Knowledge, attitudes and practices of healthcare personnel towards Care-Ethics: A perspective from the Caribbean

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Abstract

The aim of the study was to assess the attitudes of healthcare personnel in Barbados towards care-ethics which may reflect the influence of the socio-cultural background. A self-administered structured questionnaire was devised, tested and distributed to all levels of staff at the Queen Elizabeth Hospital, a tertiary care teaching hospital in Barbados. The questionnaire comprised of detailed questions regarding day-to-day aspects of ethical issues in medical practice. The respondents included medical, paramedical and healthcare administrative personnel. The response rate was 73% of 500 distributed questionnaires. There were varying opinions in many issues of care-ethics. 55% of the respondents agreed for patient autonomy, one-quarter agreed to the paternalistic view and one-third felt that the condition of a patient should be informed to relatives. There were statistically significant differences when the views expressed by physicians and nurses were compared with those expressed by the paramedical and other healthcare personnel. The responses show that ethical viewpoints of healthcare workers vary widely which could have been probably influenced by the cross-cultural perspectives. Bioethical codes should ideally be formulated taking these perspectives into account.

INTRODUCTION

Bioethics is a relatively new subspecialty in the medical field and is still in its infancy in many parts of the world (Whitehouse 2002, Aarons 2003). Healthcare ethics is not routinely taught to the medical professionals, and there are reports that even the word “ethics” has been completely ignored during the undergraduate medical curriculum (Takala and Louhiala 2003). The same may be true with the training of other healthcare providers such as the nursing professionals and other paramedical professionals. Hence it is not surprising that the theory and application of healthcare ethics in day-to-day practice are still not well known to many healthcare providers. In such a situation, practice of ethics in healthcare will be very much influenced by the cultural background and beliefs of the people in every region.

Majority of the literature and teaching on healthcare ethics emphasize on the so called “western” dimensions of ethics which are formulated and applicable to the healthcare profession in the western countries. However, there have been many recommendations that ethics in medicine has to be formulated within the context of the individual socio-economic, geo-political, religious and cultural background of a particular region (Tai and Lin 2001, Barr 1996, Ankeny 2003, Saeed 1999, Gross and Ravitsky 2003).

Traditional medical training offers little help in resolving the ethical dilemmas encountered by healthcare professionals. Although teaching of medical ethics was introduced into the medical curriculum of the Faculty of Medical Sciences in the University of the West Indies during 1991, it has been didactic in a lecture theatre setting and taught as relevant to the various branches of medicine and not as a separate course to be evaluated in its own merit. Even among other healthcare professionals there has been no effort to teach ethics and law as separate courses incorporated into the curriculum.

In Queen Elizabeth Hospital, Barbados, a 600-bed tertiary care teaching hospital affiliated to the University of the West Indies, the Hospital Ethics Committee lately started conducting “medical ethics” conferences on a monthly basis to discuss key issues and cases, which revealed diverse opinions among the participants. This prompted to conduct us a questionnaire survey in order to evaluate the basic knowledge, attitudes and practices existing among the healthcare personnel.

METHODS

Approval was sought from the Hospital Ethics Committee

prior to the study. A structured questionnaire was distributed to all the employees of the hospital during the months of April and May 2003 and collected from drop boxes in the institution. The questionnaire was developed with the inclusion of full range of response options. It was designed to examine the respondent's decision-making process in relation to ethical and legal problems and to identify the healthcare practitioner's values, beliefs and attitudes. Prior to distribution of the questionnaire a pilot study was done with a select group of healthcare workers who were asked to fill out the questionnaire and return with comments and criticism. Minor changes were made to the final instrument.

The initial part of the questionnaire consisted of demographics such as occupation, age, gender and duration of the respondents' work experience and how often an ethical or legal problem is encountered in their practice.

The questionnaire consisted of questions regarding day-to-day practice of ethics regarding the respondent's view about the following statements:

1. ‘Ethical conduct is important only to avoid legal action'
2. ‘Patient's wishes must always be adhered to'
3. ‘Doctor should do what is best irrespective of patient's opinion'
4. ‘Patient should always be told if something is wrong'
5. ‘Confidentiality cannot be kept in modern care and should be abandoned'
6. ‘Close relatives must always be told about a patient's condition'
7. ‘Patients only need to consent for operations but not for tests or medications'
8. ‘Children should never be treated without the consent of their parents or guardians' (except in an emergency)
9. ‘Doctors and nurses should refuse to treat patients who behave violently'
10. ‘If patients refuse treatment due to beliefs, they should be instructed to find another doctor'
11. ‘The law allows abortion to be performed, therefore a healthcare worker cannot refuse to do an abortion'
12. ‘Patient who wishes to die should be assisted in doing so'

The respondents were required to choose one choice from the alternatives proposed under each question in a Likert scale ranging from 1 to 5: 1- strongly disagree, 2-disagree, 3-not sure, 4-agree and 5-srongly agree.

