

FACTORS CONTRIBUTING TO NON-ADHERENCE TO MEDICAL ETHICS BY HEALTH WORKERS AT NDOLA CENTRAL HOSPITAL, NDOLA, ZAMBIA

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ABSTRACT

AIM

Study to determine factors contributing to non-adherence Medical Ethics by health workers.

RESEARCH QUESTION

Why are health personnel not adhering to Medical Ethics?

OBJECTIVE

To find out common factors contributing to non-adherence to medical ethics among health workers at Ndola central Hospital

HYPOTHESIS

There are no factors influencing non-adherence to medical ethics.

METHODS

The study was conducted at Ndola central hospital which is a 3rd level referral hospital as well as a teaching hospital. A non- interventional descriptive study was done. Health care providers were randomly sampled from the departments at Ndola central hospital. Random selection was done using an existing sampling frame (list of health care providers in each department). Study unit was drawn using simple random probability sampling, all the health care providers from different departments were listed and numbers were assigned to each name. These numbers were picked and were compared to the list. Names against those numbers were picked and were included in the sample. Quantitative data was collected using a self-administered structured questionnaire.

Prior to data collection, a formal letter (indicating the title of the study and the objective of the study) was written and submitted to the senior medical superintendent who is the head of the institution at which the study was conducted. Before collecting any data, permission was sought from the participants. They were at liberty either to agree or refuse to take part in the study or not.

CONCLUSION

On the basis of the findings derived from this study, it is obvious that a lot of factors contributing to non-adherence to medical ethics emanated from this study. The identified factors contributing to non-adherence to medical ethics among health workers at Ndola central Hospital were: Health workers feel they know what is good for the patient and not clients 95%, patients not provided with information 50%, Lack of alternative remedy in some instances 65%, Some conditions like STIs spouse should be aware 90%, Shortage of essential drugs and supplies 60%. The fact that there are factors impeding on adherence, quality of service may be compromised because quality of health service delivery in the country ought to be enhanced through adherence to medical ethics by health workers. After all, adherence to medical ethics by health workers is one of the most critical aspects of quality health service delivery in any country. Indeed, non-adherence to medical ethics affects not only the way through which health workers interact with health service users, but also the quality of health service delivered as it hinders the later from accessing better health services. Ethical standards promote the values that are essential to good communication; in turn patients can have confidence, even reciprocal reverence and unbiased medical care.

INTRODUCTION

Ndola Central Hospital is the 2nd largest, 3rd level health facility in Zambia. Under its umbrella it hosts for training facilities namely:-School of Nursing, School of Midwifery, school training theatre nurses, Biomedical college of Sciences, Medical school where medical doctors are trained. Services rendered: Medicine, Surgery General, Obstetrics & Gynecology, Orthopedics, Ambulatory Services (Casualty & OPD), Psychiatry, Dental Services and Laboratory Services.

The field of public health is grounded in law and cannot function effectively without a strong legal framework. Legal framework lays the foundations for public health authority. Public health is an thrilling part for moral discussion because it challenges us to think beyond the established consensus in much contemporary bioethics. During the last few decades the field of bioethics has developed with a special focus on moral problems relating to clinical encounters between patients and health care professionals. Occasionally bioethics is presented as the equivalent of medical ethics or in contrast to public health and population-level bioethics(14). Public health has four features that provide much of the subject matter for public health ethics: (i) it is a public or collective good; (ii) its promotion involves a particular focus on prevention; (iii) its promotion often entails government action; and (iv) it involves an intrinsic outcome-orientation. Bioethics is normative ethics applied to decision making and public policy in the domains of biology,

medicine, and health care. It is concerned with matters of basic scientific research and with the social applications of biological knowledge and biomedical technology. Medical ethics, the ethics of what role the physician plays started as early as medicine inception.

Public health ethics, in turn, has arisen alongside bioethics and the two fields of applied ethics have many strong affinities and connections. Public health and clinical medicine, differ in some way, similarly there important differences between bioethics and medical ethics. In a nutshell, the difference can be characterized by the individualistic orientation of clinical medicine and the social or population based perspective of public health. Public health is more concerned with disease trends, the environments where disease occur, and finding solutions to alleviate the risk or burden of disease in a population.

Nonetheless, public health should not overlook the rights, interests, and freedom of the individual. Whenever possible, public health goals should be reconciled with the promotion of human rights.

