the part of the interviewees. Despite my explanation of my identity from both the doctor and myself, the patients had many different theories about my identity and my intentions. Some of the patients thought I was there to give them medicine, and simply wanted to hear feedback about the hospital. Others thought, despite the disclaimer in the consent form, that I was going to compensate them monetarily for their time. There was also the general impression that I was there to evaluate the hospital, and wanted to hear from patients in my review. Even the consent form itself made some patients uncomfortable, even if they had already expressed verbal consent, as they were wary to put their signatures on a form I would be collecting.

I would have remained unaware of these discrepancies had it not been for my translator, who explained the thoughts the patients had expressed after they left. This distrust within the Moroccan system that he was witnessing while translating my interviews exists in his own family, and many others that he knows. People, especially poorer people, are nervous to speak ill of the healthcare system as it could reflect negatively on them; some believe that the hospital administration could find out and deny them care in the future. Patient 2 demonstrated this fear perfectly when, after our interview, she approached the doctor who referred her to me to explain that she had not said anything bad about her or the hospital in the interview. Patient 3 told my translator and the doctor that she couldn't speak too poorly of the hospital, as she feels obliged to make a good impression on Westerners. These sorts of statements are an open acknowledgement of somewhat incomplete answers in my interviews.

It is reasonable to expect that the results of my interviews could have been different if the patients were able to speak "freely". The fear of being caught speaking ill of the hospital, and the

impetus to make a good impression, were probably felt in varying degrees by all the informants, and could have caused them to sugar-coat their situations. Due to the reporting bias my identity created, I was unable to explore the opinions of my interviewees as deeply as I would have liked to. If I had the chance to perform this research again, I would attempt to establish longer-term relationships with patients before asking them questions, rendering them more trusting of me and more willing to elaborate on their grievances with the medical system.

However, the information I was able to collect demonstrated more strain on the doctor-patient relationship than initially indicated by my observations of consultations, and one particular proponent of this pressure was the use of French in a hospital where much of the population is not French-speaking. The patients who were incapable of speaking French felt some exclusion when the language was being employed all around them, and this resulted in a certain level of estrangement from the doctors on the part of some of the patients. Keeping my bias in mind, I conclude that the use of French in the hospital did indeed have an impact on the doctor-patient relationship with non-French speaking patients.

Part 2: Accessibility to Healthcare

After completing this research and organizing the results, I was able to form a clearer picture of the effect of French on the doctor-patient relationship. However, the process revealed a problem not originally included in the scope of my research, yet is crucial to note after the fact: regardless of the doctor-patient relationship, the employment of French in the hospital setting renders patients incredibly disconnected from the world of medicine itself.

Imagine a scenario in which you, an American with health insurance, are experiencing severe joint pain. At first you might self-medicate, using acetaminophen or ibuprofen, but if the pain did not cease, you would probably be inclined to see a doctor. You might snoop around on

the Internet for ideas, or call up your niece, a medical student, but ultimately you will let the doctor run her tests until she is able to come to a conclusion. You can tell her exactly what is wrong, and you can understand her explanation of the problem. If you felt that the first doctor's diagnosis was inadequate, you could always seek out a second opinion. Ultimately, you have a great deal of agency in your healthcare.

In Morocco, under the ward of public healthcare, this is far from the case.

To begin, many of the non-French speaking patients are unaware of their exact diagnosis or the cause of their illness. One of the doctors put it aptly when she said, "In this job, you're both a doctor and Sherlock Holmes." The patients I observed arrived in the doctor's office with piles of paperwork and unclear information about their own health situations, and the doctor spent considerable time attempting to decode notes from previous doctors. The patients were largely unable to help the doctors in their quests, as they were uninformed about their own ailments; this information was seen as inaccessible to them. During my observations, one patient arrived in the office in a wheelchair, in an emaciated and feeble state. The only information her companion, presumably a relative, was able to give the doctor was that she had given birth two months ago, and was now very ill. She had come in with complaints of joint pain, but the doctor immediately suspected the cause of her deterioration was either cancer or an autoimmune disorder, both of which are known to cause joint pain. Because of her lack of agency within the healthcare system, she was being shuffled around from doctor to doctor and was failing to obtain the appropriate diagnosis or care.

In terms of language within a hospital, even though Darija is employed in most verbal situations, it is not the language of choice in all written material. The *Dossiers de Santé*, as aforementioned, are inaccessible to many patients due to the fact that they are written in French.

