**WHAT THEY SAY AND WHAT THEY DO- VIEWS OF THOSE WHO ARE TAUGHT AND THOSE WHO TEACH UNDERGRADUATE MEDICAL/CLINICAL ETHICS IN TWO MEDICAL SCHOOLS IN KENYA**

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**ABSTRACT**

Medical or clinical ethics provide guidance for health practitioners. Such codes offer guidance and have ‘hopefully’ been taught to the medical students during training. The teaching of clinical/ medical ethics has become even more important because of great advances made in medical science and the different cultural and socioencomic circumstances in which medicine is practiced . This study sought to determine if clinical/medical ethics is taught in Kenyan Medical schools by conducting focus groups with undergraduate students and key informant interviews with lecturers and academic administrators. While medical/clinical ethics is part of the approved medical curriculum and is taught during training, we idenfitied a gap beetweeen the theory versus application of ethics education. Both undergraduates, administrators and lecturers acknowledged a lack of aderaute role modelling, mentorship and a need for training in communication skills. Becaue medical ethics is not an examinable subject, and there was no formal training of those who taught the subject, it was not given suffifient attention . These gaps can be remedied by in the short term by training faculty and idenfying suitable refernce materials. Long term meaures include develping context appropriate materials for teaching and growing mentorship skills for posiive role modeling.

KEYWORDS:

Medical (Clinical) ethics, medical training, ethical behaviour, undergraduate medical students,

**ACKNOWLEDGEMENTS**

This study was done as part of Elizabeth Bukusi’s MBE requirements at The Sindh Institute of Urology & Transplantation (SIUT) in Pakistan. Prof. Bukusi’s training was funded by an EDCTP grant (CB.2010.41302.016) whose objective was to restructure and strengthen the process of ethics review at KEMRI, which is one of the leading research institutes in sub-Saharan Africa.

The aurhor wishes to thank Prof Farhat Moazam and Prof Aamir Jaffeery who supervised the MBE thesis. Timothy Kipkosgei who supported the data collection . Sarah Okumu, Rachel Mwakisha and Petronilla Njenga for their support in adminstation and logistics.

There are no conflicting interests in this work.

**INTRODUCTION**

Ethics provide a code of conduct in many professions (1) Medical or clinical ethics provide guidance on how health providers should relate to each other and their patients (2) These include responsibilities and expectations. Ethical principles are important in providing guidance, not only for how to relate to every day concerns, but even more important is when there may be medical dilemmas. The application of ethical principles would possibly help decision making.

**History of Ethics in Medicine**

Modern medicine is traced back to the ‘father of medicine’ Hippocrates (460-375BC) and is signified in the Hippocratic Oath (3) which is still taken in some form by graduating medical doctors, and while the relevance of this traditionally administered oath has been questioned, there is no question about the need for a professional code of ethics or standards (4). The core of medical practice is the doctor-patient interaction and relationship (5) and the fiduciary responsibly therein. This relationship is not straight-forward as several factors influence it. It is in this complex inter-play of doctor-patient relationship and the factors that may influence it that the vital role of (bio) ethics and professionalism in medical practice come about.

**Code of Ethics in Kenya**

The Kenya Medical and Dental Practitioners’ Board was set up under the laws of Kenya to regulate medical practice (1) and since an amendment in 2019 is now designated as a Medical and Dental Practitioners Council (1). Its core mandates include the regulation of training of medical and dental practitioners including approval of institutions to offer training and review of their curriculum, registration and renewal of registration of both training institutions and medical practitioners. A code of ethics is provided by the Kenya Medical and Dental Practitioners’ Board (1) This code lays out the responsibilities of the board that include registration, licensure of individual practitioners and accreditation of institutions that teach medical doctors and dentists, and lastly dealing with professional misconduct. The Kenya Medical and Dental Practitioners Board, revised its code of professional conduct and discipline in January 2012 (2). There is no explicit mention of new and emerging medical advancement, or relations with the pharmaceutical industry. The code discsuses relationships between the doctor, the public, colleagues, and what is expected in terms of human rights of the patients and what to do when there is a conflict of interest .. As with all codes, the implementation remains a challenge. Such challenges include but are not limited to for example implemantaiton of maintancee of patient privacy especially in resource limited settings where patients may sometimes share a bed. It may be difficult to maintain confidentiality when treating patients in such settings.