The respondents were divided into two groups for the purpose of analysis. Medical and nursing professionals were categorized into one group while paramedical and other administrative personnel were grouped into another. The influence of gender and occupation on the responses were analysed by Chi square test. Cramer's V value was obtained to observe the strength of the difference between the above mentioned two groups. Statistical significance was fixed at the level of $p<0.05$. The data were analyzed using Statistical Package for Social Sciences (SPSS) version-8 software.

RESULTS

Among 500 questionnaires made available, 373 (74.6%) were returned of which 364 respondents answered all the questions in the questionnaire facilitating analysis. The respondents included medical staff, nursing staff, pharmacists, social workers, radiographers, laboratory technicians, support staff such as porters and maids and clerical staff. Of these 255 (70 %) were women and 109 (30 %) were men. 25% of the respondents were in the age group of 25-29 years, 23% and 21% of the respondents belonging to the age groups of 30-39 and 40-49 years respectively. 3% of the respondents were 60 years and above, while 2% of the respondents were in the age group of less than 19 years. The other age groups were distributed evenly. The majority (24%) of the respondents had a work experience of 4-6 years. 16.7% the respondents had a work experience of more than 25 years. All other durations of work experience were equally distributed in the range of 8 to 12% approximately for each decade of work experience. Table.1 shows the gender distribution of the occupation of the respondents. For the question regarding the source of the knowledge of ethics, 9% of the respondents answered that they got their ethics knowledge from the church. When asked about the preference of whom to consult if one wanted to discuss an ethical problem, 14% included their priests along with others such as the Head of their Departments and immediate

supervisors, while 1.4% answered that they will choose exclusively their priest to discuss the problem. The responses for the questions regarding different issues in ethical practice are depicted in Figures 1a and 1b.

Figure 1

Table 1: Gender distribution of occupation of the respondents (n=364)

Occupation	Females	Males
Medical students	39	16
Junior doctors	22	26
Consultant doctors	5	22
General medical practitioners	6	7
Student nurses	22	7
Nurse aides	8	1
Staff nurses	60	4
Sisters	20	-
Social workers	5	-
Radiographers	2	3
Physiotherapists	2	-
Pharmacists	6	-
Laboratory technician	1	-
Clerical staffs	14	-
Porters/ Maids	31	8
Others	12	15

Figure 2

Figure 1a: Opinion of healthcare personnel on the different issues of care-ethics

