

THE LEBANESE PHYSICIAN: A PUBLIC'S VIEWPOINT

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Keywords

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ABSTRACT

A physician's lack of humanity is a general complaint in public surveys. The physician-patient relationship is viewed by the public as being reduced to a business relationship where the patient feels that she is merely a 'client' and the physician a healthcare 'practitioner' instead of a 'care giver'. This public perception is not a phenomenon that is peculiar to Lebanon. Yet, the problem has been increasing over the years to the extent that patients feel that physicians are becoming inhumane and business oriented. While this might not characterize all physicians of the 21st century, this might be true of at least some.

Responses were collected from a study that was undertaken based on a questionnaire distributed to a pool of 650 participants from different geographical areas and different social and educational backgrounds in Lebanon. Participants were all older than 18 years and mentally competent. None were physicians. The questionnaire was open-ended and initially piloted among a random sample.

The physician traits most desired by the public were found to be: moral traits (41%), interpersonal traits (36%), scientific traits (19%) and other (4%). The most unwanted traits/behaviours were a lack of interpersonal traits (57%), a lack of moral traits (40%) and a lack of scientific skills (3%).

The physician-patient relationship was perceived, in general, as being a flawed one. What can be done to remedy the image of the Lebanese physician that has been projected in the minds of the patients and the public at large? Nine major recommendations are presented.

INTRODUCTION

The doctor smiled with a contemptuous affability that said: What's to be done? These sick people do have foolish fancies of that kind, but we must forgive them.¹

Tolstoy, *The Death of Ivan Ilych*

Ivan Ilych was a successful man until one day he fell from a ladder while attempting to show the upholsterer how he wanted the drapes to be hung. His injury became serious and the life that once 'flowed pleasantly' metamorphosed into an internal inferno. *The Death of Ivan Ilych* is a

novella written by Tolstoy when he was 57 years old. It is the story of a man living his last days haunted by a terrible thought: that he had not lived the successful life he thought he lived and that most of his life had been a lie. When Ivan fell ill, he was advised to visit a renowned physician (the 'celebrated specialist') who did not strike a chord with this particular patient. At the end of the visit, Ivan said nothing, 'but rose, placed the doctor's fee on the table, and remarked with a sigh: We sick people probably often put inappropriate questions. But tell me, in general, is this complaint dangerous, or not?'² The fact of the matter is when the physician first met Ivan, 'he put on just

¹ L. Tolstoy. 1967. *Great Short Works of Leo Tolstoy*. Translated by Louise and Aylmer Maude. New York: Harper and Row: 290.

² Ibid: 271.

the same air towards him as he himself put on towards an accused person.³ He assumed an air of distance and detachment and treated Ivan the patient as a body without a soul, although his illness engulfed much more than his injured and ailing body or 'floating kidney': it ran deep through his existential self. His consciousness of pain, mortality and finitude shattered his being; but the physician ignored that part of him which ultimately made him Ivan Ilych and constituted his identity.

From the time of this visit, the patient's main preoccupation became 'the exact fulfillment of the doctor's instructions regarding hygiene and the taking of medicine, and the observation of his pain and his excretions. His chief interest came to be people's ailments and people's health. When sickness, deaths, or recoveries were mentioned in his presence, especially when the illness resembled his own, he listened with agitation which he tried to hide'.⁴ It was not Ivan's kidney that was sick, he was sick. He did not have an illness, his illness had him.

Some years after Tolstoy, Franz Kafka in *A Country Doctor* noted that 'to write prescriptions is easy, but to come to an understanding with people is hard'.⁵ Hence the importance of the physician-patient relationship, which makes a physician a healer, and not simply a health care practitioner. The question that arises at this point is what makes a good doctor? Is it the fact that she has graduated from a reputable university with scientific knowledge? Is it dexterity and technical skill; or is there an extra something that makes this shaman in a white coat a physician who treats the person and not only the disease? To answer these questions, the views of the patients who often put their lives in the hands of these 'saviours in white coats' are essential and must be considered since they are the ones who are exceptionally anxious, exceptionally dependent, and at times, exceptionally powerless.

