A call for creation of medical ethics task force

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To the Editor: Elmahdi Elkhammas, MD in his editorial regarding the medical ethics in Libya [1] asked the question "where to start?" I would like to expand on his views and answer his question from my standpoint.

Medical ethics in Libyan medical culture can be divided into two broad classes: Violations of clear ethical issues due to the physician's ignorance, indifference, or disregard to regulations that govern the practice of medicine, and violations of medical ethics because of a genuine misunderstanding or lack of knowledge on an issue.

Under the first class falls the surgeon who never rounded on his patient after surgery and the physician who made judgment on patient's inquires based on cultural background biases rather than on his/her qualification and expertise. Raising the bar for moral standards and enforcing the rules and regulations governing the practice of medicine should help improve this class.

The second class is more difficult to identify and manage. This class includes the issues that fall in the gray zone of medical ethics. These issues are misunderstood or still debatable within the medical community. An example of such an issue is the communication between the physician and his/her patient when breaking bad news. The wide spread belief that the patient should be protected from the impact of bad news forms- in my opinion -an ethical problem. The historic background for such a belief came from the times when literacy was still in its infancy in our society and conventional wisdom dictated that the younger generation in the family or the male, being more experienced than the female, should communicate with the physician and make decisions regarding the patient without subjecting the patient to the stress of the whole ordeal. Since literacy is no longer a major problem, most people possess some degree of knowledge that enables them to make informed decisions; therefore, critical information regarding a patient's health should never be withheld from the patient. Sound decisions regarding the choice of treatment and expectation of cure and improvement almost always come from information given to physicians by the patients themselves, and not from the relatives who tend to form more emotional and often irrational decisions.

The exclusion of the patient from the decision-making process can lead to a decision driven by the family's hopes for the loved one to live forever and the physician's ambition to cause a miracle. These circumstances create a "mad Scientist" effect, tempting the physician to go over board in his/her treatment at the expense of the patient's comfort and overall interest.

End of life decision, is another extremely difficult ethical issue. Who makes the decision to withdraw support? Who determines that continuation of care is futile? Can a physician withdraw life support based on his/her assessment of futility without the family's consent?

Many other ethical issues fall under this class and listing them is out of the scope of this letter. However, this is an opportunity to call for the creation of a medical ethics task force. The project should be inclusive of people (physicians, nurses, religious scholars, social workers…etc.) who can enrich the dialogue of medical ethics and help educate allied heath professionals and the authorities who should enforce the recommended medical ethics guidelines.

References

1. Elkhammas EA. Medical ethics in Libya: where to start? Libyan J Med, AOP:061201; 2006: 1(2).