SELF-RATING PRACTICE OF CLINICAL ETHICS AND ASSOCIATED FACTORS AMONG HEALTH PROFESSIONALS WORKING IN HOSPITALS OFSOUTHWEST AND WEST SHOA ZONE, OROMIA REGION, ETHIOPIA, 2019

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Jimma, Ethiopia

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Abstract

Introduction: Clinical ethics is a type of medical ethics and refers to the field of activities that investigate what medical staff as professionals should do or how they should behave concerning a certain individual case, especially in the process of decision making. Professional ethics among medical practitioners is a growing concern of the Ethiopian public and the media and panel discussions mention a lot about it. The overall objective of this study was to assess self-rating practice ofclinical ethics and associated factors among health professionals working in hospitals of Southwest and West Shoa zone, Oromia Region, Ethiopia, 2019.

Methodology:A facility based quantitative cross-sectional study design mixed with qualitative was conducted by using convergent parallel design. The simple random sampling of six hospitals was taken from a total of eleven hospitals and the study was done on all health professionals working in six sampled hospitals.The study was done on 305 health professionals inhospitals of Southwest and West Shoa Zone between April 03 and May 04, 2019.Pretested self-administered structured questionnaire for data collection and Binary logistic regression method for data analysis was used. Semi-structured interview questionnaire for data collection and thematic analysis methodfor data analysis was usedfor qualitative one.

Result: The study indicated that only 36.4% of health professionals had good practice of clinical ethics. According to multivariate analysis factors that showed association with practice of clinical ethics were age (AOR=**2.321**, 95% CI= **(1.045, 4.525),** type of profession (AOR: **3.949**, 95% CI: (**1.427, 10.933**), attitude(AOR: **2.368,** 95% CI: **(1.064, 4.604)** andknowledge(AOR: **1.812,** 95% CI: **(1.017, 3.230)**

Conclusion: There was poor practice of clinical ethics among health professionals working in hospitals of Southwest and West Shoa zone. Factors that were associated with practicewere age of health professionals, type of profession, knowledge and attitude towards ethical principles. According to qualitative analysis reason out forpractice of clinical ethics were attitude of health professionals, knowledge of health professionals, health professional's personal behavior, orientation given during employment, patient load of the hospitals, being junior and fresh graduates and understanding of surrounding community values and norms.

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Acronyms

- CRC= Compassionate, Respectful and Caring
- CCO = Chief Clinical Officer
- OR = Odd Ratio
- CI = Confidence Interval
- AOR= Adjusted Odds Ratios
- IRB= Institutional Review Board
- ORHB = Oromia Regional Health Bureau
- ESO = Emergency Surgical Officer
- SPSS=Statistical Package for Social Sciences
- VIF= Variance Inflation Factor
- TB= Tuberculosis
- MOH= Ministry of Health

1. Introduction

1.1. Background of the Study

Medical ethics is the study of how the practice of medicine correlates with acceptable conduct of health professionals (HP) (1). Clinical ethics is a type of medical ethics and refers to the field of activities that investigate what medical staff as professionals should do or how they should behave concerning a certain individual case, especially in the process of decision making (2). Ethics can be applied to various professions in order to define a level of responsibility or a standard code of performance for those in the field (1).

Although medical ethical principles are systematically classified in different ways in literatures, these principles generally grouped as autonomy, non-maleficence, beneficence, and justice (3). The patient provider relationship is built on the patient acceptance and trust in the providers' commitment to do no harm, to treat the patient with respect and dignity, and to make the patient a full participant in decisions about his or her care (4).

The principles of medical ethics make several contributions to patient care and decision making in the medical context. They offer a way to approach ethical dilemmas that arise in the course of practicing medicine, making difficult health care decisions and interacting with patients and their families. The principles provide a way to organize our thinking about ethical issues in patient care and a shared language for health care providers to discuss these issues (2).

The challenge with ethical principles is that there is no single standard of ethical behavior to follow. Ethics is based on an individual's moral compass and what is ethical to one person is unethical to another. In order for leaders to establish and enforce ethical standards, it is best to develop a code of ethics (5).

The code of ethics provides guidance to all employees, management, physicians, and board of directors as to what is required of them when facing ethical issues. It is necessary to ensure that the medical office conducts and practices medicine in an ethical, lawful and honest manner (5).

In 2014 the Ethiopian council of minister ratified the regulation No. 299/2013 based on the Ethiopian food, medicine and healthcare administration and control authority proclamation No.

661/2009, which specifies the code of conduct for (HP) and establishment, duty and power of federal HP ethics committee. According to this regulation HP ethics committee shall examine, investigate and propose appropriate administrative measure to the authority on complaints with respect to substandard health services and incompetent and unethical HP (6).The authority is responsible for ensuring professional ethics. The professional ethics committee looks into medico legal issues and does case-based deliberations and advises the legislative body on medical malpractice (7).

1.2. Statement of the problem

All health professionals are required to uphold and abide by the oath undertaken on graduations that are recognized in different ethical documents (8). Every patient has a right to be treated with respect as an individual. Just as there has been advice to patients by health professionals about the treatment they receive, likewise they should be encouraged to ask questions about their admission, discharge and treatments and to inquire about alternatives (4).

Good communication, genuine relationships and good ethical practice are defining factors in the delivery of successful healthcare. It is imperative that health professionals remain mindful of their actions and fully embraces confidentiality and autonomy, especially as the 'grey' areas of practice can be difficult to assess. Protecting patients or others from distress; either through confidentiality or disclosing information allows management of the situation to remain optimal for all parties involved, however it is recognized that this can be difficult (9). Health practitioners seeking to provide the best possible care to their patients in the most ethical manner may find it difficult to balance the right to information with the need to avoid information overload (10).

Respecting the patient's wishes has a practical consequence: health professionals who simply overrules the patient often ends up seeing their treatments fail, because patients will probably be fighting them the whole way. Patients who are overruled do not tell the truth. But patients who are in dialogue and negotiation with their doctors are more likely to come to a reasonable compromise (11).

Individual autonomy is not absolute in the Ethiopian context. Individual decisions are not made on an autonomous basis; consensus from the public and the community elders is unusually sought in major community undertakings such as community-based interventions.In the medical

practice, direct and frank disclosure of certain medical information such as diagnoses and prognoses of grave illness or death of a family member is considered as inappropriate and insensitive. Therefore, in these conditions, doctors would communicate little information to patients and usually tell the bad news to a family member first.Honesty is the most highly valued character trait in the Ethiopian culture and truth is socially defined. However, confidentiality is not very well maintained in medical care practice in Ethiopia (7).

Professional ethics among medical practitioners is a growing concern of the Ethiopian public and the media and panel discussions mention a lot about it. The medico legal discipline is not developed in Ethiopia and currently falls under the digression of courts and the media. Medical malpractice is becoming a public concern and there is not a clear system. Yet, codes of practice exist (7).

Ethiopia being a country with diverse social and cultural identities, the issue of ethics is also diverse and dictated by context-specific realities. The country has tried to address ethics issues in different ways; however, this is yet to be strengthened. There are a number of issues related to building ethics capacity in the country using more indigenous and local experts and resources in the area. Having a supporting infrastructure and system is vital for the development of ethics in Ethiopia. One of the challenges is the enforcement of existing laws and legislations. Due to the lack of national standards, the governance of professional ethics is not very well defined by decree (7).

There are no ethics committees in the hospitals, almost throughout the country. Tikur anbessa specialized teaching hospital is the first one to have anethics committee which is functioning below its capacity. The main reasons for the retarded progress in the clinical aspect of ethics have to do with less awareness, less expertise, and existence of few ethical dilemmas, compared with too much advanced countries (7).