A physician's lack of humanity is a general complaint in public surveys. The physician-patient relationship is often viewed by the public as being reduced to a *business relationship*, where the patient feels that she is merely a 'client' and the physician simply a health-care 'practitioner' instead of 'care giver' and 'healer'. The fact that the public perceives physicians as lacking the necessary character traits that make them 'healers' is not a phenomenon that is peculiar to Lebanon.

Over the years, there has been an increasing tendency in the United States (US) and Europe in general (and in the United Kingdom particularly) to look at how patients see the health care system and what they expect from it, in order to respond to their perceptions and try to ameliorate the system. This is precisely what this study attempts

to do with respect to Lebanon. The Lebanese medical practice differs from the American practice in that it is basically more patient choice-oriented. There are around 19 state hospitals in Lebanon; some of them are not up to standard or are inactive. Hence, patients resort to private clinics and private hospitals and have the liberty to pick the general practitioners and specialists of their choice. The civil war that took place in Lebanon between 1975 and 1990 had a negative impact on the health care sector and the financing of health services. The effects are still present although the war ended 19 years ago. The role of the government and more specifically of the Ministry of Health declined and the main player became the private sector. The Ministry of Health became weak and encumbered with a lot of expenditures while the private sector enjoyed unrestricted growth. To put it simply, the Ministry of Health is the last resort for the citizen who has not managed to get any other insurance plan. Ideally, as per the law, all Lebanese citizens are entitled to health coverage from the National Social Security Fund (NSSF) which covers treatment and medication up to 85%. The remaining 15% can either be covered by the patient him/herself or by a private insurance company if the patient is affiliated with one (through their employer). The patient's choice of physicians and specialists is unlimited except in the case of certain private insurance companies which choose to impose certain general practitioners (GPs)/specialists on their 'subscribers'. That not all citizens have access to health care although it is a right, is an interesting and pressing question, but one that falls beyond the scope of this article.

This study was designed to assess the perception of the Lebanese public regarding the Lebanese physician. The results shed light on serious concerns with the physician-patient relationship.

METHODOLOGY

This study consisted of seven months of explorations and investigations of the perceptions of the Lebanese public regarding the Lebanese physician. To the best of the knowledge of this author, this is the first qualitative study that aims at doing that in Lebanon. Responses were collected from a study that was undertaken based on a questionnaire distributed to a haphazard sample of 650 participants from different areas and different socio-economic and educational backgrounds in Lebanon (instructors from schools and universities, pharmacists, engineers, architects, lawyers, technicians, bankers, managers, owners of companies, businessmen/women, artists, members of the press, publishers, electricity company workers, welding technicians, laundry technicians, government employees, politicians, housewives, school directors, secretaries, clerks, office managers, office boys,

³ Ibid: 270.

⁴ Ibid: 272.

⁵ Quoted in: A. Manson. A Theology of Illness: Franz Kafka's 'A Country Doctor'. *Lit Med* 2005; 24.2: 297-314.

traders, journalists, employees, unemployed, etc). The final size of the sample was decided by the saturation of responses. Respondents who were randomly approached on the streets, in shops, workplace, etc. They came from different areas: mainly the capital but also from cities in the North (Tripoli, Batroun, Koura), South (Saydoun, Tyre) and East (Shtoura, Baalbeck) of the country. Interestingly, everyone who was approached agreed to participate and the response rate was surprisingly, 100%. Several interpretations can be given, the most important of which can be inferred from the majority of the reactions given, which can be summarized by a recurrent, 'of course! There is too much to say about the situation in our country!' and a heart felt 'good luck with your venture, I hope it will lead somewhere' when the questionnaire was handed in at the end.

