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Baseline Survey of knowledge, attitude and practice of healthcare ethics, in healthcare practitioners of a tertiary healthcare institution in Ghana, a Sub-Saharan Country

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Abstract: Knowledge, attitude and practice (KAP) on healthcare professional's (HCP) ethical practice have been studied extensively in countries with developed economies. On the other hand studies in lower and middle-income countries (LMIC), especially in Sub-Saharan (SSA) countries are relatively sparse. The survey outlined in this article which was conducted in an SSA country tertiary care health facility in Ghana, was undertaken to explore the primary ethical knowledge and intuition, in a cohort of SSA HCP. 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 the 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 in Ghana, then there appears to be an issue of cognitive dissonance between HCP knowledge of ethics, and their actual everyday practice as HCP.

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

Introduction: Healthcare professionals (HCP) ethical (mis)behaviour may come in the way of their technical competence, whereby their ethical (mis)behaviour is not necessarily congruent with their technological development, a psychological phenomenon described as cognitive dissonance[1]. This ethics/technical competence mismatch in Sub-Saharan Africa (SSA) healthcare settings, may translate at the level of patients care into patient's discomfort and on some occasions increase patient's suffering, especially for vulnerable inpatients, as well as the quality of healthcare delivery[2,3]. 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 or other factors including workload influence,

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organisational failure, a culture of fear, low morale etc[1]. Instead, concentrating on their "technical" medical/nursing care obligations and competence, while the human element is lacking; a situation of lack of ethical sensitivity [4]. Other times, HCP misbehaviour is purely a case of "compassion fatigue" resulting from work conditions/pressure and other healthcare organizational stressors[5]. HCP knowledge-based ethical sensitivity/intuition matters in SSA have not been widely studied by locals compared to the countries in the global North, this may be attributed to what has been thought of as a relatively poor uptake of medical ethics/bioethics education in SSA higher health care institutions[6,7]. Additionally, there seems to be a struggle sometimes for some Sub-Saharan philosophers/ethicists to differentiate an African bioethics (with possible different demands), from a global North or Western bioethics [8]. 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 [9,10,11,12,13], 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 due to poverty, corruption, and bad governance [9,10,12]. It is against this background that the survey presented in the article was conceived, to investigate the basic ethical knowledge attitude and practice of HCP towards issues of healthcare ethics in a tertiary healthcare facility, in a region of Ghana. The survey will be used as a baseline measure of their ethical awareness and sensitivity, towards matters of ethics in the area of healthcare.

Method: A survey using a questionnaire method [Fig. 1] was 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, the 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 a mix of HCPs, (including physicians, nurses, midwives, dentists, physiotherapists, pharmacists and occupational therapists). A three scale Likert scale was used to understand the knowledge attitude and practice of the participants. Written informed consent was obtained before the survey was administered to the participants. Ethical clearance/approval was sought from the hospital medical directorate. Ethical approval was waived after a review of the questionnaire.

Results: This cross-survey was done at a level IV (four) military tertiary level hospital in Accra, during an educational session day in February 2020 to understand the knowledge, attitude and practice of healthcare professionals in medical ethics. 80 (eighty) participants (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 (Table 1). The analysis of the data 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. Most of the participants 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.

However, on the question of non-medically indicated abortion being a patient's non-contestable right however, 35 (43.8%) said yes to this whilst 31 (38.8%) responded "no" to the question. When participants were asked about the issue of euthanasia as "a right to die of a patient on demand" more than a quarter, 31 (38.8%) of respondents said "yes", whilst 33 (41.2%), answered "no" to the question.

Table 1 Knowledge, attitudes and practice of healthcare ethics in healthcare practitioners (n=80).

Question	Results	Frequency (%)
1. Do you consider medical ethics relevant to the practice of medicine?	Yes	100.0
	No	0.0
	Not sure	0.0
2. Do you usually consider the four principles as proposed by Beauchamp and Childress in resolving ethical issues in your practice of medicine?	Yes	86.2
	No	3.8
	Not sure	10.0
3. Is virtue important in the practice of medicine?	Yes	77.5
	No	0.0
	Not sure	22.5
4. Is patient autonomy important in the doctor-patient relationship?	Yes	88.75
	No	8.75
	Not sure	2.5
5. Are indigenous cultural practices of Prima facie importance in the doctor patient-interaction?	Yes	37.5
	No	12.5
	Not sure	50.0
6. Do you consider non-medical abortion a patient's non-contestable right?	Yes	43.75
	No	38.75
	Not sure	17.5
7. Do you consider euthanasia as a right of a patient on demand?	Yes	38.75
	No	41.25
	Not sure	20.0
8. Should the religious beliefs of the healthcare professional be brought to bear on the doctor-patient relationship decision-making interaction?	Yes	41.25
	No	41.25
	Not sure	17.5
9. Are health professionals obliged to satisfy all patients' treatment requests in relation to available resources?	Yes	66.25
	No	26.25
	Not sure	7.5
10. Do doctors necessarily need to resort to strike action in resolving industrial disputes with their employers?	Yes	65.0
	No	23.75
	Not sure	11.25

