**Baseline survey of knowledge and understanding of healthcare ethics, in a cohort of healthcare practitioners in a sub-Saharan Africa tertiary health care institution.**

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**Abstract.**

Healthcare professionals (HCP) ethical knowledge, orientation and behaviour has been studied in countries with developed economies. Out of these studies has resulted publications in many journals. On the other hand studies in lower and middle income countries (LMIC), more so Sub-Saharan (SSA) countries are relatively sparse. The survey outlined in this article which was conducted in a SSA country tertiary care health facility in Ghana, was undertaken with the intention to explore the primary ethical knowledge and intuition, in a cohort of SSA HCPs. The aim was to determine their baseline ethical knowledge and sensitivity, deficits if any, in basic ethical concepts and determine gaps in ethical knowledge. The information obtained from the study was to inform possible future direction of ethics education, which currently has a relatively low uptake in SSA settings. The results indicated the respondents thought of ethical issues in the course of their work. However if one is to go by reports of unethical behaviour among some HCP available in the public domain, then there appears to be an issue of cognitive dissonance among HCP knowledge of ethics, and their actual everyday behaviour as HCPs.

**Key words: Healthcare ethics, knowledge, healthcare professionals, Sub-Saharan Africa, ethics education.**

**Introduction.**

Healthcare personnel (HCP) ethical (mis)behaviour may come in the way of their technical competence, whereby their ethical (mis)behaviour is not necessarily congruent with their technical competence. This ethics/technical competence mismatch in sub-Saharan Africa (SSA) health care settings, tends to translate at the level of patient care to patient discomfort, and on some occasions increased patient suffering especially for vulnerable inpatients, as well as the quality of health care delivery(1) (2). These patients are already vulnerable as they are separated from the comfort zone of their home surroundings and family. This mismatch might be due to the HCP just being plain naive about his/her ethical obligations, instead with all their attention being concentrated on their “technical” medical/nursing care obligations and competence, while the human element is lacking; or a situation of lack of ethical/moral sensitivity (3). Other times HCP misbehaviour is purely a case of “compassion fatigue” resulting from work conditions pressure and other health care organizational stressors (4).

HCP knowledge based moral/ethical sensitivity/intuition matters in SSA has not been widely studied compared to the countries in the global North, this may be attributed to what has been thought of as a relative poor uptake of medical ethics/bioethics education in SSA higher health care institutions (5) (6). Additionally there seems to be a struggle sometimes for some SSA philosophers/ethicist to differentiate an African bioethics (with possible different demands), from a global North or Western bioethics(7). On the other hand a fair amount of publications highlighting unethical practices, misbehaviour, and corrupt practices bordering on malfeasance among HCP in SSA are in the public domain (8) (9) (10) (11) (12), which gives cause for concern. Especially for SSA, some of the principal factors attributed to such acts of what may be classified as unethical behaviour or acts of malfeasance are poverty, corruption and bad governance(8) (9) (11). It is against this background that the survey presented in the article was conceived, to investigate the basic ethical knowledge and understanding or attitude of HCP towards issues of health care ethics. The survey will be used as a baseline measure of their ethical awareness and sensitivity, towards matters ethical, in the area of healthcare.

**Aim of study**:

To explore the basic health care ethics knowledge and understanding, of health care professionals (HCPs) In a tertiary care health facility, in a region of Ghana.

**Method**:

Use of a quantitative method (administered survey of a Likert-like question/answer type), [Fig. 1] administered to a cohort of HCP at a tertiary level hospital in Ghana. Participants were asked to voluntarily participate in an anonymised response to the questionnaire. Participants were informed of their right to refuse to participate, after the purpose of the test was fully explained to them. At the request of many participants, sex, demographic information and professional classification of the respondents, were excluded from the data collection and analysis in a pre-testing agreement. The respondents were a mix of both sexes and were a mix of HCPs, (including physicians, nurses, midwives, dentists, physiotherapists, pharmacists and occupational therapists).

**Results**:

80 (eighty) respondents returned their completed questionnaires out of 97 (ninety seven) staff members approached, this gave a participatory rate of 82.45%. The 17 (seventeen) non-respondents refused to participate, once they had looked at the questionnaire contents. The analysis is limited to those who responded and completed the questionnaire, and the result is summarised in [Fig. 2]. The analysis of the results was done using SPSS version 15.All the respondents (100%) thought medical ethics was relevant to the practice of medicine. 69 (82.2%) respondents said they took into consideration the principilist ethics paradigm in resolving ethical problems that crop up in their practice. 62 (77.5%) of the respondents thought being virtuous was important in the practice of medicine. 71 (88.8%) felt patient autonomy was of importance in the doctor-patient therapeutic relationship. 30 (37.5%) thought “indigenous cultural practice” or considerations were of prima facie importance in the doctor-patient interaction. Interestingly 40 (50%) of respondents responded “not sure”, to this question. As to the issue of non-medically indicated abortion being a patient’s non-contestable right, 35 (43.8%) said yes to this whilst 31 (38.8%) responded “no” to the question. On the issues of euthanasia being “a right of a patient on demand” 31 (38.8%) of respondents said “yes”, whilst 33 (41.2%), answered “no” to the question.