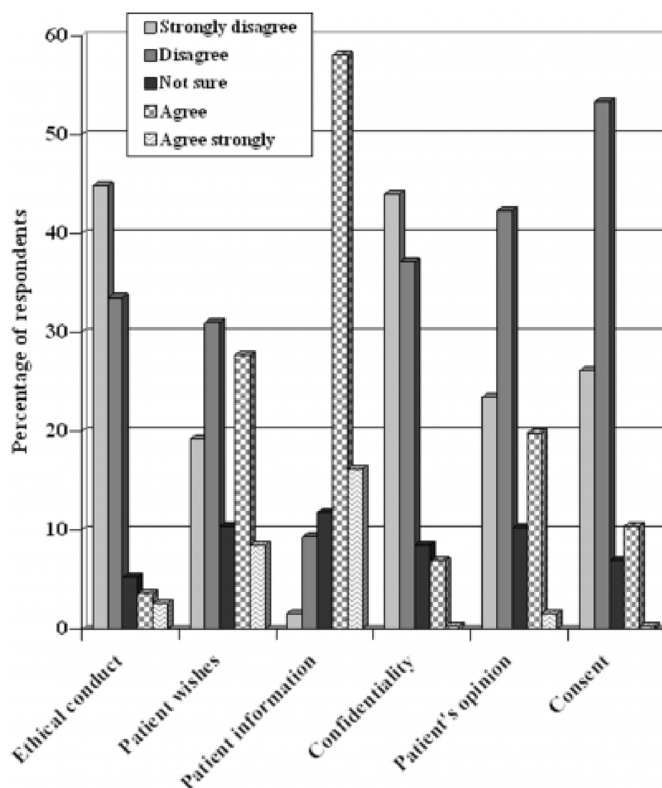
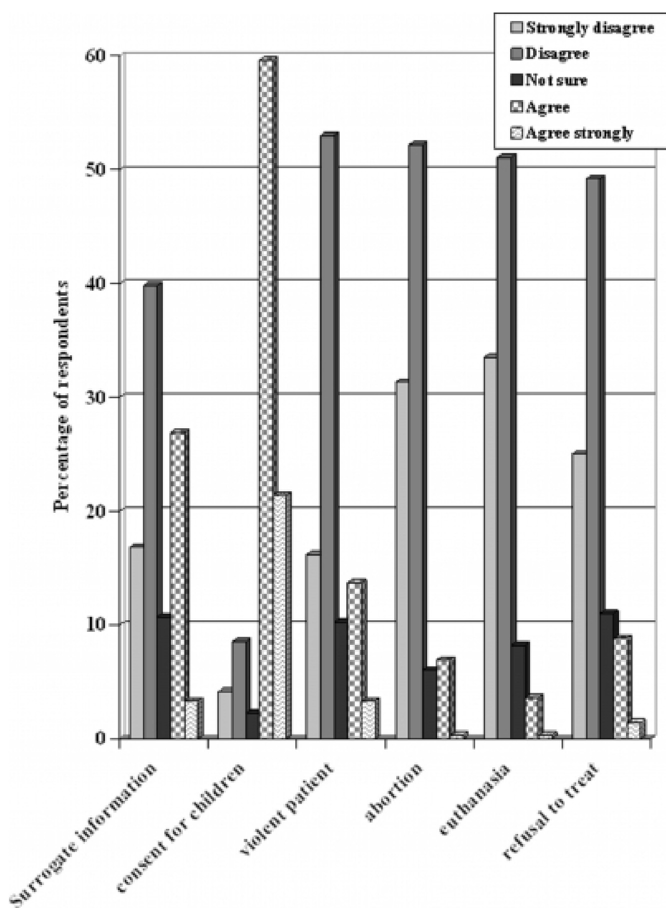


Figure 3

Figure 1b: Opinion of healthcare personnel on the different issues of care-ethics



The influence of gender in the practice of medical ethics is depicted in Table.2. There were only two issues which had a statistically significant difference with respect to gender: 1. 'ethical conduct's importance' and 2. 'if a healthcare worker should refuse to treat a violent patient'.

Figure 4

Table 2: Influence of gender on practice of ethics

Issues in practice of medical ethics	Gender	Disagree	Agree	Chi square	Cramer's V
Ethical conduct- important only to avoid legal action	*Male*	88	10	5.7	0.13*
	Female	197	12		
Patient's wishes must always be adhered to	*Male*	50	42	1.3	0.06
	Female	133	90		
Patient should be always informed of wrongdoing	*Male*	10	85	1.2	0.05
	Female	30	185		
Confidentiality – not important	*Male*	89	8	0.05	0.01
	Female	207	18		
Doctor should do best irrespective of patient's opinion	*Male*	73	21	0.47	0.05
	Female	166	57		
Consent only for operations – not for tests and medications	*Male*	84	12	0.77	0.05
	Female	205	27		
Close relatives should always be told about patient condition	*Male*	57	39	2.29	0.08
	Female	149	71		
Children should never be treated without consent of parent	*Male*	14	89	0.18	0.02
	Female	32	206		
Doctors & nurses should refuse to treat a violent patient	*Male*	12	82	4.12	0.11*
	Female	170	50		
If law allows abortion, doctors cannot refuse to do abortion	*Male*	88	11	2.04	0.07
	Female	216	15		
If a patient wishes to die, he or she should be assisted in doing so	*Male*	94	4	0.34	0.03
	Female	214	10		
If patients refuses treatment due to beliefs, they should be instructed to find another doctor	*Male*	76	15	2.47	0.08
	Female	194	22		

* $p<0.05$

The influence of occupation in the practice of ethics is given in Table 3. Except the issue on whether 'patient wishes should be always adhered to', there were statistically significant differences in the opinions between the two groups. This implies that the medical and nursing professionals had significantly stronger opinions when compared to the other staff (paramedical staff, maids, porters, clerical staff, etc.) in most of the issues regarding the practice of ethics.