On the issue of whether the "religious beliefs" of the HCP be "brought to bear" on the patient in the doctor-patient interaction, the respondents were divided. 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 respectively. On the question of whether HCPs' are "obliged to satisfy all the patient's treatment request" in relation to the available resources, 53 (66.2%) responded "yes" and 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, attitude and practice 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 their attitude in day-to-day work situations. Interestingly the majority of the HCP by their admission have not had any formal ethics training/ education in the past five to ten (5-10) years at least, post-professional training/education. In Sub-Saharan Africa settings, healthcare ethics does not feature as a priority or front burner issue[6,7]. Just the challenges of everyday living[9,10], due to systemic inefficient healthcare organisational problems and scarce resources problems[14] systemic corrupt practices[15] coupled with traditional thoughts on illness and illness locus of control; tend to make adverse events/outcomes appear "fatalistic" or "acts of the spirits" [16]. Our study however reflects the contrary position in this instance. Scrutiny of SSA healthcare staff ethical (KAP) does 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 [17]. They expressed the need for a comprehensive ethics education as part of the medical school curricula. 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[7]. 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[3,18,19,20]. This, unfortunately, seems to be a situation in other SSA countries as well[21,22]. Of interest, is the fact that the majority of the respondents in this particular study felt that HCP should accede to "all treatment requests in difference to available resources" (response to questionnaire number 9). It demonstrates a certain attitude in my view not out of concern for patient rights, but rather a lax health care culture. An example of this is the tendency of needless polypharmacy prescription in the health care practices in Ghana [23,24], which in the view of some HCP in Ghana, makes them look competent and knowledgeable in the eyes of their patients. The preceding examples of unethical practices referred to reflect the mismatch between knowledge and attitudes; or otherwise said, between what is thought to be known or learnt, as opposed to what is practised. This reinforces the need for ongoing ethics education among healthcare professionals as part of obligatory annual continuing professional development (CPD) activities. 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[25]. One such useful method (among others) is the concept of the ethical behaviour test, (which addresses not only the ethical reasoning of nurses but the link between reasoning and behaviour), developed against the background of Kohlberg's stages of moral cognitive development and his definition of morality [26].

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 for creating an ethical ambience and climate, to support the ethical life of the HCP and the patients they look after [27,28]. I say this because where the HCP 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 relationship between the organisation's human capital and the organisation, and by extension, acceptable ethics-led patient care.

Conclusion: The overall impression from this survey indicated that most of the Ghana healthcare professionals thought about the relevance of medical /healthcare ethics in carrying out their duties. Additionally, it appears most of the healthcare professionals in the survey thought virtue was important in the practice of healthcare. For starters, these responses are encouraging. On some contentious questions like cultural beliefs, religion, and non-medical indicated abortion and euthanasia, respondents were divided. 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". This, one may refer to as moral knowledge, as opposed to formally acquired knowledge from a healthcare ethics course. Surveys of this nature not only bring out the perceived ethical knowledge and orientation or lack of in HCP in Ghana settings.

Such surveys additionally flag up areas of need in ethical education, including developing an appropriate curriculum for ethics education. Such an enhanced ethics curriculum will not only serve as a platform for local ethics education training but additionally allow the HCP to directly/indirectly contribute to their ethical development. This hopefully will lead to professionally rounded HCP who are not only technically competent but also ethical in every sense. Eventually, such a healthcare workforce will be much more beneficial to the vulnerable patient population. The limitations of the survey were the small sample size that does not represent the HCP population of Ghana, also only one centre was surveyed. Additional limitations were the extant of topics covered by the survey questionnaire, and 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 policymakers as well as HCP educators

towards improving healthcare ethics education in SSA countries while enhancing the ethical preparation and orientation of SSA HCP.

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