According to analysis of medical malpractice claims and measures proposed by the federal HP ethics committee of Ethiopia in 2015, the total number of complains presented to the committee against health professionals in three year period from 2011-2013 was 60. The committee verified that only 23.3% (14) of complain do have an ethical breach. Around 72% out of total cases

presented to the committee happened in the hospital. Out of total cases verified to have an ethical breach 8 (57%) of them happened in the hospital (12).

According to reports of complaints handling committee of Tulu Bolo hospital there are around 73 complaints was presented to the committee in between January and June of 2018. Even though a number of complaints is related to ethical breach, no classification was done to identify whether the case contain ethical breach or related to legal issue. Since the hospital establishment a number of disciplinary measures have been taken against staff acting unethically, but no quantitative information kept on its type and magnitude (13).

According to different literatures factors that can increase health professionals' practice of clinical ethics principles were knowledge, attitude, professional qualification, educational level, information load health professionals have in relation to ethics, desirable level of income in the eyes of health professionals and female gender. But factors that had both negative and positive association with practice of ethical principles were age, work experience and frequency of ethical issues encountered in practice. Even though marital status and religion were included in number of studies they did not show any association with practice of ethical principles (18, 19, 21 and 25).

Since, there was no study that indicates the presence and depth of the problem in the area; it is evident that assessment of ethical practice was needed in the area.

2. Literature Review

This chapter presents review of literature related with practice of clinical ethics and factors associated with it. It mainly described what the practice of clinical ethics looks like in different HP in different countries. In addition this review described the knowledge level of HP on ethics, the attitude they had on its practice and how this can affect the practice of ethics. There was also description of different factors related with ethical practice and what their relationship looked like.

2.1. Practice of clinical ethics

A cross sectional study among resident doctors and ward nurses in Nepal indicated thatresidentdoctors and ward nurses had significant difference in practice with respect to informing close relatives about patient opinion, adhering to patient wish, seeking consent for treating children, adherence to confidentiality, conducting abortion if law allowed and refusal to examine female patient in the absence of a chaperone (14).

A study done in Pakistan among interns and residents indicated that there were significant differences between interns, junior and senior residents with respect to adherence to patient's wishes, paternalistic attitude of physicians, treatment of children without parental consent, euthanasia, confidentiality and treatment of noncompliant patients (15).

According to the study done in Tabriz teaching hospital Iran, on nurses' ethical performance or practice, 91.9% believed that they act ethically (16).

A study among physician residents of university of Alexandria hospital, Egypt indicated that only 48% of physicians had compliance with principles of medical ethics.The majority of residents complied with the ethical principles of taking informed consent, not harming the patient, respecting the dignity of patient, privacy and confidentiality (17).

A study in two hospitals in Nigeria showed that there was a gap in the knowledge of ethics in healthcare delivery. Especially almost half of the respondents believed that ethics was only used for legal purpose and there was a gap in practice of some ethical principles like adhering to patient wishes. Around two third of the respondents said that they do what is best irrespective of patient wishes (18).

A cross sectional study among medical doctors in Addis Ababa indicated that only 30% of medical doctors had good practice of medical ethics (19).

According to the survey done among physician on clinical ethics dilemma in Ethiopia, several physician reported witnessing unethical behavior by colleagues such as referring patients to their own private clinic or shouting at them. But very few of them reported dilemmas associated with limiting treatment of the seriously ill and dying patient, or issues regarding euthanasia (20).

2.2. Socio-demographic factors related to practice of clinical ethics

A cross sectional study done on related factors of compliance to code of ethics from midwives perspective in Tehran Iran indicated that compliance to code of ethics was strongly associated with the income level of midwives (p=0.004).According to the findings educational level, employment status and work experience had no association with compliance to code of ethics (21).

According to the study done in Tabriz teaching hospital Iran, nurses' ethical performance or practice was significantly associated with age.But nurse's ethical performances had no significant association with work experience and marital status (16).

A study among physician residents of university of Alexandria hospital, Egypt indicated thatfemale physicians (61.8%) practice principles of medical ethics than male physicians (31.2%) (17).

A study of medical ethics in sub-Saharan Africa in two hospitals in Nigeria showed that therewas a difference in knowledge and practice of ethical principles between physicians and other health care providers (18).

A study carried out at federal medical center Bida, Nigeria indicated that professional qualification and years of experience are significantly affecting knowledge, attitude and practice of participants towards nursing ethics and law. But age and sex of participant had no significant association with knowledge, attitude and practice of participants (22).

According to the study in three referral hospitals in Uganda, those health professionals who had higher level education were more likely to have satisfactory knowledge than those nurses/

midwives having a diploma certificate. But age, gender and work experience was not associated with having satisfactory knowledge about basic concepts of health ethics (23).

A cross sectional study among medical doctors in Addis Ababa indicated that those medical doctors found in the age group of 25-29 were more likely to practice code of ethics than those in the age group of 30-34. But marital status, religion, work experience, level of education, ethics training and sex of respondent was not associated with practice of ethics (19).

2.3. Health professionals' exposure to ethical dilemma and training experience related to ethics

A study done in Pakistan among interns and residents indicated thatsignificant proportions of respondents face ethical issue frequently. But this happens more frequently to junior residents (15).

Another cross sectional study on related factors of compliance to code of ethics from midwives perspective in Tehran Iran indicated thataround 59% of respondents never attended an ethics class or training. But the remaining 41% of them attended training related to ethics from workshop, seminars, congress and educational class during employment (21).

A study among physician residents of university of Alexandria hospital, Egypt indicated that98% of physician admitted facing ethical problems (17).

2.4. Attitude of health professionals towards clinical ethics

A cross sectional study among resident doctors and ward nurses in Nepal indicated thatresident doctors and ward nurses had significant difference in attitude with respect to informing close relatives about patient opinion, adhering to patient wish, seeking consent for treating children, adherence to confidentiality, conducting abortion if law allowed and refusal to examine female patient in the absence of a chaperone (14).

A study among physician residents of university of Alexandria hospital, Egypt indicated that 60.2% of residents had satisfactory level of attitude towards principles of medical ethics (17).

A cross sectional study among medical doctors in Addis Ababa indicated thatthose medical doctors with favorable attitude were more likely to practice code of ethics than those health professionals with unfavorable attitude (19).

2.5. Knowledge of health professionals about clinical ethics

A cross sectional study among resident doctors and ward nurses in Nepal indicated that there was difference in the knowledge of the contents of Hippocratic Oath between doctors and nurses. Over 85% of both nurses and doctors didn't know the contents of Nuremberg code and Helsinki declaration (14).

A questionnaire-based, cross-sectional study carried out in south India indicated poor knowledge (23%) of medical and dental professionals, on national guidelines for ethics and Helsinki declaration. Nearly 98% of medical professional and 79% of dental professionals had awareness of presence of the institutions ethics committee (24).

A study done in Pakistan among interns and residents indicated only small proportion of respondents had knowledge of ethical principles (15).

Another cross sectional study on related factors of compliance to code of ethics from midwives perspective in Tehran Iran indicated thatcompliance to code of ethics had significant association with midwives awareness related to code of ethics (21).

According to the study done in Tabriz teaching hospital Iran, nurses' ethical performance or practice was significantly associatedwith information resource related to ethics (16).

A study done in Spain indicated that more than half of nurses enrolled in the study reported having poor knowledge of ethical issue and legal regulations. According to this study source of knowledge for young and older nurses were different, the younger one obtain from academic institution whereas older one acquire through experience, seminars or on their own effort (25).