Figure 5

Table 3a: Influence of occupation on ethical issues

Issues in practice of medical ethics	Occupation*	Disagree	Agree	Chi square	Cramer's V
Ethical conduct- important only to avoid legal action	*Medical*	213	12	35.7	0.31 (*p*<0.001)
	Paramedical	72	10		
Patient's wishes must always be adhered to	*Medical*	122	94	2.4	0.08
	Paramedical	61	38		
Patient should be always informed of wrongdoing	*Medical*	191	27	8.7	0.15 (*p*=0.01)
	Paramedical	79	27		
Confidentiality – not important	*Medical*	222	12	45.5	0.35 (*p*<0.001)
	Paramedical	74	14		
Doctor should do best irrespective of patient's opinion	*Medical*	185	38	32.3	0.3 (*p*<0.001)
	Paramedical	54	40		
Consent only for operations – not for tests and medications	*Medical*	208	20	14.0	0.19 (*p*<0.001)
	Paramedical	81	19		
Close relatives should always be told about patient condition	*Medical*	150	66	6.5	0.13 (*p*=0.001)
	Paramedical	56	44		
Children should never be treated without consent of parent	*Medical*	35	202	12.9	0.18 (*p*=0.002)
	Paramedical	11	93		
Doctors & nurses should refuse to treat a violent patient	*Medical*	181	37	8.0	0.15 (*p*=0.02)
	Paramedical	71	25		
If law allows abortion, doctors cannot refuse to do abortion	*Medical*	217	15	16.4	0.21 (*p*<0.001)
	Paramedical	87	11		
If a patient wishes to die, he or she should be assisted in doing so	*Medical*	217	7	9.0	0.16 (*p*=0.01)
	Paramedical	91	7		
If patients refuses treatment due to beliefs, they should be instructed to find another doctor	*Medical*	193	22	8.8	0.15 (*p*=0.01)
	Paramedical	77	15		

* Medical = Physicians and nurses; Paramedical = Other healthcare staff including porters, maids, clerical staff etc

94% of the respondents disagreed to the view that 'ethical conduct is important only to avoid legal action'. 55% of the respondents agreed that the patients' wishes should be always adhered to. 89% agreed that 'patient should always be told if something is wrong'. 93% agreed that confidentiality is important and should not be abandoned, while at the same time 33% agreed that close relatives must always be told about a patient's condition. Also 23% agreed to the paternalistic view that doctor should do what is best irrespective of patient's opinion. 89% of the respondents disagreed to the view that patient's only need to consent for operations but not for tests or medications and 85% of the respondents felt that children (except in an emergency) should never be treated without the consent of their parents or guardians. Regarding non-compliant and violent patients, about 18% agreed that 'doctors and nurses should refuse to treat patients who behave violently' and 10% agreed that 'if patients refuse to undergo treatment due to their beliefs, they should be instructed to find another doctor'. Only 7% of the respondents agreed to the view that if the law allows abortion to be performed, a healthcare worker cannot refuse to do an abortion and only 3.7 % agreed that if a patient wishes to die, he or she should be assisted in doing so.

When asked whether patients should be informed when something goes wrong, 6 women (of 30) strongly disagreed to the view, and there was no male (of 10) who strongly disagreed.

In response to the question regarding abortion, there was no female who agreed strongly to the view that it should be performed if law allows abortion, although there was one male (of 11) who agreed strongly to the view. In contrast, in response to the question regarding assisted suicide, there was no male who agreed strongly to the view that if patient wishes to end his or her life he or she should be assisted to do so, while there was one female (of 10) who strongly agreed to the view.

DISCUSSION

This type of survey was the first of its kind in the country and of importance because the findings raise some fundamental and important issues for ethics education. The varying opinions of the healthcare personnel with respect to the day-to-day ethical issues, point to the need for appropriate training among healthcare staff and sensitize them to these issues in the workplace. The study also suggests that it is important to develop a curriculum of bioethics relevant to the Caribbean with its diverse ethnic, religious, and cultural background.

Care-ethics is a division of bioethics which deals with the ethical dimensions of day-to-day patient care. The attitudes towards informed consent, truth telling, confidentiality, abortion, euthanasia and treating a non-compliant patient are aspects of care ethics, which may well be influenced by the social, cultural and religious background as well as the gender of the healthcare provider.