Lebanon's population is estimated to be around 3,925,502 (July 2007).⁶ This selection was to ensure a minimum degree of generalizability. As such, the perceptions of the public reflected in the study does not portray that of a particular area or particular socio-economic group of the country, rather it reveals a general attitude on the part of the Lebanese public. However, doctors and nurses were excluded to ensure objectivity. As such, responses from either group were excluded. All participants were over 18 years of age (18 being the legal age when people can make their medical choices without a guardian, can work and be considered capable of pursuing their rational plan of life) and judged to be mentally competent. All participants had seen a physician at least once in the year during which the study was taking place. The questionnaire was open-ended and initially piloted among a random sample for feasibility and clarity and to make sure that respondents will not give what they may perceive to be socially desirable responses. Full confidentiality was assured and guaranteed: participants were not required to place their names on the questionnaires, although some chose to do so. The questionnaire was analyzed following grounded theory procedures. Memos in text and diagram forms were made during the comparative process as coding began. The study also included 128 unstructured interviews with some participants who voiced their desire to relate personal stories. The profile of interviewed respondents can be seen in Table 1 below.

Audio-taped face-to face interviews, each lasting around 15 minutes, were carried out on the site chosen by the participants (which varied from either home or workplace) to ensure comfort and ease. Interviews were copied verbatim. Participants were urged not to give the names of physicians nor the hospitals or clinics with which the physicians were affiliated in order to respect the privacy of the physicians concerned and to minimize unnecessary

Table 1. Profile of Interviewed Respondents

Categories	Proportions of respondents
Female	48%
Male	52%
Beirut	63%
Other cities and suburbs of Beirut	37%
Education	
Secondary	49%
Tertiary	51%

factors that might affect the objectivity of the interview. The responses of patients were recorded and transcribed, recurring ideas were documented through and iterative method of repetitive comparison, and content analysis was made. Interviews were studied; transcripts were analyzed and labelled, which eventually led to the recognition of concepts and categories. Later, appearing concepts were regrouped and emerging categories were sorted, contrasted and compared until new and more complex ones started to emerge. This process continued until saturation. Various stages of coding were used alternately while continuously going over the memos and diagrams. Finally, the themes which emerged were incorporated and polished to identify core ones capable of linking most categories. To check the reliability of the categories that emerged and the clustering under the categories, inter-rater reliability was assessed by two additional judges (one philosopher, from the American University of Beirut and one Professor of Pharmacology from at the American University of Beirut Medical Center). The additional judges were in almost perfect agreement in their categorization with the initial investigator and the few discrepancies that surfaced were resolved by consensus.

The ratio of participants was 54% males to 46% females; and 82% were residents of the capital city Beirut, the rest resided in other areas of Lebanon.

The questionnaire included the following questions:

1. What are three main characteristics that you like in physicians in Lebanon?
2. What are three main characteristics that you dislike in physicians in Lebanon?
3. What comments do you have about the physician-patient relationship prevailing in Lebanon?

A space was left open for further comments.

RESULTS

A number of traits/ behaviours were indiscriminately described by respondents. These traits were classified

⁶ Lebanon Profile. (2007). *Facts*. Available at: <http://www.worldpress.org/profiles2/Lebanon.cfm> [Accessed 12 Feb 2007].

Table 2. Traits desired in a physician: Perspectives of the Public

Traits/behaviours	Definition
Humane:	The physician is caring and deals with the patient as a human being not as a thing or an object.
Honest:	The physician is truthful about the diagnosis and does not hide information from the patient.
Ethical:	The physician is respectful of time and moral laws, and does not view medicine as if it were a business or a trade.
Not materialistic:	The physician does not treat the patient simply as a commodity that will bring her money. Rather, as a patient who suffers from an illness and has to be cured. Money comes in the second place for her.
Compassionate:	The physician feels with her patient.
Humble:	The physician does not act as if she were a demigod and has a respectful attitude towards all patients regardless of their socio-economic background. She is modest and does not treat her patients as if they were inferior to her.
God fearing:	The physician does not act as if she were all powerful and does not forget that she is ultimately accountable for the consequences of her actions or omissions.
Good listener:	The physician is ready to give enough time to her patient and is attentive. She does not read the newspaper or the internet while she is interviewing him, nor ask a question without listening to the answer.
Respects patients:	The physician respects her patients and does not treat them as if they were objects. They are persons with rights and dignity and a physician should keep this in mind during her encounter with them.
Has good interpersonal skills:	The physician is someone with whom the patient can feel that he can actually open up. She should be welcoming and comfortable to talk to.
Gives time to patients:	The physician is ready to give each patient the amount of time necessary to understand his case, to answer his questions, to offer explanations and treatment.
Caring:	The physician makes her patient feel that she is caring and not simply a scientist or a surgeon waiting to operate on him.
Patient:	The physician is ready to answer all questions even if they seem dull to her and is willing to provide explanations as often as is necessary.
Smiles:	The physician has a friendly appearance. The facial expressions are part of the healing process. Being greeted by frowning faces does not help the patient. It creates hurdles in the healing process. Patients worry about calling such doctors when something is wrong.
Is not haughty:	The physician has a humble attitude that will allow a comfortable exchange of opinions and ideas with patients.
Explains thoroughly:	The physician is ready to give each patient the amount of time necessary to understand his case; to answer his questions; explain the situation to him and to offer him treatment.