Biomedical ethics has often stressed the importance of individual interests of patients, notably the right to autonomy and privacy. Some writers have categorized public health ethics in three overlapping ways: professional ethics (the values that help public health professionals to act in virtuous ways); applied ethics (the values that help to illuminate hard problems in public health policy and practice); and advocacy ethics (the overarching value of population health and social justice).

Professional ethics are concerned with the ethical dimensions of professionalism and the moral trust that society bestows on public health professionals to act for the common welfare. Professional ethics are role oriented, assisting health practitioners to behave in good ways as they undertake their functions. A common framework used in the analysis of medical ethics is the "four principles" approach postulated by Tom Beauchamp and James Childress in their textbook *Principles of biomedical ethics*. It recognizes four basic moral principles, The four principles are:⁽⁶⁾

- Respect for autonomy - the patient has the right to refuse or choose their treatment. The principle of autonomy recognizes the rights of individuals to self-determination. This is all about respect for individuals' ability to make informed decisions on matters which concern that particular person ^[7]Respect for autonomy is the basis for informed consent. For example an individual has the right to refuse to participate in research and should not be coerced to do so, on the other hand the patient can choose to accept or refuse treatment. Life decisions, patients have the right to refuse treatment and choose an early death if they so wish.^[8]
- Beneficence - a practitioner should act in the best interest of the patient, refers to actions that promote the well-being of others. As a result individuals should take actions that serve the best interests of patients. However, uncertainty surrounds the precise definition of which

practices do in fact help patients. James Childress and Tom Beauchamp in *Principle of Biomedical Ethics* (1978) identify beneficence as one of the core values of healthcare ethics.

- Non-maleficence - "first, do no harm". The concept of non-maleficence is embodied by the phrase, "first, do no harm," a lot of people contemplate that it should be the main or primary consideration: that it is more important not to harm patients, than to do them good. This is partly because enthusiastic practitioners are prone to using treatments that they believe will be effective, before first assessing them sufficiently to ensure they are safe.
- Justice - concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality). Justice - concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality). If resources are unfairly distributed, it gives rise to health inequities which are as a result of the systematic and unjust distribution of these critical resources. On the other hand, there is no social justice without equity in health and vice versa. Therefore, achieving the best level of population health requires (causally) that we pursue social justice more broadly.

Some other principles that are sometimes discussed include:

- Respect for persons - the patient (and the person treating the patient) have the right to be treated with dignity.
- Truthfulness and honesty - the concept of informed consent has increased in importance since the historical events of the Doctors' Trial of the Nuremberg trials and Tuskegee syphilis experiment.

These morals do not provide solutions as to how to handle a particular situation, but provide a useful framework for understanding conflicts. On the other hand, autonomy and beneficence/non-maleficence may also overlap. For example, a breach of patients' autonomy may cause decreased confidence for medical services in the population and subsequently less willingness to try and find help, which may result in inability to achieve beneficence. The principles of autonomy and beneficence/non-maleficence may also be expanded to include effects on the relatives of patients or even the medical practitioners, the overall population and economic issues when making medical decisions.

Informed consent- in ethics usually refers to the idea that a person must be fully informed about and understand the potential benefits and risks of their choice of treatment. A person who is not informed is in danger of making a choice not reflective of his or her values or wishes. Confidentiality is commonly applied to conversations between health personnel and patients. Under legal framework protection physicians are prevented from disclosing their discussions with patients to others.

STATEMENT OF THE PROBLEM

Non-adherence to medical ethics may be a problem of the health workers themselves or it may indeed be the matter beyond their control looking at the numerous problems the health systems in many developing countries and Zambia is not excluded. On the other hand some of the health workers may have that bad mentality of not wanting to follow the laid down ethics. As earlier mentioned we look at the mentioned principles to figure out the problem of non-adherence to medical ethics. Some questions may be raised as to whether the health personnel no longer think of these ethics as they render the health services.

Many diseases are characterized by loss of autonomy, in various manners. Autonomy is a general gauge of health. This makes autonomy an indicator for both individual well-being, and for the good of the profession. This has penalties with reverence to medical ethics: "is the aim of health care to do good, and benefit from it?"; or "is the aim of health care to do something worthy to others so an individual and humanity, benefit from this?". Autonomy can come into conflict with beneficence when patients disagree with recommendations that healthcare professionals believe are in the patient's best interest. Western medicine, the approach is different to wishes of a mentally competent patient to make his individual choices, even in cases where the medical team believes that he is not acting in his own best interests.