A study among physician residents of university of Alexandria hospital, Egypt indicated that69.5% of physician working in this hospital had satisfactory knowledge related to different ethical principles (17).

A study in two hospitals in Nigeria showed that there was a gap in the knowledge of ethics in healthcare delivery (18).

According to the study in three referral hospitals in Uganda, only 15.8% of midwives/ nurses had satisfactory knowledge regarding to ethical principles and those who had diploma or higher level education were more likely to have satisfactory knowledge than those nurses/ midwives having a certificate. But age, gender and work experience was not associated with having satisfactory knowledge about basic concepts of ethical principles (23).

A cross sectional study among medical doctors in Addis Ababa indicated thatthose medical doctors who had knowledge of code of ethics were 83.5% more likely to practice code of ethics when compared with those did not have knowledge of code of ethics (19).

Most of the studies discussed above used quantitative cross-sectional study design (14, 15, 16, 17, 18, 19, 21, 22, and 24) and some used qualitative methods additionally (19). Most of the studies used self-administered structured questionnaires as data collection tool (14, 15, 16, 17, 18, 19, 21, 22, and 24). In addition some of the studies used observation (17). In most of the studies participants practices were self-reported, this may reflect what they believe it to be rather than the actual practice. In studies that used observation as additional data collection tool high number of refusal occurred and issues of privacy and confidentiality rose. In turn use of observation in such cases may have Hawthorne effect and observer bias. Since ethical concept is neglected for most of the managers and health care professionals working in hospitals, it is difficult to get health professionals who have enough information regarding to the ethical practice of the facilities both within the facilities and in related administrative offices.

This paper was focused on those points included under the four universally accepted ethical principles of healthcare delivery. It addressed what the practice of these ethical principles looks like in the selected health facilities and identification of those factors that contributes for the applicability of the principles or those that hinders its application.

Generally, most of the studies discussed above address the knowledge level of health professionals related to healthcare ethical principles (15, 16, 17, 18, 19, 21, 23, 24, and 25). According to most of the studies the knowledge level of HP was low. But in relation to attitude some of the studies described that HP had good attitude towards the application of ethical

principles (14, 17, and 19). In relation to practice of clinical ethics principles, some of the studies reported poor practice of clinical ethical principles (14, 15, 16, 17, 18, 19, and 20). The possible factors that affect practice of clinical ethics principles were knowledge level of HP, HP attitude towards its implementation, age of HP, work experience of HP, educational level, income level of HP, gender, profession, religion, marital status, ethics training, presence of ethics committee and frequency of ethical problem encountered in practice (15, 16, 17, 18, 19, 21, 22 and 23). Even though, some of the papers described level of practice of healthcare ethical principles, most of the studies focused on the knowledge level of HP and attitude towards the implementation of ethical principles.

2.6. Significance of the study

In Ethiopia, principles of ethics are being integrated into healthcare delivery in different approaches like professional code of ethics, code of conduct and creating compassionate, respectful and caring (CRC) health work force. So, this study aims to identify the practice ofhealthcare ethical principles and identification of factors that affect the applicability of ethical principles. This study may lay the groundwork in the area where little is known about ethics especially in hospitals serving the rural population. The findings will provide insights for designing and implementing proper interventions. In turn this study helps to fill information deficit related to clinical ethics in the area. Since, there was only small number of studies done in the area of principles of ethics available this study will initiate and promote further research.

2.7. Conceptual Framework

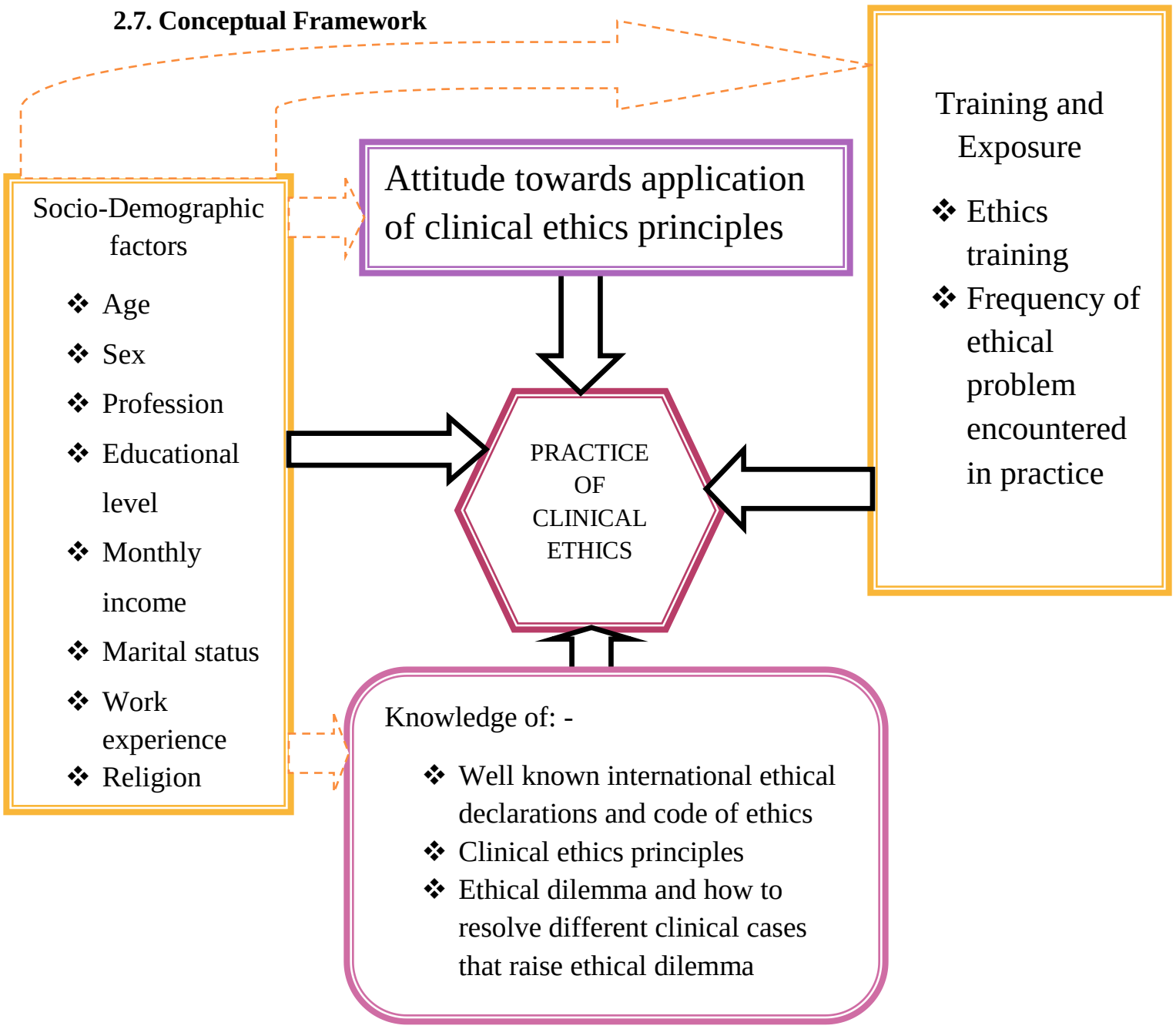


Figure 1:-Conceptual framework that shows factors associated with practice of clinical ethics

3. Objectives

3.1. General Objective

The overall objective of this study was to assess self-rating practice of clinical ethics and associated factors among health professionals working in hospitals of Southwest and West Shoa zone, Oromia Region, Ethiopia, 2019.