**The teaching of Ethics for the practice of medicine in an era of medical advancement**

The KMDB approved curriculum (ref and date) has medical ethics as part of the curriculum to be taught in medical schools. The exact and mode of teaching is determined by the university as they submit their curriculum to the Commission of University Education for approval and accreditation. The details of how the teaching is implemented has not been a subject of study therefore this study sought to evaluate the teaching of ethics to undergraduates in the two oldest medical schools.

Occurrence of medical errors and the thin line that sometimes exists between error and negligence is a neglected aspect of medical teaching (6) which raises the need to define the important clinical ethical issues that practitioners grapple with and to ensure that these are systematically ingrained and taught to the next generation of medical practitioners. Training in medicl ethics training will provide them with a platform with which to address the challenges they will encounter once they begin to practice. Boyd (7) argues that the current practice of medicine is fraught with new and emerging issues because of the advancement of science therefore increasing the urgent need for medical ethics as the problems that arise can no longer cannot be resolved simply by appealing to professional codes, or to science, religion, the law or even common sense.

**METHODS**

**Study Design and Tools/Guides**

This was a qualitative study undertaken between May to August 2013. The study tools consisted of an In-depth Interview Guide, Focus Group Discussion Guide and a teaching observation check list.

The In-depth Interview Guide was used to interview academic administrators who had oversight for the training of and lecturers who taught ethics to medical students. This tool had both closed and open-ended questions that allowed for further exploration of issues that arose during the interviews. Focus Group Discussions were held for undergraduate students which began with a definition of medical ethics to help ensure a clear understanding of the topic for discussion. This paper however will focus solely on the teaching of undergraduate medical students.

**Data Collection**

The data collection was limited to the first two universities to train medical doctors in Kenya: Moi University and University of Nairobi. Permission to proceed with data collection was obtained from the Kenya Medical Research Institute Ethics committee and then from both institutions: from the Vice Chancellor at one institution and from both the Principle and the Dean at the other university.

Key Informant Interviews (KIIL): All those contacted for interviews expressed willingness to be interviewed and appointments were thereafter made with the identified key staff holding administrative positions (e.g. Dean and/or Principal) and with lectures identified by these administrators as those who teach or who coordinate the teaching of clinical or medical ethics. All KII were held at the offices of the respective interviewees as this was most convenient for them. All interviews were conducted in English and were audio recoded except for one where the interviewee asked for notes to be taken but did not consent to audio recording. All KII lasted between 20- 45 minutes

Focus Group Discussions (FGDMS): the FGDs were conducted in two different cities where the respective medical schools were located. The lecturers/ administrators at the universities were asked to request willing medical students to attend r the FGDs. At Moi University, the coordinator of the medical/clinical ethics contacted willing final year medical students who attended the FGDs at the prearranged times. At Nairobi University contact persons were provided to the Principle Investigator for the undergraduates. These contact persons contacted other willing students and asked them to come for the FGD at the pre-arranged times. The two FGD for undergraduate students included students from different years of study, but the majority were in the final year of the program. All the FGDs were conducted by the Principle Investigator.

The FGD’s had between 5 to12 participants and lasted between 1.5 to 2.15 hours. They were conducted in English and each participant gave written consent for pacticipation and the discussions to be audio recorded. Light refreshments were provided at the FGD and participants were reimbursed their travel costs to the venue. Travel reimbursement was Ksh 500 (6 USD).

Data from the KIIs and FGDs were recorded on an audio recorder and transcribed by the PI. Informed consent sheets and data informational sheets were kept in separate folders and in separate compartments of a locked filing cabinet in the PI’s office.

**Data analysis**

The socio demographic data of the participants and their affiliated institutions are presented as simple descriptive statistic. The transcripts from both the FGDs and in-depth interviews were read and explored several times to identify cross cutting themes and emerging themes from the discussions. Main and sub themes which captured the spirit and essence of the FGDs and KII were identified and grouped as per different participants, i.e. those who teach and undergraduate medical students.