under general categories. Four general categories of traits desired in a physician were identified in the study.

The physicians' traits most desired by the public were moral or ethical traits (41%), interpersonal traits (36%), scientific traits (19%) and Other (4%).

The scientific qualities identified were: experienced, competent and knowledgeable. When asked about the reason behind not putting so much emphasis on scientific qualities, respondents replied that they already had faith in the scientific qualifications of their physicians. According to them, the problem lies in the fact that most physicians lack other skills that are equally important in their dealings with patients.

Under the category of ethical qualities, eight main traits were identified: Honest, humane, ethical, not materialistic, humble/modest, compassionate, respects patient, and God fearing. When asked to elaborate on what was meant by 'God fearing,' respondents indicated that physicians tend to forget that they too are mortal, their powers are limited and should not be abused to serve only their own interests, but should be used to help their patients. One person summarized the position by emphasizing that the physician 'should remember that there is an after life, that there is a God who will judge him for his actions. He is not a God himself. He should be afraid of the day of judgment when it comes.' This patient's comment echoes Bernard Shaw's advice in *The Doctors Dilemma* to make it obligatory for a physician who uses a brass plate to have on it a caption which says:

'remember that I too am mortal'. Under the category of Interpersonal qualities, eight traits were identified: good listener, gives time to patients, caring, patient, explains thoroughly, smiles, has good interpersonal skills, and is not haughty. Definitions of these traits/behaviours are presented in Table 2. The definitions are from the viewpoint of the public.

The traits that the public 'disliked' in a physician were reported as being primarily lack of interpersonal skills (57%) and lack of moral/ethical traits (40%). Very few concerns were voiced regarding their physicians lack of scientific skills (3%). Other insignificant comments were about tidiness, attire and proximity to place of residence.

Nine major negative Ethical/Moral skills were identified: materialistic, arrogant, treats patient as a number or a case, dishonest, disrespectful of patients, not caring, inhumane, careless/negligent and does not admit mistakes. Ten major negative interpersonal traits were also identified: does not give the patient enough time, hurried, high handed/haughty, treats patients as if they were inferior, does not respect appointments, does not discuss with patients, does not listen to patients, pretentious, unfriendly and is annoyed with questions. People voiced a common complaint that physicians are becoming more and more inclined to send them to 'machines and ask them to do tests'. Actual physical examinations seem to be disappearing from the modern medical scene. Definitions of these traits/behaviours are presented in Table 3. The definitions are from the viewpoint of the public.