On the issue of whether the “religious beliefs” of the HCP be “brought to bear” on the patient in the doctor-patient interaction, 33 (41.2%) of the respondents said “yes”, whilst 31 (41.2%) answered “no” to that. 14 “17.5%) answered “not sure”, to this particular question. On the question of whether HCP are “obliged to satisfy all the patient’s treatment request” in relation to the available resources, 53 (66.2%) responded “yes” to the question, whilst 21 (26.2%) said “no” to the question. On the last question of whether “doctors necessarily need to resort to strike action in resolving industrial disputes with their employers” 52 (65.0%) responded with a resounding “yes”, 19 (11.2%) answered “no” to that, while 9 (11.2%) responded “not sure” to the question.

**Discussion**.

This cross-sectional survey was meant to explore the knowledge and (what l choose to describe as “unprimed”) ethical intuition of a cohort of HCPs, employed in a tertiary care setting in Ghana. Primarily it was to explore their ethical knowledge and inclination, and how it may impact on their attitude in day to day work situations. I used the wording “unprimed” being that the HCPs had not had any formal ethics training/ education in the past five to ten (5-10) years at least post professional training/education (in fact majority of the participants [no. 63] by their admission, have had no formal ethics education). This way their intuition has hopefully not being primed recently (in the past 1-2years) with formal ethics education. I would think such a survey of HCPs is important especially in SSA settings, as part of an on-going effort towards quality ethical improvement initiatives in SSA settings. In these settings healthcare ethics does not feature as a priority or front burner issue (5) (6). Just the challenges of everyday living (8) (9)), systemic inefficient healthcare organisational problems and scarce resources problems (13) systemic corrupt practices (14) coupled with traditional thoughts on illness and illness locus of control(15), tends to make adverse events/outcomes appear “fatalistic” or “acts of the spirits”.. Scrutiny of SSA healthcare staff ethical knowledge attitudes and behaviour (KAP) do not relatively come up often in medical ethics journals, however one such study of medical students in their clinical years at a Nigerian teaching hospital, showed the clinical students lacked formal education in medical ethics but rather seem to

pick up bits and pieces as they progressed through their course. The students however appreciated the limited knowledge of medical ethics imparted to them in a brief ethics course. They expressed the need for a comprehensive ethics education as part of the medical school curricula (16).This re-enforces a point raised earlier about the paucity of bioethics education in health sciences higher education centres in SSA countries, and the need for more medical ethics/bioethics education in higher institutions in SSA (6).. it is thus not a chance occurrence that despite the respondents of the survey accepting the importance of medical ethics and virtue in the practice of medicine, to date, there are instances of bad behaviour by HCP in Ghana and other SSA countries (2) (17) (18) (19). This unfortunately seems to be a situation in other SSA countries (20) (21), and reflects the mismatch between knowledge and attitudes; or otherwise said, between what is thought to be known or learnt, as opposed to what is practiced. Again this re-enforces the need for ongoing ethics education among health care professionals as part of obligatory annual continuing professional development (CPD) activities.

With particular reference to the survey administration “dynamics” described earlier, of interest was the worry initially along with suspiciousness, of a good number of the respondents about whether the survey was a form of “entrapment” on their truthfulness and professionalism; were they to answer the questions (rightfully or wrongly). This despite the nature and the reason of the survey being carefully explained to them (including the assurance that their responses were anonymised). It is clear that not educating HCP in SSA countries, potentially short changes them on what is considered ethically acceptable practice norms, despite their technical competence. Contrasting briefly the situation of healthcare ethics education and mindfulness in SSA to that in the global North countries, more especially in nursing ethics and education, the effort and drive towards ethics education and mindfulness of HCP (along with technical competence) has led to attempts at quantifying the ethical knowledge and moral preparedness of HCP (22). One such useful method is the concept of the ethical behaviour test, (which addresses not only the ethical reasoning of nurses, but the link between reasoning and the behaviour), developed against the backgroundof Kohlberg’s stages of moral cognitive development, and his definition of morality (23).

An un-addressed issue in SSA country healthcare systems over and above HCP professionalism and ethical competence matters, is the issue of healthcare organizational ethics. This issue is one that I think is important towards creating an ethical ambience and climate, to support the ethical life of the HCPs and the patients they look after (24) (25). I say this because where the HCPs and by extension healthcare managers are primed/sensitised by way of appropriate and adequate ethics education, one will assume that there will be a harmonious relation between the organisations human capital and the organisation and by extension acceptable ethics laced patient care.