3.2. Specific Objectives

- To assess self-rating ethical practice among health professionals working in hospitals of Southwest and West Shoa zone, Oromia Region, Ethiopia, 2019.
- To identify factors that affect ethical practice among health professionals working in hospitals of Southwest and West Shoa zone,Oromia Region, Ethiopia, 2019.

4. Methods

4.1. Study Area and Period

This study was conducted in public hospitals found in Southwest and West Shoa zone Oromia region. There were a total of eleven public hospitals with in the two zones. Four public hospitals found in Southwest Shoa zone and the remaining seven found in West Shoa, West Shoa zone has an administrative center of Ambo which is around 117km away from the capital Addis Ababa. This zone has a total population of around 2.1 million. Southwest Shoa zone is one of recently established administrative zone in Oromia region. Previously it is under West Shoa. This zone has a total population of around 1.18 million and the administrative center of this zone is Woliso which is 115km away from the country and regional capital Addis Ababa. According to the two zones and the respective hospitals human resource managers' information there are around 934 health care professionals working in the eleven hospitals found within the two zones. There are four general and seven primary hospitals found within the two zones. There are a total of 406 health professionals currently working in six sampled hospitals of the two zones.

The study was conducted from March 21 up to May 12, 2019.

4.2. Study Design

A facility based quantitative cross-sectional study design mixedwith qualitative was conducted by using convergent parallel design.

4.3. Source Population

The source population of the study was all health professionals working with in eleven public hospitals of Southwest and West Shoa zone, Oromia region.

4.4. Study population

The study population was all health professionals working in six sampled public hospitals.

4.5.Inclusion and Exclusion criteria

- Those HP who have more than six months of experience wereincluded in the study.

4.6. Variables for the study

4.6.1. Dependent variable

- Practice of clinical ethics

4.6.2. Independent variables

- Socio-Demographics factors
  - Age
  - Sex
  - Educational level
  - Monthly income
  - Profession
  - Work experience
  - Religion
  - Marital status
- Training and Exposure
  - Ethics training
  - Frequency of ethical problem encountered in practice
- Attitude
- Knowledge

4.7. Operational Definitions

Health Professional: An individual involved with the delivery of health or related health services namely: - general practitioner, specialist, emergency surgical officer, nurse, and midwifery.

Good practice of clinical ethics: A health professional that scored ≥ 75% out of the total score forpractice related questions was categorized as having good practice of clinical ethics and otherwise poor practice/scored with five likert scales (0–4) 0 for never practiced to 4 for always practiced (actual total score would be between 0 and 68, actual score of 51 would be 75% of the total)(25) .

Knowledgeable: A health professional that correctly answered ≥15 out of 19 on the knowledge based questions and otherwise not knowledgeable (25).

Favorable attitude: A health professional that scored ≥75% out of the total score on attitude questions was categorized as having favorable attitude and otherwise having unfavorable attitude /scored with five likert scales (0–4) 0 for strongly disagree to 4 strongly agree (actual total score would be between 0 and 68, actual score of 51 would be 75% of the total) (25).

4.8. Sample size determination

Sample size for quantitative study was determined using single population proportion formula. The following assumptions were made to calculate the sample size.

1. Proportion of health professionalswho had good practice of clinical ethics from previous study done in Addis Ababa was 30 % (25)
2. Margin of error taken to be 5%
3. A 95 % confidence level was also accepted (Zα/2= 1.96)
4. Estimated non response rate of 10% was considered.

Based on this

$$n = \left[\frac{(Z\alpha/2)^2 (P (1-P)}{d^2} \right] = \left[\frac{(1.96)^2 (0.3 (0.7))}{0.05^2} \right] = 323$$

Where n: the required sample size

Z: confidence level

P: proportion of practice of clinical ethics

d: margin of error

10% of the sample size was added for non-respondents. The required final sample size became **355.** Out of the eleven hospitals found within the two zones six of them selected randomly, by proportional allocation four hospitals from West Shoa and two hospitals from Southwest Shoa

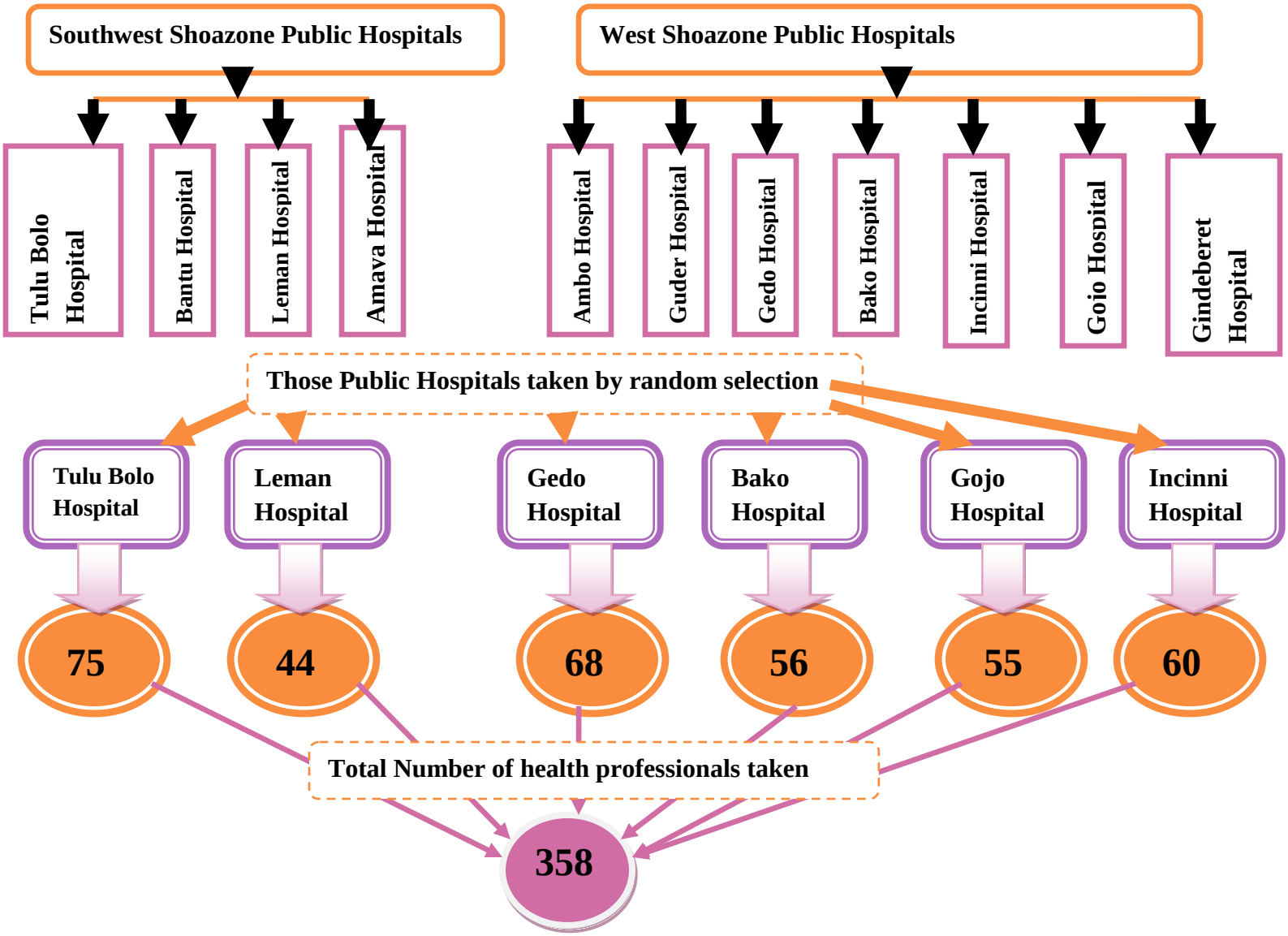
zone. Then all health professionals currently working in the hospitals and had an experience of more than six months were included in the study they were 358health professionals.