Table 3. Traits not desired in a physician: Perspectives of the Public

Traits/behaviours	Definition
Materialistic:	The physician is basically concerned about making money not about curing her patients.
Inhumane:	The physician does not feel with her patient's pain and suffering and treats them as a disease.
Not caring:	The physician treats the patient as if he were a case and not as a human being. There is no personal touch or interest in the physician-patient encounter.
Negligent:	The physician sometimes gives prescriptions that the patient is allergic to, forgets to request necessary test or to follow up on important issues.
Does not admit mistakes:	The physician does not admit that she made an error either in treatment or in judgment.
Dishonest:	The physician often does not tell the patient what is really wrong with him, and does not admit it when she is faced with something beyond her capacities.
Hurried:	The physician makes the patient feel that she is busy and needs to see the next patient.
Does not discuss with patients:	The physician does not discuss with the patient his situation, rather, simply requests tests or offers treatment.
Unfriendly:	The physician is not welcoming and does not make the patient feel comfortable in her presence.
Treats patients as a number or case:	The physician does not deal with the patient as a person. In the presence of the physician, the patient feels as if he were reduced to an organ or an illness.
Disrespectful:	The physician does not respect the patient. She does not greet him properly when he enters and sometimes ridicules him.
Arrogant:	The physician treats the patient as if he were an inferior being and assumes a superior attitude because she is a doctor.
Does not respect appointments:	The physician keeps the patient waiting for a very long time.
High-handed:	The physician holds a standoffish attitude vis-à-vis the patient which often causes a barrier in communication.
Treat patients as inferior:	The physician acts as if the patient is a person with lesser intelligence, less deserving than she is, and communicates with him condescendingly.
Pretentious:	The physician pretends she knows the solution to all problems and can treat the disease even if she ought to refer the patient to someone else.
Annoyed with questions:	The physician makes the patient feel that he has asked too many questions.
Does not listen to patients:	The physician is not attentive to what the patient has to say. She does not concentrate on complaints nor on answers to questions which she raises mechanically.
Does not give patients enough time:	The physician sees the patient for a short time and acts as if he is not her priority. She is too busy for him.

An ordering by priority of the desired traits revealed that the public viewed being honest, humane, ethical, a good listener, experienced, not materialistic and spending enough time with the patient as the most important characteristics. Surprisingly, scientific competence did not rank high in priority except for the issue of being experienced in practice and training. Being materialistic, arrogant, not giving enough time to patients, treating them as numbers or as pure cases, being hurried and being high handed, were the most prominent disliked character traits. The physician-patient relationship was perceived as being in general a flawed one, characterized by materialistic gain and a feeling of being treated as a 'number' and not as a 'person'. The concern that physicians are becoming materialistic is not peculiar to Lebanon but seems to be universal phenomenon: 'has money trumped professionalism',⁷ or is it a pragmatic desire to prosper that is overriding the essence of what it means to be a doctor? An empirical explanation does not offer a moral justification. As May puts it:

Money is a useful but unruly servant. We need to take care that it sustains rather than obscures what we

profess on behalf of patients, clients, students, and parishioners when we dare to cut, burn, or laser their bodies or advise them.⁸

The results arrived at in the study do not show a dramatic deviation from other studies done in other countries. For example, the European Task Force on Patient Evaluations of General Practice (EUROPEP) carried out a systematic literature review, including studies done on the priorities of patients regarding primary healthcare.⁹ It was revealed that 'humanness' was one of the most valued traits. After that came competence/accuracy, patients' involvement in decisions, 'time for care' and 'other aspects for availability/accessibility'. A study in the West of Scotland showed that 'the most important requirement of general practice is to have a doctor who listens and does not hurry me'.¹⁰ The Lebanese public seems to echo similar concerns.

The public survey also revealed that 94% of the comments about physicians written in the provided free space

⁸ W.F. May. Money and the Medical Profession. *Kennedy Inst Ethics J* 1997; 7(1): 12.

⁹ M. Wensing & H.P. Jung. A Systematic Review of the Literature on Patient Priorities for General Practice Care. Part 1: Description of the Research Domain. *Soc Sci Med* 1998; 47: 1573-1588.

¹⁰ L. Carroll & F.M. Sullivan. Good Health Care: Patient and Professional Perspectives. *Br J Gen Pract* 1998; 48(433): 1507.

⁷ J. Kassirer. Commercialism and Medicine. *Camb Q Health Ethics* 2007; 16(4): 378.

Table 4. Sample Quotations from the Public about Physicians and Medicine

'Doctors in general are ok, but you find some that want to make money only.'

'Curing patients is second on the list. First comes making money.'

'Medicine is a holy job. I had two good doctors. They were ok. A bit materialistic. But they treated my illness.'