**Conclusion.**

The overall impression from this survey indicated that most SSA healthcare professionals may think about the relevance of medical /healthcare ethics in carrying out their duties. Additionally it appears most of the health care professionals in the survey thought virtue was important in the practice of healthcare. For starters these responses are encouraging. Some contentious questions like cultural beliefs, religion, non-medical indicated abortion and euthanasia clearly divided the respondents, which did not surprise me. Interestingly in informal discussions post the survey, a fair number of the participants thought of ethics in terms of “Judeo-Christian morality gleaned from the Bible”, as

opposed to formally acquired knowledge from a healthcare ethics course. Of interest, is the fact that majority of the respondents felt that HCP should accede to “all treatment request in relation to available resources”. It demonstrates a certain culture in my view not out of concern for patient rights, but rather a health care culture tendency of polypharmacy prescription, in the health care practices in Ghana (26) (27).

Surveys of this nature not only bring out the perceived ethical knowledge and orientation or lack of in HCP in lower and lower middle income countries, especially in SSA settings. Such surveys additionally flag up areas of need in ethical education, including developing an appropriate curriculum of ethics education. Such an enhanced ethics curriculum will not only serve as a platform of local ethics education training, but additionally allow the HCP to directly/indirectly contribute towards their own ethical development. This hopefully will lead to a professionally rounded HCPs who are not only competent, but also ethical in every sense. Eventually such a healthcare workforce will be much more beneficial to the vulnerable patient population. Obviously the survey has limitations as to the size of the cohort relative to the actual HCP population of the country, the extant of topics covered by the survey questionnaire, some degree of limitation as to the results and analysis due to the respondents insisting on some respondent descriptors (professional grade, sex, age and years of service) being excluded from the data collected. These Excluded descriptors could have introduced some nuances to the collected data and analysis. That said, more studies of such nature in various SSA settings will better inform policy makers as well as HCP educators towards improving healthcare ethics education in SSA countries, while enhancing the ethical preparation and orientation of SSA HCPs.

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**Ethical approval.**

Ethical clearance/approval was sought from the hospital medical directorate. Ethical approval was waived after a review of the questionnaire by the directorate.

**Declaration of interest.**

None.

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Fig. 1

****4. Is patient autonomy important in the doctor-patient relationship?

|  |  |
| --- | --- |
| N Valid  Missing | 80  0 |

**Is patient autonomy important in the doctor-patient relationship?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid Yes  No  Not Sure  Total | 71  7  2  80 | 88.8  8.8  2.5  100.0 | 88.8  8.8  2.5  100.0 | 88.8  97.5  100.0 |

5. Are indigenous cultural practice of Prima facie important in the doctor-patient interaction?

|  |  |
| --- | --- |
| N Valid  Missing | 80  0 |

**Are indigenous cultural practice of Prima facie important in the doctor-patient interaction?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid Yes  No  Not Sure  Total | 30  10  40  80 | 37.5  12.5  50.0  100.0 | 37.5  12.5  50.0  100.0 | 37.5  50.0  100.0 |

6. Do you consider non-medically indicated abortion a patient’s non-contestable right?

|  |  |
| --- | --- |
| N Valid  Missing | 80  0 |

**Do you consider non-medically indicated abortion a patient’s non-contestable**

**right?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid Yes  No  Not Sure  Total | 35  31  14  80 | 43.8  38.8  17.5  100.0 | 43.8  38.8  17.5  100.0 | 43.8  82.5  100.0 |

7. Do you consider euthanasia as a right of a patient on demand?

|  |  |
| --- | --- |
| N Valid  Missing | 80  0 |

**Do you consider euthanasia as a right of a patient on demand?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid Yes  No  Not Sure  Total | 31  33  16  80 | 38.8  41.2  20.0  100.0 | 38.8  41.2  20.0  100.0 | 38.8  80.0  100.0 |

8. Should the religious beliefs of the health professional be brought to bear in the doctor-patient relationship decision making process?

|  |  |
| --- | --- |
| N Valid  Missing | 80  0 |

**Should the religious beliefs of the health professional be brought to bear in the doctor-patient relationship decision making process?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid Yes  No  Not Sure  Total | 33  33  14  80 | 41.2  41.2  17.5  100.0 | 41.2  41.2  17.5  100.0 | 41.2  82.5  100.0 |

9. Are health professionals obliged to satisfy all patients’ treatment requests in relation to available resources?

|  |  |
| --- | --- |
| N Valid  Missing | 80  0 |

**Are health professionals obliged to satisfy all patients’ treatment requests in relation to available resources?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid Yes  No  Not Sure  Total | 53  21  6  80 | 66.2  26.2  7.5  100.0 | 66.2  26.2  7.5  100.0 | 66.2  92.5  100.0 |

10. Do doctors necessarily need to resort to strike action in resolving industrial disputes with their employers?

|  |  |
| --- | --- |
| N Valid  Missing | 80  0 |

**Do doctors necessarily need to resort to strike action in resolving industrial disputes with their employers?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Frequency | Percent | Valid Percent | Cumulative Percent |
| Valid Yes  No  Not Sure  Total | 52  19  9  80 | 65.0  23.8  11.2  100.0 | 65.0  23.8  11.2  100.0 | 65.0  88.8  100.0 |

Fig.2