The sample size for the qualitative study was done by selecting two key informants from each hospital. The selected key informants were the hospital chief clinical officer(CCO) and the hospitals compliant handling committee head. Key informants selected based on their position in the hospital. So the total sample size for the qualitative study was 11.

4.9. Sampling Technique

Six hospitals out of the total eleven were selected by simple random sampling technique. In which four hospitals selected from West Shoa and the remaining two from Southwest Shoa. All health professionals currently working in these hospitalsand had an experience of more than six monthswere taken as study participant.

For the qualitative study purposive sampling technique was used to select a key informant from each organization.


Southwest Shoazone Public Hospitals
West Shoazone Public Hospitals
Tulu Bolo Hospital
Bantu Hospital
Leman Hospital
Amava Hospital
Ambo Hospital
Guder Hospital
Gedo Hospital
Bako Hospital
Incinni Hospital
Goio Hospital
Gindeberet Hospital
Those Public Hospitals taken by random selection
Tulu Bolo Hospital
Leman Hospital
Gedo Hospital
Bako Hospital
Gojo Hospital
Incinni Hospital
75
44
68
56
55
60
Total Number of health professionals taken
358

4.10. Data collection tools, Procedures and Quality assurance

Data for quantitative study was collected by using self-administered questionnaire that is developed from different literatures (15, 16, 21, 23 and 25). The questionnaire contains six parts. First it contains questions related with the facility detail. Then itincludes socio-demographic information like age, sex, marital status, religion, level of education, type of profession, monthly income and years of experience and also asks for the experience of health professionals with respect to ethical practice. The remaining parts assess the attitude, practice and knowledge of health professionals related with clinical ethics. Totally the questionnaire contains 62 items out of these there were seventeen questions each for attitude and practice and nineteen questions for knowledge.

Before the actual data collection begins pretest was done on 20 health professionals from Mojo hospitals and necessary adjustment made especially on the knowledge part of the questionnaire.Internal consistency was checked by using cronbach's alpha and the result found to be 0.79 for questions related to attitude of health professionals towards clinical ethics, 0.83 for questions of knowledge of health professionals and 0.706 for questions related to practice of clinical ethics.

Data for qualitative study was collected by face to face interviews. The interview was recorded properly. One independent reviewer read the transcript and gave comments before analysis and report writing.

4.11. Data Processing and Analysis

The collected quantitative data were entered into Epidata version 3.1and exported into SPSS version 23 for analysis. The frequency distribution of socio-demographic characteristics was done. Variables having a p-value of less than 0.25 in the bivariate analysis were exported to multivariate analysis for determination of association. Binary logistic regression model was used for analysis.

For the qualitative data, the tape recorded audios were transcribed and then translated to English. The final transcript read carefully and repeatedly, relevant items labeled, then most important identified. Identified themes labeled and relevant one chosen and then the final result written.

Multi-collinearity was checked by using variance inflation factor (VIF). It has a value of 1.20

4.12. Ethical clearance

Ethical clearance was obtained from the Institutional Review Board (IRB) of Jimma University through department of health policy andmanagement.Clearances were also obtained from Oromia Regional Health Bureau (ORHB) and from each selected hospitals. Voluntary verbal consent was taken from all of the study participants included both in quantitative and qualitative study

5. Result

5.1. Socio-demographic characteristics

Out of 358 health professionals included in the study 314 responded that makes the response rateof 88%. But 9 of these questionnaires were incomplete and not included in the analysis. The main reasons for the non-responses were work load, some of them are on annual leave during data collection and some refusal also happens. So out of 305 respondents the majority, 79% of respondents were male and 62% of respondents found within the age category of 25-30.Single and married respondents almost share 98% of the total having equal contribution. Protestant religion account for 44% of respondents and60% of the study participants were nurses. Almost 83% of these health professionals had first degree certificate (Table 1).

Table 1: Table indicating frequency and percentage of socio-demographic characteristics

Ser. No.	Name of variables and its category	Frequency	Percentage	Remark
1	• Sex			
	Male	242	79.3	
	Female	63	20.7	
2	• Marital status			
	Single	149	48.9	
	Married	149	48.9	
	Others	7	2.2	
3	• Age			
	<25 years	27	8.9	
	25-29 years	190	62.3	
	30-34 years	70	23	
	>34 years	18	5.9	
4	• Religion			
	Orthodox	105	34.5	
	Catholic	14	4.6	
	Protestant	134	44.1	
	Muslim	13	4.3	

	Wakefeta	38	12.5
5	• Profession		
	General practitioner and specialist	56	18.3
	Emergency surgical officer	25	8.2
	Nurse	184	60.3
	Midwifery	40	13.1
6	• Work experience		
	<4 years	168	55.1
	4-8 years	88	28.9
	>8 years	49	16.1
7	• Monthly Income		
	<5000 birr	101	33.1
	>5000 birr	204	66.9
8	• Level of education		
	Diploma	32	10.5
	Degree	253	83
	Masters and above	20	6.6

Key informants: In-depth interview of eleven key informants was done. Six of them were chief clinical officers (CCO) of the respective hospitals and out of the remaining five key informants two of them were nurses working as head of compliant handling committee. The remaining three were non-health professionals' two working as head of complaint handling committee and the other one as head of discipline committee since no complaint handling system was in place in Leman hospital. In hospitals in which CCO was not available during data collection, his/her delegate was interviewed.

5.2. Health professionals' exposure to ethical dilemma and training related to ethics

Among the 305 study participants 31% (93) of respondents said they never experienced ethical dilemma/ethical problem/. In relation to clinical ethics training 17% of respondents never took any training related to ethics. But around 70% of respondents got pre-service training experience

related to ethics in educational center. The remaining respondents got ethical training from workshop, seminars and orientation during employment(Table 2).

Table 2: Table that contains frequency and percentage of exposure to ethical dilemma and training related to ethics

Ser. No.	Name of variables and classifications	Frequency	Percentage	*Remark*
1	Frequency of facing ethical dilemma/ethical problem/			
	Never	93	30.5	
	Once a year	71	23.3	
	Once a month	56	18.4	
	Once a week	41	13.4	
	Every day	44	14.4	
2	Experience in relation to attending ethics training			
	Never	51	16.7	
	Workshop and orientation	21	6.8	
	Seminars	21	6.9	
	Formal education	212	69.5	

5.3. Practice of clinical ethics

Among 305 of total respondents 36.4% of study participants had good practice of clinical ethics. The remaining 63.6% of study participants had poor practice of clinical ethical principles (Table 3).