'My cardiologist is a hero. I will always remember him and thank him.'

'There is no government, there is no mercy, there is no humanity. Where is the government?'

'Not all doctors respect the oath! Some should not be doctors.'

'Some doctors are good but some are too materialistic.'

'I do not trust doctors in Lebanon and, in my opinion; doctors are inhumane merchants.'

'Respect for proper ethical and professional standards vary to a considerable degree but in general there is an obvious need to foster and strengthen a climate for greater awareness of the rights of patients and respect for ethical principles that ought to govern the conduct of professionals in the medical field.'

'Medicine is now a trade with the illnesses of people.'

'Medicine is a noble profession practiced by people who are not noble.'

'The medical sector has no ethics at all.'

'Doctors are pretentious and full of themselves. They have no consideration for our feelings!'

'I think it is really awful because it became a "business career" not a humane one. Most physicians do not care about the patient, but they care about money and success (being well-known).'

'It is scary to see how ethics is shaky in the medical field and how medicine is corrupted by "wasta" (personal connections) and greed for power.'

'They reduce medicine to a cold lifeless prescription.'

'Physicians do not know how to speak properly with patients.'

'There is no government! Where is the ministry of health?'

'Pathetic!'

'Doctors these days are robots, they have no heart!'

were negative comments while 3% were positive or mixed comments. Sample quotations are presented in Table 4.

The question that arises at this point is: what accounts for this more or less negative perception that the Lebanese community has of physicians? Most people were aware that the physician, upon entering the profession of medicine, takes 'a certain oath', some of them referred to the Oath of Hippocrates, but they felt that doctors did not live up to this oath that enjoins them to put the health of the patient as their priority. They spoke of the long lost days of 'traditional medicine' when the doctor used to *care*, an idea reminiscent of the famous address Dr. Francis Peabody gave to students of medicine not so long ago: 'for the secret of the care of the patient is in caring for the patient'.¹¹

DISCUSSION

Has the long-established and time-honoured code of ethics changed? The essence of medicine has not changed simply because the physician-patient relationship is

quintessentially the same. It is still a relationship where a patient entrusts a healer with his/her health. The physician is a member of a noble 'profession' and every time she wears the white coat she has to remember the vows she has made to herself, to her profession and to society at large. The patient is still a patient: an exceptionally vulnerable human being who entrusts the healer with her health. She is not a client because medicine is not a business and health not a commodity. These facts set the boundaries of the medical encounter.

The importance of being a humane physician cannot be overemphasized. Humane physicians have been sufficiently commemorated in novels, novellas, poems, and paintings. What is needed is that they be commemorated in medical schools as well. As such, it is important for physicians, residents and students of medicine to see how patients actually perceive physicians and attempt to nourish and sustain the humane part in them which is perhaps there, but needs a little brushing up. Medical Ethics is a neonate in Lebanon, a country where medicine is still regarded a pure science which has nothing to do with the humanities. As a result, students of medicine study the science of medicine and still view attempts at offering courses in medical ethics as a novelty with which they do not really have to cope and a burden on their curriculum which is already overloaded. Some veteran physicians feel that medicine is a scientific discipline and ethics an intruder to the field. But with the rise of modern technology, can we afford to continue ignoring the humane aspect of a profession which is quintessentially humane? A profession which is often faced with moral dilemmas? One of the most important goals that this study hopes to accomplish is to highlight what physician and philosopher Edmund Pellegrino once said, namely that, 'Medicine is the most humane of sciences, the most empiric of arts, and the most scientific of humanities.'¹² The Institute of Medicine in the United States has already pioneered a project on Medical Professionalism which stresses the importance of humanism within the medical profession and has proposed a number of objectives, the achievement of which will result in significant improvement in healthcare. One of these objectives is patient centeredness. It is high time for Lebanon to seriously consider and implement such projects within its medical programs and medical schools.

Where do we go from here? A few suggestions come to mind. These suggestions will be presented briefly as each can be a topic for a separate article.

The informal curriculum

A lot of work will have to be done on the informal curriculum in teaching hospitals and medical schools.