**Ethical Considerations**

Approval to undertake the study was obtained from the Kenya Medical Research Institute Ethics Review Committee (SSC 3537 dated 24th May 2013), and the Sind Institute of Urology and Transplantation ERC (SIUT-ERC/ERC-A4-2013 dated 2nd February 2013). In addition, permission was obtained from relevant academic institutional/organizational heads. Prior written informed consent was also obtained from all individuals who participated in the Key Informant Interviews (KII) and the Focus Group Discussions (FGD) and a copy of the consent form was provided to all participants for their records.

**FINDINGS**

**The Current approved University Curricula for Medical Students**

Both universities had an approved curricula for the training of medical doctors. One university curriculum did not identify clinical /medical ethics as a separate subject to be taught but ‘ethics’ was included during the teaching of other units which include the first two years of the programme. There were no specified books or text recommended or used for the teaching.

The other university identified ethics as a specific subject, and taught ethics in the first year under “Behavioural Sciences and Introduction to Ethics”, and in the final year as “Medical Ethics and Medical Legal Issues”. The final year is taught using a specific course book a copy of which is provided to all students (current version was from July 2012, reprinted June 2103 by the College of Health Sciences’ printing unit).

At both universities, ethics was not examinable as a core subject, but was examined within the other core disciplines. There were no lecturers identified as having been trained specifically in clinical / medical ethics by either the adminsitators, the lecturers or the medical students, but both the medical students and lecturers indicated that those teaching had some interest in the subject.

**Socio Demographic Information**

Lecturers: A total of ten individuals were interviewed from the two universities, 6 from one and 4 from the other. The age range was from 51 to 66 years. Those in administrative positions (dean/principle) had served in that role for between 3-6 years. Those teaching had held those positions for between 10-33 years. The minimum qualification was a Masters’ degree. Those interviewed whose initial training was in medicine had done masters in either Internal Medicine, Psychiatry or Obstetrics and Gynecology. Others with training in medical sciences (e.g. Biochemistry) or Pharmacy had PhD level training. The majority of those interviewed were male (8, 80%).

Undergraduate students: A total of 35 undergraduate students attended a total of 4 FGDs. There were 20 from one university and 15 from the other. The age range at one university was between 20 to 26 years with an average of 25.45 years. The majority were in the final year, with only one from second year and two from the 4th year of training. The other university had an age range between 25 to 30 years with an average of 27.46 years. All were in the final year of training. There was a total of 11 female students among the 35 participants (31%); 6 out of 15 at one institution (40%) and 5 of 20 at the other institution (25%).

**Themes identified**

Theory versus Practice of Ethics Education

The first emerging theme was that ethics was taught in a theoretical manner and not evident in practice. Each university had an approved curriculum that listed some aspects of clinical/medical ethics to be taught, and those trained in medicine in Kenya who were currently lecturers and the undergraduate students at both institutions indicated that ‘some’ aspect of ethics was taught. Ethics was taught as an introductory course in the first or second year of trainings part of the behavioural science courses and thereafter it was up to the individual lecturers to decide if they wanted to include any additional teachings in their courses. As a result, the teaching of medical/clinical ethics was not systematic or consistent through the major part of the clinical years.

Some lecturers felt that there was a clear attempt to ensure that medical/clinical ethics were taught during the course of teaching;

*But I believe that as we teach, there are certain ethical principles that we try to impart in the practical aspect of the theoretical course that they did earlier* (KIIL)

Other lecturers realised that there were shortcomings in the teaching;

*You know procedures……. giving people opportunity to make choices. And helping them to understand why we do things and why we may not do them and what options they have. If I understand it [ethics] to mean that, then I think we are not giving it enough...enough attention and I say that because, I think it is related also to communication skills. I think we do very poorly on that. Extremely poorly in fact I think this is going to be the next flash point for litigation…* (KIIL)

The medical students indicated that what was in the curriculum and what was actually taught in practice was pale in comparison. The students at one university acknowledged that ethics was taught but the training was, however, not felt to be sufficient. The students also expressed concern at the gap between the theory they sometimes learned and what they saw in actual practice in the clinical arena;