All forms, including health insurance, referrals, prescriptions, and others, are also written in French. Even the writing on the hospital whiteboards, and the signs within the hospital, were written in French. This creates an atmosphere of inaccessibility from the beginning of the patient experience, and is difficult to overcome with the considerable language barrier.

These non-French speaking patients are not complacent, however, and do attempt to exercise their agency with regards to their own care in true Moroccan fashion. One woman came into a consultation and promptly told the doctor she had osteoporosis and needed medication to treat it. Since this woman had not been diagnosed with osteoporosis, and in fact did not present with any telltale symptoms, the doctor asked her why she thought she had the illness. After a conversation and some extrapolation, it was evident that the woman had been hearing talk of other women with osteoporosis, and the women had told her that she could have it as well. Self-medication is another method of taking care into one's own hands. In Morocco, as one doctor said, "Everyone is a doctor." This particular doctor had been coughing at work when one of her patients offered to make her some medicine that her brother swears by. These behaviours can be explained in part by tradition; Morocco's society by nature is collectivist, meaning the transfer of information and cures among the people is commonplace. However, part of this comes out of necessity, as so many people are unable to learn and understand what plagues them.

The inability on the part of the patients to understand the language of medicine also creates a dependency on the doctors, who are required for interpretation. In the Western world as well, we depend on doctors for a great deal, but there is a certain level of understanding we as patients can be expected to attain as we receive care, and in Morocco this standard is considerably lower. This level must be low enough that it can be explained in Darija, making the information palatable to the public.

All of this anecdotal evidence demonstrates that in the case of Morocco, where Darija-speaking patients interact with a French medical system, the agency of the patients to understand and take control of their own care is highly limited. This was apparent throughout the course of my research. I witnessed countless patients pass through the office with chronic conditions they had little hope of eliminating, and many of the patients I interviewed were dismal about the state of their own health, but did not feel as if they could demand better. With the opportunity for French education closed for many of these patrons, they have little chance at understanding the medical terminology and navigating a system built to exclude them. Therefore, even aside from the doctor-patient relationship, the use of French as the language of medicine reduces the capacity of these patients to take their health into their own hands.

CONCLUSION

There are three main points to take away from this study. The first addresses the initial research question, and recognizes that the employment of French throughout Moroccan hospitals has some sort of negative impact on the doctor-patient relationship. From the perspective of the doctors, the use of French in the hospital does not affect this relationship, and they simply see the multiplicity of languages involved as part of the status quo. For them, French is the language of medicine, Darija is the language of everyday life, and these spheres can exist in tandem with one another. The patients, however, believe differently: for those who don't speak French, the omnipresence of the language distances them from the doctors. All of the patients included in this research preferred the use of Darija in the hospital setting as opposed to French.

The second takeaway was not the principal focus of my research, but came about as a by-product of the observation and interviews: the agency of non-French speaking patients is adversely affected by the use of French in Moroccan hospitals. Since every aspect of the medical

system is in French, these patients have not only a shallower understanding of their own conditions, but consequently a limited capacity to improve their own health. This system also creates a dependency of the patients onto the doctors, who must act as interpreters between the supply portion and the demand portion of the field, in turn reducing the agency of the patients.

Finally, this research illuminated the importance of identity and bias in research, and its effect on the scope and shape of information available to the researcher. My identity impacted my results in a variety of ways, but my status as a Western researcher prompted a clearly noticeable reaction on the part of the patients. Most felt the need to impress me, ensuring a rosier international view of the country, or to stay out of trouble with hospital administration, both of which were explained to my translator. It is therefore reasonable to assume that I could have received far different answers in my research depending on my identity. This experience reinforced for me the importance of establishing relationships in research; all ethnographic research involving sensitive subjects requires a greater investment in the population being researched. Ideally, continued research on this topic would involve a broader scope of hospitals, a researcher with the ability to speak Darija, and time to form more established relationships with interlocutors.

Moving forward, the situation of language in hospitals is difficult to address. In a country with a multiplicity of languages in intersection, there will always be portions of the population left out of the scope of one particular sphere or another. However, all of the languages in Morocco are highly politicized, and when one language takes precedence over another, it can signify the deliberate exclusion of certain portions of the population. If another wave of Arabization were to occur, it could be wise to begin with higher education, the primary perpetuator of these stratified systems. Not all of Morocco supports the switch from French to

Arabic, notably the country's elite; the status quo serves them very well. However, for the ordinary citizen, for whom command of Arabic is smoother than French, it could be both liberating and equalizing to let go of the colonizer's last remaining shackles, language, once and for all.