¹¹ M.C. Donaldson. The Care of the Patient with Vascular Disease. *J Vas Surg* 2007; 45(2): 431.

¹² E. Pellegrino. 1979. *Humanism and the Physician*. Knoxville: The University of Tennessee Press: 17.

The working and teaching environment has to be one where moral values are upheld and emphasized. Senior physicians have an especially important role to play in this regard since they are the role models that students, interns, and residents look up to and emulate.

The formal curriculum

The formal curriculum is basically heavily oriented towards the hard core basic sciences. Courses and training in biomedical ethics and medical professionalism have to be taken more seriously. The importance of courses and training in ethics are not sufficiently appreciated. Such courses must become part of the core curriculum.

Ethics committees

Unfortunately, it is a fact that most hospitals in Lebanon do not have ethics committees and some of the ethics committees that exist do not fulfill the role that they are intended to play. In addition to case consultations, a lot of emphasis should be placed on educating committee members, hospital staff and the community in matters of biomedical ethics.

The Lebanese accreditation

As it is, the Lebanese Accreditation System Index does not account for medical ethics. Many hospitals seeking Lebanese accreditation do not concern themselves with patients' quality of care, patients' rights and issues of medical ethics. A lot of work has to be done in this area.

Entrance exams to medical schools

The humanistic qualities of the applicant should be assessed during the interview (the panel should include not only members of the medical staff but also a psychologist and an ethicist). Psychological tests should be included to evaluate the candidate's reaction under pressure and in certain situations of stress, in an attempt at trying to identify certain character traits that are essential for being a good physician. Also, the candidate's school record should accompany his/her application. Thus, a high achiever who has been developing into a selfish and aggressive being cannot be a good candidate. The physician has to be an understanding, caring person as well as a good listener with a community service record in order to be a good candidate for medical school.

Changes in the *Lebanese Code of Medical Ethics*

The *Lebanese Code of Medical Ethics* was first written 1994.¹³ The last amendment was in 2004 when the *Rights*

¹³ Syndicate of the Lebanese Order of Physicians. 1994. *Lebanese Code of Medical Ethics*. Beirut, Lebanon.

of *Patients and Informed Consent* article was introduced. Still, the changes that have been made are not enough and some are still vague and give the physician the power of personal interpretation. Moreover, the importance of the *Code of Medical Ethics* needs to be emphasized to new and veteran physicians alike and the public needs to become aware of its rights. The Code of Medical Ethics is not taught to students of medicine; however, physicians are expected to be aware of its content and are held accountable for it, since; article 61 of the Lebanese Code of Medical Ethics states that any infraction of the code will incur disciplinary actions. This, however, falls beyond the scope of this article.

Empowering patients

This is a key element in quality health care delivery. Physicians tend to treat 'enlightened' patients differently because they know that these patients have a right to expect a certain mode of treatment and that they owe them a certain way of behaving. As such, one way of empowering patients would be through educating patients about their rights, their illness and their options. This can be done by means of patient education campaigns, billboards, broadcasting segments, pamphlets and public lectures. In 2005, the author of this article presented a public lecture entitled '*How Much do Patients Know?*' in which the rights of patients and informed consent were discussed. It was revealed that a striking majority of the audience was not aware that patients had the right to 'informed consent'.

Introducing a culture of medical ethics

A culture of medical ethics is sadly still absent in Lebanon in general. Journals, books and videos that deal with medical ethics are almost absent from the Lebanese scene. The author of this article has always relied on international mail to buy her books. International news segments relating to euthanasia, abortion, cloning etc, are given minimal time on the local news (does not exceed 1 or 2 minutes). Even though there may be efforts to introduce principles, notions, ideas and practices pertaining to medical ethics, we are not yet at a point where they are generally applied or taken for granted. The general climate is that ethics is viewed as an intruder to the profession of medicine which is mainly viewed as a science.