*The consultants ask … what is the diagnosis? What are you going to do about it… they do not have time to listen or to make any comments about ethics* (FGDMS)

Undergraduates and lecturers expressed concern over not getting enough information on consequences or expectations as not enough was taught on the legal aspects of medicine. This aspect of medicine has become increasingly important as the social standing that doctors had once held in the community was changing, there was a rising awareness of litigation in the public domain however this was not reflected in systematic teaching of ethical behaviour;

*That is one aspect that we feel we have a shortcoming, that we do not do enough……. perhaps we need to get legal minds to engage…. and legal specialists ………it is an area that we need to emphasize… anything we do, they need to think of what the legal consequences are* (KIIL)

Lack of attention in teaching ethics

There was a consensus among admin, lecturers and medical students that there was insufficient emphasis or attention to the teaching of clinical or medical ethics across the board. All interviewed parties agreed that medical students are under pressure to learn and there is the need for students to pass examinations so that what was not examined was likely not to be given much attention. Despite this, unanimously across the board everyone- undergraduates and lecturers agreed that medical ethics was an important subject.

*Medical ethics is a terribly important subject and must be taught well… The weeks we have to teach this is not exhaustive… there is not enough time to teach… There are many emerging new things that come up that were not thought of when the course was set up* (KIIL)

There was an awareness that because of the load of medical school, students weighed what they needed to give attention to;

*When they look at it and see it is only one or two units and likely not to contribute to the overall passing or failing, they will ignore it* (KIIL)

At one university, ethics was taught within various departments and within the various subjects. The examination of ethics also occurred in this context, with there being some questions within the general examination of the medical disciplines. In the second university, attendance of 80% of the tutorial discussions was required. There was no examination of the subject. The students felt that the importance of the training was not high, and they did not value these teachings at this stage therefore they also did not prioritize it;

*I focus on medicine, psychiatry and surgery which will make me pass… I will not think about the CAT [continuous assessment test] in forensic pathology which has ethics… it will contribute very little to my final passing* (FGDMS)

*The eyes cannot see what the mind cannot see…. the system has failed, we do not even know the framework… we do not even know if it is a legal requirement for us to learn ethics…. It is not being taught well …. My colleague knows what he needs to know in surgery...but he does not know what he needs to know in ethics...and he cannot quantify it…* (FGDMS)

*Anatomy has 9 units and ethics has 0 units…. It is clear what one will focus on* (FGDMS)

The students expressed a disconnect between the teaching in the early years and the teaching in the final year of training. There seemed to be a rush at final year to teach what needed to be taught but had not been covered throughout the previous years;

*They jump second and third year and then bring it[Ethics] in fifth year… to find my notes from those years…. they even get lost… and many of us synthesize knowledge when exams are close… you rearrange the knowledge and it makes sense, since they are no exams... no one pays it attention… and it is clouded by other topics… like anatomic pathology and post mortems …....and then the classes are not well attended… whoever put the training in 2 and 5 year did not serve us well* (FGDMS)

*It is like then you are taught [ethics} like a ‘bolus dose’ like you must know everything before you leave.* (FGDMS)

Lack of role modelling

The third theme emerging was that there was a lack of role models that set standards for the students to emulate. Leading by example was noted to be a challenge by the adminisrtators and lecturers. The lack of mentorship was in part thought to be due to lack of training for those who teach and also the physical availability of those who taught due to other competing interests;

*We need more mentorship than that is currently available… and for you to mentor someone…. You need to be available. … The back ground of the ethical issues is because someone is rushing to go* [elsewhere] (KIIL)

The amount of time the lecturers spent with the students and the choices and clinical decisions was of concern to all. The lecturers realized they had opportunity to influence the students, but leading by example was identified as an important part of training which was difficult to achieve. The medical students similarly indicated that the consultants seem to be more concerned with medical diagnosis and treatment of the patients but did not emphasize the ‘softer’ aspects and overall medical care which are the aspects of medical practice that ethics usually is applied. Because of the high work load, there was a sense that there was not enough time to explain things to students or the treatment plan to the patient;

*In the hospital… it is about moving the queue so you hardly ever get to see the consultants show you how to do anything* (FGDMS)