The concept of non-maleficence is embodied by the phrase, "first, do no harm," a lot of people contemplate that it should be the main or primary consideration: that it is more important not to harm patients, than to do them good. This is partly because enthusiastic practitioners are prone to using treatments that they believe will be effective, before first assessing them sufficiently to ensure they are safe. Furthermore many treatments carry some risk of harm. In some instances, e.g. in unavoidable conditions where the outcome without treatment will be severe, risky treatments that stand a high chance of harming the patient will be warranted, because the danger of not treating is also very likely to do harm. Hence the principle of *non-maleficence* is not consummate. Additionally some health workers ensure that they protect themselves at the expense of the patient, ie patients are not protected against any danger of contracting nosocomial infections therefore violating the principle of non-maleficence (do no harm) e.g health worker putting on same pair of gloves and attending to all patients without changing gloves. This may result in transmitting of infection from one patient to another. Health workers have claimed that the gloves are not enough to cater for the members of staff who are on duty including students. It has been brought to the attention of the health authorities but the resources are not just adequate.

It has been argued that mainstream medical ethics is biased by the assumption of a framework in which individuals are not simply free to contract with one another to provide whatever medical treatment is demanded, subject to the ability to pay. Tassano^[14] has questioned the idea that Beneficence might in some cases have priority over Autonomy. He contends that desecrations of Autonomy more often reflect the interests of the state or of the supplier group than those of the patient.

Confidentiality is mandated in America by Health Insurance Policy and Accountability Act (HIPAA) laws, specifically the Privacy Rule, and various state laws, some more rigorous than HIPAA. In Zambia privacy is entrenched in the rights of the patient and professional code of conduct which demands that every health worker be it physician, or any other health professional has to abide by it. Some health workers have a tendency of discussing the patient's diagnosis on top of their voices in presence of other patients or with other people. At times patient files are left in areas where anyone can access the files and read through. It is a challenge where a patient diagnosed with a sexually transmitted infection refuses to disclosure the diagnosis to a spouse. Some health care services demand that the spouse be informed like STI so that they both commence treated hence disclosure of information. Another area where confidentiality is challenged is in the termination of a pregnancy in individuals below adult age, where patient's parents are not aware. Many states in the U.S. have laws governing parental notification in underage abortion.^{[15][16]}

Weak Functioning Professional Bodies and Complaints Mechanism may also lead to non-adherence to ethics as noted by Sikika(17) that Health Facility Governing Committees and Health professional bodies' roles are to assure Health care workers adhere to their profession ethics. The HFGC and health professional bodies that are weak exacerbates poor adherence to professional ethics following most of such practice by HCWs being not worked upon or punished. Unavailability or availability of non-functioning complaints mechanisms leaves service user not knowing what to do after facing situations where service was denied or compromised following poor adherence to professional ethics.

Informed consent- in ethics usually refers to the idea that a person must be fully informed about and understand the potential benefits and risks of their choice of treatment. A person who not informed is in danger of making a choice not reflective of his or her values or wishes. Informed consent is not precisely the process of obtaining consent, or the exact authorized requirements, which differ from area to area, for capacity to consent. If the patient is not able to, there is an alternative on how informed consent can be obtained, patient can choose somebody to do it on his behalf or in some institutions the head of the institution can do so.

Under informed consent, most of the health workers do not provide the patient with information surrounding their treatment ,there is an assumption that informed consent is only when a health worker seek a go ahead from a patient when performing a certain procedure such that the aspect of providing information is ignored. On the other hand there is fear amongst the health workers that if patient is given all the information and knows the side effect of a certain procedure or intervention he/she may refuse the treatment and an alternative treatment may not be available especially in the poor resource countries and therefore the health worker may be blamed for that.

Culture differences can clash with medical ethics. Some cultures do not place a great emphasis on informing the patient of the findings after investigation, particularly when malignancy is

diagnosed. In American medicine, the principle of informed consent now takes precedence over other moral standards, and usually they find out whether they want to know the diagnosis.