Table 3: Table that contains result of health professionals' practice of clinical ethics

Ser. No.	Name of variables and classifications	Always	Mostly	Sometimes	Rarely	Never
1	How often do you obtain informed consent from a patient before rendering a service?	104	79	91	15	16
2	How often do you provide health service for your benefit that does not serve the needs of your patient?	134	62	67	17	25

3	How often do you work with or give any professional support to other health professional not licensed by appropriate organ?	100	65	83	47	10
4	How often do you render the same level of care to your clients in over-time and regular practice?	92	79	84	36	14
5	How often do you provide any preferential treatment to a client/patient by considering the relationship established with you in other health institution where you works?	60	67	99	45	34
6	How often do you use an apparatus or health technology or intervention which is proved up on investigation to be capable of fulfilling the claims made in regard to it?	93	85	82	31	14
7	How often do you refuse on ground of your personal belief to provide services such as contraceptive,legal abortion and blood transfusion?	101	58	79	40	27
8	How often do you sign and write your name on official documents relating to patient care such as laboratory and other diagnostic requests and results, prescriptions, certificates, patient records and other Reports?	171	66	37	13	18
9	How often do you administer or prescribe medicine or formulations about which you do not know about its composition and pharmacological action?	158	52	42	27	26
10	How often do you administer or prescribe medicine not registered in the National Medicine List without compelling reason?	129	66	70	19	21
11	How often do you report impairment in other health professional to the appropriate organ if you are aware of it?	56	91	87	42	29
12	How often do you report your own impairment to the appropriate organ if you are aware of it?	53	91	89	44	28
13	How often do you report any unprofessional/unethical conduct of another health professional to the appropriate organ?	60	78	97	46	24
14	How often do you assure your patient and respect the confidentiality of the information patient provided to you and the diagnosis?	154	101	24	21	5
15	How often do you preserve the privacy of the patient?	155	95	39	10	6
16	How often do you respect patient choices?	111	110	61	14	9
17	How often do you inform a Patient of any wrong doing?	95	94	62	36	18

According to the in-depth interview of key informants there was problem of practice of clinical ethics in service provision. The practices of ethical principles in the clinical setting need to be regular practice. But it only comes intermittently as initiatives like the current one CRC. Most of the health professionals had been driven by their own personal judgment. Working in the best interest of the patient was becoming difficult for health professionals without including their

own. May be rules or regulations were there but not applied or enforced all the time. But still there was lots of health professionals got fined, suspended or totally dismissed with cases related to ethics. There were also lots of professionals given warning with cases related to ethical breach in clinical service delivery.

One of the CCO of one hospital said

"Even though, lots of health professionals were good and caring for the patient, there were some rude which do not care for the patient…….also there were others who came to work in abnormal state of mind ……they insulted the patient, they even go to fight with patient…"

According to the key informants common examples of areas where ethical breach occurs were not taking informed consent for services other than operation, failure to show respect to the patient and neglecting patient preference especially when the patient refuse to accept services.

One head of complain handling committee said

"……even if it was difficult to know exactly what was happening between health professionals and patients sometimes we saw some health professionals never speak to the patient apart from the first time they took patient complain……."

5.4. Attitude of health professionals on clinical ethics

Among the total respondents44.6% (136) had favorable attitude towards clinical ethics and the remaining 55.4% had unfavorable attitude (Table 4).

Table 4: Table that indicates result of health professionals' attitude towards clinical ethics

Ser. No.	Name of variables and classifications	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	Patient wishes must always be adhered to	80	137	41	29	18
2	Patient should always be informed of wrong doing	76	104	48	50	27
3	Confidentiality cannot be kept in modern care and should be abandoned	121	96	23	53	12
4	Health professionals should do irrespective of patient's opinion	99	100	38	53	15
5	Close relative should always be told about patient's condition	55	78	52	88	32

6	Children should never be treated without the consent of their parents	69	95	35	69	37
7	If law allows abortion, health professionals cannot refuse to do abortion	65	86	38	75	41
8	If there is disagreement between patients/families and health care professionals about treatment decisions, health professionals decision should be final	68	101	46	55	35
9	Ethical conduct is only important to avoid legal action	87	122	26	52	18
10	Ethics as part of a syllabus should be taught in every Health care teaching institution	138	109	30	12	16
11	Health professionals are receiving income from referring patients for medical tests	89	88	34	38	56
12	Consent is only required for surgeries, not for tests and medicines	110	107	32	32	24
13	If a patient wishes to die, health professional should be assisted in doing so	113	83	47	42	20
14	It is ethical to refuse a patient given a situation, a male health professional needs to examine a female patient and female attendant is not available	49	62	49	89	56
15	If patient refuse treatment due to belief, they should be instructed to find another doctor	57	90	55	73	30
16	Hospital staff can use patient pictures in public forum without the consent of the patient	141	80	40	27	17
17	Health professionals should refuse to treat patient who behave violently	100	93	43	55	14

5.5. Knowledge of health professionals in relation to clinical ethics

Out of 305 health professionals36.1% (110) of health professionals were knowledgeable about clinical ethics.

5.6. Factors associated with practice of clinical ethics

According to the bivariate analysis of each and every independent variable age, type of profession, income status, training related to ethics, attitude and knowledge were significantly associated with practice of clinical ethics at a p-value of less than 0.25. So these variables were considered for the multivariate analysis. Accordingly only age, type of profession,knowledge and attitude were found to have significant association with practice of clinical ethics.

5.6.1. Socio-demographic factors

In relation to age, Health Professionals within the age group of 30-34 years were **2.321** times more likely to have good practice of clinical ethics than those in the age group of 25-29 years.(Adjusted odd ratio (AOR)=**2.321** and 95% Confidence interval (CI)= **(1.045, 4.525).**

According to the multivariate analysis result related to type of profession indicated that midwives were **3.949** times more likely to have good practice ofclinical ethics than general practitioners.(AOR: **3.949**, 95% CI: (**1.427, 10.933**).

5.6.2. Attitude of Health Professionals towards clinical ethics

The multivariate analysis result related to attitude indicated that health professionals with favorable attitude were **2.368** times more likely to have good practice of clinical ethics than those health professionals with Unfavorable attitude. AOR:**2.368,** 95% CI: **(1.064, 4.604).**

Key informants believed that attitude was one determinant reason out for practice of clinical ethics. According to qualitative findings health professionals with favorable attitude were more likely to have good practice of clinical ethics than health professionals with unfavorable attitude. There was a complex situation in which you would saw a mixture of one health professionals who was going to risk everything he or she had or the other one who was not ready to serve the community. Job need to be done on trying to create honest and health professionals with courage that serves the public.

But they stressed that there were lots of health professionals who have positive attitude and ready to serve the community but other factors hinder its expression. They believed action must be taken on changing the attitude of health professionals towards the positive side that can benefit the society.

Chief clinical officer of one Hospital said

“we as health professionals were not properly cultivated to have and share similar positive attitude to serve the community…..as the name makes us one….the agenda of making patient benefit first was fading……”

Another CCO of one hospital said

“The focus of professionals was shifted from service delivery to incentives they could get by providing services…..”

5.6.3. Knowledge of health professionals on clinical ethics

The multivariate analysis result related to knowledge indicated that knowledgeable health professionals were **1.812** times more likely to have good practice of clinical ethicsthan not knowledgeable health professionals/ AOR: **1.812,** 95% CI: **(1.017, 3.230**(Table 5).

According to the key informants knowledge of health professionals on clinical ethics was one key determinant reason out for its practice. They believed that knowledgeable health professionals could practice clinical ethics more than not knowledgeable one. So the result of qualitative study supported the quantitative one.

Knowledge of ethical principles or values, code of conduct, patient right and professionals responsibility helps health professionals in service delivery. Some health professionals did not know the right of patient in the eyes of ethical principles and his or her responsibility towards patients. Interventions that could increase health professional’s knowledge on ethical principles must be taken. For example, giving training, workshops or seminars on ethical issue, disseminating guidelines on patient right, health professionals responsibility and code of conduct.

But they believed knowledge by itself was not enough to have good practice of clinical ethics. Since you might see a number of professionals who had knowledge of their responsibility but they did not obey.

One CCO of one Hospital said that

“Even though knowledge could not give us 100% assurance for practice, there were a number of unethical acts done to the patient that arise due to lack of awareness of health professionals. ….knowledge of responsibilities would act as reminder for health professionals not to act unethically,…..it contributes for respecting patient right….”