APPENDIX

Consent Forms

1. Doctor consent form

School for International Training

Multiculturalism and Human Rights - Rabat

Consent Form

Project Title : Powerful Words: an Exploration of Linguistic Hierarchy in Moroccan Hospitals

Researcher : Ellelan Degife

Purpose : You are being asked to participate in a research study conducted by Ellelan Degife from Pomona College. The purpose of this study is to explore the nature of doctor-patient relationships in hospitals in Rabat and how they are shaped by the linguistic landscape of Morocco. This study will contribute to this student's completion of her Independent Study Project.

Research Procedures: Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of shadowing doctors throughout their work and periodically answering questions, with a potential interview component. You will be asked to continue with your duties and routines and to provide answers to a series of questions related to the nature of doctor-patient relationships and their relationship to language in Morocco. With your permission, you will be audiotaped during the interview.

Time Required: Participation in this study will require two to three hours of shadowing and approximately 30 minutes of interview time. In most cases, only one session will be requested by the researcher.

Risks: The researcher does not perceive any risks or more than minimal risks from your involvement in this study.

Benefits: There are no direct benefits to respondents from participating in this study. This research explores the nature of hospital dynamics relating to language, and therefore could benefit the healthcare sector.

Confidentiality: The results of this research will be documented as an ISP paper and presented orally to the SIT MOR students and staff. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. The researcher retains the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the researcher. Upon

2. Patient consent form

School for International Training

Multiculturalism and Human Rights - Rabat

Consent Form

Project Title : Powerful Words: an Exploration of Linguistic Hierarchy in Moroccan Hospitals

Researcher : Ellelan Degife

Purpose : You are being asked to participate in a research study conducted by Ellelan Degife from Pomona College. The purpose of this study is to explore the nature of doctor-patient relationships in hospitals in Rabat and how they are shaped by the linguistic landscape of Morocco. This study will contribute to this student's completion of her Independent Study Project.

Research Procedures: Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of an interview that will be conducted with individual participants in hospitals in Rabat. You will be asked to provide answers to a series of questions related to the nature of doctor-patient relationships and their relationship to language in Morocco. With your permission, you will be audiotaped during the interview.

Time Required: Participation in this study will require approximately 30 minutes of interview time per session.. In most cases, only one session will be requested by the researcher.

Risks: The researcher does not perceive any risks or more than minimal risks from your involvement in this study.

Benefits: There are no direct benefits to respondents from participating in this study. This research explores the nature of hospital dynamics relating to language, and therefore could benefit the healthcare sector.

Confidentiality: The results of this research will be documented as an ISP paper and presented orally to the SIT MOR students and staff. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. The researcher retains the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, all information that matches up individual respondents with their answers, including audiotapes, will be destroyed.

Participation & Withdrawal: Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind. You may also refuse to answer any individual question without consequences.

Questions about the Study: If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact the researcher, Ellelan Degife, at ead02014@mymail.pomona.edu or ellelandegife@gmail.com.

Giving of Consent: I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

I give consent to be audiotaped during my interview. _____ (initials)

Name of Participant

Name of Participant (Signed)

_____ Date

Name of Researcher (Signed)

_____ Date

Interview Guides

1. Doctors

- Why did you want to become a doctor?
- Tell me about the languages you learned in primary and secondary school.
- Tell me what you remember of medical school.
 - What did you think of studying in French?
- How long have you been a doctor? Walk me through your career.
- What does a typical day for you look like?
- Describe an interaction with a patient you had today.
- What languages do you speak on a typical day, and when?
- Do you often speak with patients alone?
- How do you feel about French being the language of medicine?
- How do you think your patients feel about hospitals?

2. Patients

- Have you been here before?
 - Do you come here often?
 - Is it for a chronic condition?
- Do you normally come with family or not?
- Describe your most recent hospital visit, or this hospital visit.
- What is your first language?
- What is the language you feel most comfortable speaking?
- What language do you speak at the hospital?
- When you are with multiple doctors, what language do they speak in with each other? To you?
- Would you rather everyone speak the same language in a hospital?
- How does it make you feel when doctors speak in a language you don't understand?
- Do you have an opinion of doctors in general?

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