The existence of unethical behaviours among health workers hinders the accessibility of quality health services for citizens as it creates disharmony in the relationship between health workers and clients/patients. Once there disharmony in the relationship between health personnel and clients/patients, the later will not be pleased with the services rendered to them. This dissatisfaction implies poor quality of the health services on offer. In other words, non-adherence to medical ethics by health workers do not only affect the quality of services citizens receive but also erodes the reputation of health professionals and all other officials in the health system. Such a negative perception may further hinder the people's access to public health services.

SIGNIFICANCE OF THIS STUDY

The results are of great importance as a review some of the factors contributing to non-adherence to public health ethics will give the institution an opportunity to resolve some of the problems. When the problems are resolved it entails that medical, biomedical and nursing students shall not imitate some of members of staff who are not adhering to the public health ethics because Ndola central hospital is a training institution. If health workers are not adhering to medical ethics not only does it affect the quality of services citizens receive but also erodes the reputation of health professionals and all other officials in the ministries.

It may influence decision making in policy formulation through the provision of empirical driven feedback to students, administrators and staff. This study will also provide guidance so that measures can be put in place in order to encourage health workers medical, biomedical and nursing students to adhere to public health ethics which will later benefit the public. The study will provide a framework for a much wider country specific study and it will provide a framework for improving the health of the public.

METHODS

The study was conducted at Ndola central hospital which is a 3rd level referral hospital as well as a teaching hospital. There are four schools: school of medicine –training doctors, schools of nursing, registered midwives and registered theatre nurses, college training laboratory technologists and Community health assistant school training community health assistants.

The research was non-intervention, descriptive quantitative study. Descriptive case studies describe in-depth the characteristics of one or a limited number of cases. This was descriptive study in the sense that the researcher ventured into the unknown (factors contributing to non-adherence) by trying to investigate an issue. This research design was suitable to meet the objectives and also looking at the period in which the project is to be done within short duration, so descriptive study was very suitable.

The study population was the health care providers (ie doctors, nurses, laboratory technicians) at Ndola central hospital because all the health workers are supposed to adhere to health ethics as they deliver the health care services.

Health care providers were randomly sampled from some of the departments at Ndola central hospital. Random selection was done using an existing sampling frame (list of health care providers in each department). Study unit was drawn using simple random probability sampling, all the health care providers from different departments were listed and numbers were assigned to each name. These numbers were picked and were compared to the list. Names against those numbers were picked and will be included in the sample.

Quantitative data was collected using a self-administered structured questionnaire. Prior to data collection, a formal letter (indicating the title of the study and the objective of the study) was written and submitted to the senior medical superintendent who is the head and the institution at which the study was conducted. Before collecting any data, permission was sort from the participants. They were at liberty either to agree or refuse to take part in the study or not.

Descriptive Biostatistics was used which involve the use of bio-statistical procedures which deal with collection and data processing. Data was summarized to make it more informative and comprehensible.

Searching for studies and reports providing data on factors contributing to non-adherence to public health ethics by health workers in Zambia were conducted. Relevant published and unpublished studies were found by electronic search in local databases

PRESENTATION OF FINDINGS

A total of 60 health workers were interviewed, among the respondents were doctors, laboratory personnel and nurses.

Table 1: Factors contributing to non-adherence to medical ethics

S/no	Factor	Yes	No	Total
1.	Health workers feel they know what is good for the patient not vice versa	57(95%)	3(5%)	60(100%)
2	Shortage of essential drugs and supplies	36(60%)	24(40%)	60(100%)
3.	Lack of alternative remedy in some instances	39(65%)	21(35%)	60(100%)
4.	Some conditions like STIs spouse should be aware	54(90%)	6(10%)	60(100%)

Table 2: other factors acknowledged from 10% up to 50% of health workers

1.	Fear that patient may refuse treatment if aware of side effects	27(45%)	33(55%)	60(100%)
2.	Lack of provision of information to patients	30(50%)	30(50%)	60(100%)
3	Forgotten some of the ethics	6(10%)	54(90%)	60(100%)
4	Inadequate supervision of the health care providers	11(18%)	49(82%)	60(100%)

RESULTS AND DISCUSSION OF FINDINGS

Out of 60 respondents, 95% reviewed that they do not adhere to medical ethics because they feel that they know what is good for the patients hence patients are not at liberty to choose their treatment as a result health workers do what they know is good for the patient. What was discovered in this study is related to the results in a study titled “the challenge of patient adherence by Martin L et al 2005. A study was set out to explore clinician compliance with patient advice directive and to determine whether particular external factors may influence decisions to either honor or forego preset directives. When confronted with a specific patient scenario, most of the provider decisions were influenced by the entity of clinical situation.