One head of complain handling committee of one hospital said

"….knowledgeable health professionals could identify good or bad activities in service delivery. This in turn helps them to refrain from doing so, especially activities that result in bad outcome…"

Ser. No.	Name of variables and its category	Practice		COR(95% CI)	AOR (95% CI)	p-value
		Good	Poor			
1	Age					
	<25 years	6	21	0.401(0.155, 0.940)	1.636(0.600, 4.462)	0.336
	25-29 years	79	111	1.00	1.00	
	30-34 years	20	50	0.741(0.251, 2.031)	2.321 (1.045, 4.525)	0.017
	>34 years	6	12	0.571(0.150, 2.172)	1.458(0.448, 4.742)	0.531
2	Profession					
	General practitioner	23	32	1.00	1.00	
	Emergency surgical officer	9	16	0.246(0.089, 0.681)	0.966(0.315, 2.958)	0.951
	Nurse	73	111	0.314(0.95, 1.033)	0.886(0.456, 1.721)	0.721
	Midwifery	6	34	0.268(0.107, 0.671)	3.949(1.427, 10.933)	0.037
3	Monthly Income					
	<5000 birr	30	71	1.559(0.935, 2.597)		0.089
	>5000 birr	81	123	1.00	1.00	
4	Experience in relation to attending ethics training					
	Never	15	36	1.8(0.628, 5.162)		0.274
	Workshop	6	3	0.375(0.073, 1.920)		0.239
	Seminars	9	12	1.00	1.00	
	Formal education	77	135	1.315(0.530, 3.262)		0.555
	Orientation	4	8	1.5(0.342, 6.583)		0.591
5	Attitude					
	Favorable Attitude	66	70	2.355(1.219, 4.576)	2.368(1.064, 4.604)	0.012
	Unfavorable Attitude	45	124	1.00	1.00	
6	Knowledge					
	Knowledgeable	27	83	2.323(1.385, 3.907)	1.812(1.017, 3.230)	0.044
	Not Knowledgeable	84	111	1.00	1.00	

Table 5: Table indicating the bivariate and multivariate analysis result for each variable

5.6.4. Personal behavior

As key informants stated that, personal behavior of health professionals could be one reason out forpractice of clinical ethics. There were lots of health professionals who failed to adhere to the basic clinical ethical principles due to their bad personal behavior. Bad personal behaviors of

health professionals had effect on clinical service delivery, good patient communication and counseling.

One head of complaint handling committee said

“The personal behavior of health professional was one essential factor, especially when there were health professionals who were addicted to some kinds of stimulants or sedatives. It becomes difficult to expect friendly clinical ethical service from them all the time….patient might not be confident to reveal his/her true problem……”

One CCO of one hospital said

“…..health professional’s personal behaviors determine patient’s willingness to adhere to providers counseling and trust on health professionals…..”

5.6.5. Orientation during employment

As the statements of the interviewee indicated health professionals had to be given enough information and guidance about the organization and the service he or she was going to provide, so that he or she was ready to rectify ethical problem they would face in the service delivery. Thoroughly orientation of organizational rules and regulations, ethical responsibility of health professionals, and responsibility to the public had to be given to new employees during their first entry. These would increase familiarity of employees to the new environment, facility, staff or work.

One head of complain handling committee said

“……newly employed health professionals or those new to the facility had to be given enough orientation on how to provide service to the community….orientation given during employment makes health professionals pre-informed of some special challenges that he/she might face…..”

Another one said

“…orientation might act as refreshment to the previously trained professionals….”

5.6.6. Patient load

Key informants believed that facilities with low patient load were more likely to have health professionals who have good practice of clinical ethics. So they believed health professionals working in such facilities face no difficulty in providing clinical service that might raise ethical issue. In hospital service it was better to make proper deployment of health professionals in order to had balance of clients per provider. When there was proper balance between client and provider it enable health professionals to properly implement their ethical responsibility. But high amount of patient load might create dissatisfaction among health professionals that might lead to ethical breach.

One head of complaint handling committee said

"…….since our facility was new it do have low patient load. Health professionals working here face minimal difficulty in providing service at the required standards…..health professionals face no time constraint in providing service……you would see no sign of pressure and tension due to work load….."

5.6.7. Junior and fresh graduates

Key informants stated that junior and fresh graduates had added motivation to serve the public than the experienced one. They said they were more caring and shows respect when compared with the health professionals having more experience. Being inexperienced might expose health professionals to a number of ethical issues, but they tried to resolve by giving primary consideration for the patient benefit.

One discipline committee head said

"……we saw that junior and fresh graduates were more motivated to serve the community……you saw when they were trying to do what they could to please the patient…they were also glad for having close connection to the patient and help them regain normal and healthy condition…."

5.6.8. Understanding of the surrounding community values and norms

Most of the key informants stressed that, health professionals who had knowledge of the surrounding community values and norms, the better he or she had good ethical practice.

Knowledge of the surrounding community values and norms create better understanding and communication between the patient and the provider. So this could result to better application of clinical ethical principles. Health professionals who had knowledge of community culture face minimal difficulty in resolving ethical issues, which could have connection with community values and norms. Even sometimes it helps health professionals to understand patient wishes in advance before the client expresses his own.

CCO of one Hospital said

"…..knowledge of the community values and norms play essential role in providing good and ethical care to the patient….especially in physical examination and treatment choices…. knowing the community helps the provider to refrain from doing or mentioning things not supported by the community…"

One head of discipline committee said

"…it was good to had a health professionals grew here or in such kind of populations…."

Another CCO of one hospital said

"It was good for health professionals to be familiar with the society culture..."

6. Discussion

This study investigated practice of clinical ethics principles and the possible factors associated with practice of clinical ethics of health professionals in hospitals of Southwest and West Shoa zones. According to the findings in these hospitals only 36.4% of health professionals had good practice of clinical ethics principles. These shows around 64% of health professionals had poor practice. The qualitative study supported this finding which indicated that there was a gap in practice of clinical ethics in healthcare service delivery among the study hospitals.

A study of knowledge, perceptions and practices towards medical ethics among physician residents of University of Alexandria hospitals,had result close with the result of this study, in which only 48% of physicians had good practice of clinical ethics (21). A study of medical ethics in sub-Sahara Africa in two hospitals in Nigeria also indicated gaps in the practice of ethical principles (22). A study of practice of code of ethics and associated factors among medical doctors in Addis Ababa supported this claim in which only 30% of medical doctors had good practice of code of ethics (25).Another survey done among physicians in Addis Ababa reported witnessing unethical behavior by physicians (26).

The possible explanation for the similarity of result between these studies might be, in Africa there is no absolute autonomy. It was difficult to find large number of patients who could decide their fate by themselves. Some of them leave it to the physician, others to the family members or even to the close relatives and neighbors. So the similarity in population characteristics especially the presence of religious traditional community became a factor for health professionals not to fully exercise ethical principles devised by the western community.

But against this study the study done on knowledge and performance about nursing ethic codes from nurses' and patients' perspective in Tabriz teaching hospitalsin Iran indicated that 91% of nurses reported having good practice of ethics (19). The possible explanation for the difference might be due to difference in methodology or measurement tool or it might be due to difference in environment.

One of the factors that showed significant association with practice of clinical ethics was age. According to the findings for health professionals within the age group of 30-34 years were 2.321 times more likely to have good practice of clinical ethics than those in the age group of 25-

29 years. One study done on ethical performance of nurses in Iran supported this finding, which said older nurseshad higher ethical performance (16).