*Perhaps it is because we have many patients and the consultants are not there all the time……. the consultants seem to focus on the pathology and the treatment, but they do not seem to be concerned about the social aspects or any ethical concerns*. (FGDMS)

While there was willingness if asked, the consultants would not necessarily volunteer to teach clinical/medical ethics because of the pressure of work or other demands on their time or because there was no recognition of the need to teach medical ethics. Students noted that even when ethical challenges and dilemmas occurred, there were missed opportunities to engage the students and enable them to learn best practices;

*When there is a special need or an ethical matter, it is referred to someone else or the social workers or the psychiatrist and the medical students do not get to deal with it or to participate in the understanding of how to handle it* (FGDMS)

As there was no particular system put in place to ensure lecturers and consultants modelled ethical behaviour, students identified for themselves individuals who were good role models based on their keenness to teach the ethics and their behaviour towards patients during clinical ward rounds.

*Some of the consultants try hard and a few of them focus on the whole patient, it is not a general requirement, it is personal initiative dependent on the consultant* (FGDMS)

*There are some ethical doctors… like ward I was in… it was the first time I saw lumbar punctures done under local anaesthesia…. And he ensures that patients are counselled before they start chemotherapy… so they are some positive role models* (FGDMS)

Medical students also modelled behaviour from the postgraduate students who they spent most of their time with during clinical work. They therefore learned whatever these postgraduates had in turn learned during their undergraduate year.

Lack of training in communications skills

Lecturers and undergraduate medical students alike admitted to challenges in the teaching of communication skills -noting that this was either not taught, or not taught well when taught, and was further compounded by the lack of senior role models to show them how to communicate well;

*If I look at medical ethics to encompass provider and participant interaction meaning communicating procedures giving people opportunities and choices, getting people to understand what we do and why we do it…. Then we are not giving it enough attention. ….. I say that because it is related to communication skills and we do very poorly, very poorly, it will be the next flash point for litigation* (KIIL)

Students indicated that they needed to be able to learn communication skills as this would enable them to work effectively e.g. by delivering bad news to patients and/or explaining complex medical issues in a way patients would be able to understand and consent to treatment plans;

*Beyond breaking bad news, there is just the matter of communicating with patients… a doctor will examine a patient and never inform him of what has been found* (FGDMS)

*The nature of the patients we have also makes it difficult… if someone does not have a good understanding of the language or the issues……no one has time to talk to the patient and they say…. Get the consent and put the patient on the list... they should sit with the consent form and let you hear how the whole process should be done…. someone undergoing an extensive procedure…. Someone should explain... we never get to see how that happens. If it is the ward round where the decision is made and the next time we see the patient in the theatre with the signature in the right place…. we need to see how they handle the questions and the concerns the patients would have* (FGDMS)

Without examples or mentorship , the medical students admitted that when they were not able to adequately handle challenges with communication, they also passed the responsibility to others.

**DISCUSSION**

Developing countries like Kenya still face critical issues in its healthcare systems. We found that university administrators, lecturers and undergraduate medical students in the two oldest medical schools agreed that the teaching of medical/clinical ethics falls shor of their desires or expectations. The main themes identified were the lack of attention paid to the teaching of medical ethics, the gap in the theory taught versus what they saw in practice, a lack of role modelling from the lecturers and inadequate training in communication skills.

*Theory versus Practice of Ethics Education*

The gap in the theory taught to the students compared to what they experienced in practice during rounds can be attributed to the lack of formal texts and refereencees used during the training. In addition the lack for formal training of those who train – specifically in bioeethics or medical ethics as an adiditonal competency. The CUE approves all curriculums in institutions of higher education and has recenetly taken up reviews at univeersitiees to asceetain that standards are being met (8). Teaching of ethics was also not consistent throughout the years, which presented students with conceerns as by the time they were exposed to practical rounds, they had little to no knowledge or had forgotten what was taught before. And when this is not deliberately incooprated into theee practical bedside teaching then thee opportunity to put the theory into practice is lost. This was also the case in anobservation of ethics education in a South African medical school (9). The solution presented there was to incorporate different ethics modules throughout the medical school years and have assessments based on the theory taught and what was observed in the clinical rounds (9)

Researchers notes that medical education in Africa is not a level playing field when compared to the more developed countries (10) as many “givens”, e.g. political and financial instability and provisions of the tools or the infrastructure to support the healthcare worker are not easily available.. Therefore, ethical principles are applied differently in these environments, and lecturers should ensure teaching is comprehensive to include applications of the principles and not just theoretical concepts. it would be imperative the practice of medicine is still effective and ethical even in resource strapped environments. It is thus even more important to teach the students the principles of ethical behaviour in contexts where the students can engage, debate, question and have examples of how to apply these in the environments in which they will practice medicine (Boyd 2018; Moodley 2007).