Half 50% of health workers acknowledged that health workers are too busy to provide information to patients amidst critical shortage of health personnel. Some health care providers did not have time to provide information to clients as they were overwhelmed with work and had little or no time. Therefore, health communication is critical for people's awareness to, looking for, and use of health information. Surprisingly 50% of health personnel believe that Lack of provision of information to patients has nothing to do with adherence to medical ethics.

Sikika(17) also noted that lack of information on the part of the citizens particularly with regard to what services which are available . Due to lack of information among health service users on how much should be paid for what kind of services, some of health service workers exploit the citizens’ ignorance to ask for and pocket informal payments.

Some 65% of the respondents felt that lack of alternative treatment in some instances is a cause of non-adherence to medical ethics because if a patient refuses the treatment health workers have offered him/her, there is no any other alternative hence the patient may stay without any treatment. The findings in this project are similar to Koocheretal 2012 (26) “You will have no choice but to make decisions with possible ethical consequences at some point”. A lot of the health personnel may have faced at least one ethical dilemma that required a decision and possibly action. Health workers may find themselves in a situation where someone has generated

the problem; in this case a health worker has to make a decision in relation to that problem. How a health worker tackles that problem may have noteworthy repercussions for their reputation and career? Early recognition of risks can prevent many potential ethical problems from escalating to the point of causing harm.

90% of health workers said that forgetting some of the ethics is not an issue to adherence to medical ethics meaning that they are very much aware of the medical ethics. There are two things involved in non-adherence: Unintended non-adherence includes reasons such as not able to remember, and mix-up, which means that despite wanting to adhere, they were unable to. Intended non-adherence occurs when there is a cognizant choice not to adhere to the instructions, and is best understood in terms of perceptual factors such as believing that the medicine won't work or is against their ethics, or practical factors, such as the side-effects as a result of using the drug. Health personnel in the present study demonstrated to the fact that they have not forgotten but fully aware of the medical ethics which means that it is intentional non-adherence to medical ethics due circumstances health workers would have found themselves into.

Majority 90% of the respondents feel that some conditions like STIs spouses need to know the status of the partner so that they equally start the treatment. These findings are similar to what Dr Bernard Lo noted in terms of confidentiality, Dr Bernard Lo (24) noted that one reason for HIV testing is to protect those who are exposed to those who are HIV positive. Subsequently, some prerogatives require health professionals to submit information to government health authorities when they have diagnosed an STI. This information may be used for epidemiological purposes. Information also can help to inform his or her sexual contacts, so that they may also be treated.

Some health workers reviewed that shortage of drugs and supplies is a hindrance to sticking to medical ethics. In the previous project at the same institution it was discovered that shortage of essential drugs is an obstacle to improving health of the public as attested by 65% of health workers. Clients may be asked to buy their own drugs and supplies because there are no drugs at the institution some times. This is a problem because most people in Zambia are poor and cannot afford to buy drugs and supplies hence they may choose to stay home without any treatment or stay on the ward without treatment. So equally in this present study health workers could not adhere to medical ethics because of shortage of medical supplies where there are expected to use their initiatives sometimes.

Majority 82% of the health workers reviewed that inadequate supervision of the health care providers had nothing to do with non-adherence to medical ethics, meaning that whether workers are supervised or not they can still adhere to medical ethics. Apparently, few 18% health personnel attributed non-adherence to insufficient supervision. These discoveries are not in line with Sikika (2012) in a study on Health care workers' adherence to professional ethics a score card report on the experience from 45 health facilities in six districts of Tanzania mainland who noted that poor management and inadequate supervision of health workers leaves them unchecked resulting to poor adherence to professional ethics. Furthermore they noted that

supportive supervisions are very crucial in promoting the health workers 'adherence to their professional ethics, since supportive supervisors will not only be interested in the welfare of their subordinates but also ensure they follow up their professional conduct and fulfillment of their job obligations

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