Involving the public

The Lebanese public needs to be involved in healthcare policies. Issues like abortion, euthanasia, stem cell research and others are legislated by a small group of people. For example, the Lebanese National Consultative Committee of Bioethics, which consists of 19 members at present (among whom only one is

knowledgeable in bioethics), is the entity which is consulted before decisions pertaining to policy issues are made. The public is never involved in the decision making process. The opinion of consulting the public is never taken and public polls are never done, although decisions are often made about issues that affect the general public. This must change if one is to begin building a culture of trust. There are several ways to involve the public. A good start would be for the Syndicate of the Lebanese Order of Physician or the Lebanese National Consultative Committee of Bioethics, under the auspices of the Ministry of Health, to host meetings for individuals who represent the general public to assemble and discuss rationally specific issues pertaining to bioethics. The results of the discussions can be communicated to authorities who will take them into consideration before drafting any law. Still, more avenues will have to be created to educate the public in matters pertaining to bioethics. While this is an important issue, it falls beyond the scope of this article.

LIMITATIONS

The study has its shortcomings in that it could still have been done in a wider area with a wider sample. The sample is a haphazard sample of convenience. Since the selection of participants was arbitrary, it is clearly not a representative one and results cannot be generalized. Still, the study yielded significant information and can be used as groundwork for further studies in Lebanon and the Middle East. In hindsight, including age as part of the selection criteria might have yielded new information. For example, it would have been interesting to see whether the younger generation feels more strongly about paternalism than the older generation. It would also be interesting to include the educational level in the selection criteria: would more learned people want to be involved in their care more than the less erudite? It would have also been very useful if there were a study showing the perceptions of the medical staff in order to compare them with those of the public; a project worth pursuing.

Religion has been purposefully omitted from the selection criteria due to it being a sensitive issue to raise in the country because of the prevailing political situation (characterized by rift and instability largely due to sectarianism), and to its lack of vital relevance to the study. Religious distinctions in Lebanon are very sensitive and easily upset. Identifying the perceptions of groups with their religions might be misconstrued as a bias for or against certain religious groups. In addition, it might lead to a lower response rate: certain groups will consider the study as being against them and will refuse to participate. Some might opt against objective answers and decide to give a more favourable image of what their religious groups 'ought' to think. Others who refuse the idea of

sectarianism altogether might refuse to partake in a study that has religion as a selection criterion. Furthermore, any result related to religion will be misinterpreted and politicized.

CONCLUSIONS

The responses of 650 participants from different socio-economic backgrounds who have received medical care showed a general discontent with the medical profession as it is being currently practiced in Lebanon. What is sought is a physician-patient relationship characterized by humanity and authentic caring in which the physician acts as the fiduciary of the patient.

In 1997 at a Conference entitled *Contemporary Health Care and the Ethic of Medicine: What is a Physician to Do?*, Edmund Pellegrino, now Chairman of the Presidents Council on Bioethics (USA), foresaw a desolate future for the profession of medicine. According to him, there will be 'those who choose to follow the moral imperative – the high ground – and those who become purely businessmen and entrepreneurs.'¹⁴ It is a challenge that Lebanese physicians have been facing for quite some time and more than just a few are falling prey to the temptation that lured Asclepius, the god of medicine. Yet, as Pellegrino himself put it, physicians have great moral power if only they chose to use it.

The Death of Ivan Ilych portrays the physician as guilty of two sins of modern medicine: curiosity at its worse and detachment from the plight of the sick. The 'celebrated specialist' enters with full confidence, as if he were in command of the situation and is a shaman capable of eradicating all illnesses. However, he forgets to look into the fatigued and weary face of his ailing patient who looked at him with 'eyes glistening with fear and hope.'¹⁵ A patient he reduced to a number and to a disease. Ivan's fate has thrown him a strong blow. His physician, like most physicians today, is guilty of his own mistake: he ignored the wisdom behind the adage emblazoned on his graduation portmanteau: *Respice finem* it said: Consider the end.

Biography

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¹⁴ American Academy of Family Physicians (AAFP). June 1997. *Ethicist Ed Pellegrino Foresees a Divided Road Ahead For Medicine*. Available at: <http://www.aafp.org/fpr/970600fr/13.html> [Accessed 29 July 2007].

¹⁵ Tolstoy, *op. cit.* note 4, p. 291.