*Lack of attention in teaching ethics and role modelling*

These two themes are discussed together as the factors contributing to lack of attention afforded to ethics as a subject and lecturers not modelling ethical behaviour are similar. The lack of formal training in ethics education made those who teach – do so out of passion for the subject. Most teachers/lecturers tend to model the teaching method they were taught, incorporating what they see worked/didn’t work for them in their own teaching styles (11). Without formal teaching and thee heavy workload because of limited time it is possible for ethics to be overlooked in place of other subjects in the medical curriculum that have more extensive content and are examinable.

Brain drain has caused human personnel in the healthcare sector to be outweighed by the rising population of patients (5,12). The uneven doctor to patient ratio makes lecturers overworked which can account for the lack of role models and attention given to teaching in medical schools. Many physicians also work in private hospitals to supplement their incomes (12) and these part-time jobs have implications, e.g. on the amount of preparation given to lectures and how the students are taught during their clinical ward visits. Other authors (13) however argue that simply increasing the number of doctors may not do much to offset the structural forces at play in the provision on health care in low- and middle-income countries such as Kenya. Additionally, students can learn from both negative and positive role models. Students adapt unprofessional behaviour of negative role models leading to a learned insensitivity (14) however these negative role models can also provide an example of the behaviour to not exhibit towards patients.

*Lack of training in communication skills*

Despite designated teaching in ethics, the aspect of communication was still not thought to be comprehensively taught or not present at an optimum time, that is before the students begin or during their clinical wards rounds. The educational level of patients and their ability to understand sometimes complex medical terms or procedures raises concerns as to whether the consent obtained from patients is really valid (15). Often, patients do not understand the procedure they are about to undergo and they have no opportunity to ask questions or have their condition explained in a language of their choice (9,15). Patients studied (15) suggests the need for a detailed explanation for the patient by the doctor about their disease conditions and treatment options; that doctors should be kinder, more courteous, gentle and should not be rude as ways to improve patient-doctor relationship.

Given the changing social environments, doctors too are gaining awareness on their rights and power which recently resulted in a country wide labour strike in Kenya. This, termed as medical disruption (15) poses challenges on how to navigate ethical dilemmas centred around providing care, doing no harm (which may be caused by lack of service delivery during a labour strike) and justice to both patients and health care workers. Communication both from the doctors to the patients , to fellow colleaues and thok those in authority remains a core skill needed for everyday function and to reesolcee complex human resource and welfare matters.

While there is no one right way to deal with resolve these dilemmas however having discussions about them can lead to increased problem-solving abilities of the students whenever they face challenges. Ethics education would allow students the ability to integrate, interpret and apply knowledge to ethical dilemmas as they arise in practice (9).

**CONCLUSION**

Medical ethics provide guidance on how health providers should relate and provide care to patients. Medical ethics is an important aspect of medical teaching. The identified gap between what is in the curriculum, the theory and the practice of ethics is important to address. To addeeess this several practical steps can be taken.

Formal training for those who are designated to teach this subject would be important. In addition some aspects of ethics should be included in every year of medical school and it shoud be an examinable subject to give it the seriousness it merits.

In addition, idenfification of text books for use and encouragement of the development of material sutiable to our specific settings should be encouraged. We also recommend that the methods of teaching should be strengthened and incooprated into the clinical settings to eable students graduate with experience in moral resoning for resovling ethical dilemnas. Lastly enabling good mentorshop and good role modelling by adequately resourcing medical schools and the faculty would also be step in the righ direction to produce the next generation of not just competent but compassionate medical practitoineers. .

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