Caribbean region although easily defined by the geographical norms, every nation in the region has its own unique characteristics in terms of the structure of the society, its tradition and historical aspects of the religious background. Majority of the population in the region belong

to the African Diaspora, and their acculturation and religious conversion were at different periods of time during the history. It is a well known fact that the vast majority of the Afro-Americans are staunchly religious and they value the teachings of the Church more than the secular thoughts. This has been true from the slavery period, and the perception that Church is the domain of those who practice morally correct standards in their familial and social lives persists until this date in the Caribbean (Barrow 1996). We hypothesized that this strong religious background may have a profound influence in the practice of ethics in a hospital setting, since religion makes a big difference in clinical healthcare delivery to both provider and the patient, although not invariably (Hanson 1998).

Cultural background is also likely to influence attitudes of healthcare providers towards healthcare ethics, although cultural difference has been largely ignored in the subject of bioethics (Hern et al 1998). Barbados has been predominantly a “matrifocal” (if not a matriarchal) society with women being the important persons to run the family in the majority of the households (Barrow 1996). Hence we analyzed if gender has any influence over the practical aspects of healthcare ethics, although we could not establish any statistically significant difference in the opinions regarding practice of ethics between genders.

The theory of contemporary medical ethics is a typical American product and it remains questionable whether it will spread globally as easily as the Coca-Cola (Hern et al 1998). The four principles as championed by Beauchamp and Childress are based on the western thoughts namely autonomy, justice, beneficence and non-maleficence, however, may not be a globally applicable framework (Takala 2001). Even in western countries such as the United Kingdom there are dissenting voices regarding the application of the principle of autonomy in medical field which are being supported by an argument that it erodes the trust between the patient and the treating physician (Herrisone-Kelly 2003). Hence it is not surprising that around 45 % of the respondents in the present study did not agree to the view that the patient's wishes should always be adhered to. Similarly about a quarter of the respondents agreed to the paternalistic attitude of physicians while treating a patient.

There was an overwhelming majority support for the informed consent. This may be due to the trend of increasing litigation against healthcare personnel by patients. However, the responses to the question regarding confidentiality were quite varying. While a majority agreed to the view that patient confidentiality is very important and should not be abandoned, one-third of the respondents also felt that patient's relatives should be told of the patient's condition. This may be perhaps due to the impact of the communitarian concept which is quite expected in the small islands of the Caribbean. The cross-cultural dimension and difference in patient approach has been one of the major issues in present day bioethics (Kuczewski and McCruden 2001).

Continuing treatment for a non-compliant patient has always been an ethical dilemma. This situation is largely influenced by the system of healthcare delivery and in managed care settings it is difficult to both continue and abandon the management of such a patient (Browne et al 2003). In the present study, the majority opinion against discontinuing the management of a patient when the patient refuses to undergo treatment and /or if the patient is violent again may reflect the influence of the socio-cultural background of the respondents. However it may also reflect the supererogatory view of the respondents.

Volumes have been written about abortion, although the cross-cultural dimensions in practicing abortion are missed in the western literature (Nie 1999). In the present study, the overwhelming disagreement for abortion may reflect the influence of religious values in the respondents. Although abortion has been legalized in the United States, there are reports that abortion clinics in that country are mostly attended by the Afro-Americans especially women without their partners, presumably due to their low socio-economic conditions (Anonymous 1999). Ironically, despite majority of the Barbadian population being Afro-Americans, more than 93% of the respondents voted against abortion. This may be perhaps due to the high quality of life in Barbados, which ranks very high according to the United Nations Development Index. In a similar vein, there was overwhelming disagreement for the practice of euthanasia. Our earlier research showed that in our hospital, management is continued in medically futile situations and our physicians never agree to discontinue mechanical ventilatory support even in brain-dead patients (Hariharan et al 2003).

There are previous reports that the beliefs of professionals substantially differ from the recommendations of their professional bodies and the majority opinion in bioethics (Dickenson 2000). The varying opinions of the respondents

in the present study may be easily explained by the very meager acquaintance of the healthcare personnel with day-to-day ethics. On the job education in medical ethics, particularly in a multidisciplinary setting could assist to bridge the gap in ethical approaches between different healthcare personnel. Thus bioethics is one branch of medicine which needs to be viewed and taught in the context of the region where it is practiced, akin to something like “Medicine in the Tropics” and a universally applicable code is difficult to be formulated.

CONCLUSIONS

Issues regarding care-ethics in a hospital setting have varying opinions from different sections of healthcare personnel. There is a need for a uniform teaching of medical ethics taking into account the socio-cultural background of the region.

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