But against this, the studyof practice of code of ethics and associated factors among medical doctors in Addis Ababa indicated that doctors in the age group of 25-29 were more likely to practice code of ethics than those in the age group of 30-34 (25). But according to the studies done in Nigeria and Uganda age of health professionals had no association with ethical practice (22, 24). These might come due to difference in study area or population difference.

Another factor that had an association with practice of clinical ethics was type of profession. So according to this study midwives were 3.949 times more likely to have good practice of clinical ethics than general practitioners. This might be due to the fact that midwives is mainly related to mothers and child care that requires great focus and care and also this was area of practice that had much political emphasis than others. According to a number of studies professional qualifications had significant association with practice of ethical principles. Studies done in Nepal, Pakistan and Nigeria indicated that there was a difference in practice of ethical principles between physicians and other health professionals (15, 17, 22and 23).

Another factor that had significant association with practice of clinical ethics was attitude of health professionals towards ethical principles. According to this study health professionals who had favorable attitude towards ethical practice were more likely to have good practice of clinical ethics when compared with those having unfavorable attitude towards ethical practice. This indicated that health professionals who had good attitude were more likely to practice ethical principles. The qualitative study also identified attitude as one reason out for health professionals'practice of clinical ethics. According to key informants the more health professional with favorable attitude the better he or she could have good practice of clinical ethics. This goes with the study done in Ethiopia on medical doctors that said those medical doctors with favorable attitude were more likely to practice code of ethics than those with unfavorable attitude (25).

Additional factor that showed association with practice of clinical ethics were knowledge of health professionals on clinical ethics. According to this study knowledgeable health professionals could practice clinical ethics more than not knowledgeable one. The qualitative

study supported this finding which saidhealth professionals who had enough knowledge had good practice than those with poor knowledge. Knowledge might help in identification of right or wrong or good or bad. Some unethical acts might be punishable by law. So awareness of such principles might help health professionals to refrain from doing so. A study of practice of code of ethics and associated factors among medical doctors in Addis Ababa supported this finding in which knowledgeable health professionals were 83.5% more likely to have good practice when compared with not knowledgeable one.

In addition qualitative studies identified personal behavior of health professionals, orientation given during employment, patient load of the facilities, being junior and fresh graduates and understanding of the surrounding community values and norms as reason out for health professional's good practice of clinical ethics.

6.1. Limitation of the study

Hence the practice data of this study was collected by self-administered questionnaire, their response might be what they believed it should be rather than the actual fact. So this study might have respondent bias.

7. Conclusion and Recommendation

There was poor practice of clinical ethics among health professionals working in hospitals of Southwest and West Shoa Zone. Factors that are associated with good or poor practice of clinical ethics were age of health professionals, type of profession,knowledge of health professionals and attitude towards ethical principles. According to qualitative analysis reason out that were associated with practice of clinical ethics were attitude of health professionals, knowledge of health professionals, health professional's personal behavior, orientation given during employment, patient load of the hospitals, being junior and fresh graduates and understanding of surrounding community values and norms.

Therefore, Federal Ministry of Health (MOH) and Oromia Regional Health Bureau should devise mechanisms that might help to minimize poor ethical practice of health professionals and should work on attitude and personal behavior of health professionals through different mechanisms. Health facilities should provide enough orientation to new employees and work on mechanisms that develop knowledge of health professionals on the surrounding community values and norms. Academic Institutions should work on knowledge and attitude of health professionals on ethical issue and should try to do further research with use of observation and with large study area including all kinds of health professionals and with use of patient perspective.

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9. Annexes

9.1. Annex 1: Consent Form

Title of Study**:** practice of clinical ethics and associated factors among health professionals in Hospitals of South West and West Shoa Zone Oromia Region Ethiopia, 2019.

By: Hora Bekele

Institution: Jimma University

Sponsor: Jimma University

Request**:** I request you to take part in a research study. The study aims to assess practice of clinical ethics and associated factors among health professionals in Hospital of South West and west Shoa Zone Oromia Region. In Ethiopia there is poor practice of clinical ethical principles and codes of conduct of health care professional in healthcare delivery. An understanding of factors associated with the poor practice of ethics may help in rectifying the factors and preparation of proper intervention both at facility level and administrative level of the regional or federal government. The study session is expected to last about 10 minutes. During this time, you will be asked some questions related with practice of ethical principles, the knowledge you have in this area and your attitude towards healthcare ethical principles application.

Risks and benefits**:** This study may help to improve our understanding of ethical principles and associated factors. There will be no costs to you for taking part in this study.

Confidentiality**:** All Information obtained about you will be kept confidential and will be used only for the purposes of the study. Your name will not be required. The finding of the study may be published or disseminated without revealing your identity.

Consent**:** You are free to take part or to withdraw from the study at any time, there will be no penalty.

Questions**:** If you have any questions, concerns or complaints about the study, please call:-Hora Bekele, phone number: - 0901603890 .E-mail –ayalew3184@gmail.com

Signatures**:** Your signature below indicates that you agree to participate in this study. You will receive a copy of this signed document.

_____ _____

Signature of participant and Date

_____ _____

Signature of investigator and Date

9.2. Annex 2: Questionnaire

Questionnairesto be administered to health professionals. Answer as many questions as possible

A. General Information

Questionnaire number ID ☐

1. Date of data collection DD/MM/YYYY_____/_____/_____

2. Health Facility details

   a) Name of Hospital _____

B. Socio demographic information

1. Your age in years? _____
2. Sex Male ☐ Female ☐
3. Marital status
   Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐
4. Religion
   Orthodox ☐ Catholic ☐ Protestant ☐ Muslim ☐ Wakefeta ☐
   Others specify_____
5. Level of education (highest level of formal education completed)
   Diploma ☐ Degree ☐ Masters and above ☐
6. What is your profession
   General Practitioner ☐ Specialist ☐ ESO ☐ Nurse ☐ Midwifery ☐
7. How much do you earn in a month in birr?
   _____
8. How many years of experience you have?

C. Personal Experience

1. How often do you meet an ethical problem (face ethical dilemma) in the course of your work?
   Never ☐ Once a year ☐ Once a month ☐ Once a week ☐ every day ☐
2. What is your experience in relation to attending educational class/ training about health professionals' code of ethics?

   Never attended ☐ Workshop ☐ Seminars ☐

   Educational class at University/ college ☐ Orientation during employment ☐

D. Information related to attitude questions

Ser. No	Attitude questions	Possible answers				
		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	Patient wishes must always be adhered to	⬭	⬭	⬭	⬭	⬭
2	Patient should always be informed of wrong doing	⬭	⬭	⬭	⬭	⬭
3	Confidentiality cannot be kept in modern care and should be abandoned	⬭	⬭	⬭	⬭	⬭
4	Health professionals should do irrespective of patient's condition	⬭	⬭	⬭	⬭	⬭
5	Close relative should always be told about patient's condition	⬭	⬭	⬭	⬭	⬭
6	Children should never be treated without the consent of their parents	⬭	⬭	⬭	⬭	⬭
7	If law allows abortion, health professionals cannot refuse to do abortion	⬭	⬭	⬭	⬭	⬭
8	If there is disagreement between patients/families and health care professionals about treatment decisions, health professionals decision should be	⬭	⬭	⬭	⬭	⬭

	final					
9	Ethical conduct is only important to avoid legal action	⬭	⬭	⬭	⬭	⬭
10	Ethics as part of a syllabus should be taught in every Health care teaching institution	⬭	⬭	⬭	⬭	⬭
11	Health professionals are receiving income from referring patients for medical tests	⬭	⬭	⬭	⬭	⬭
12	Consent is only required for surgeries, not for tests and medicines	⬭	⬭	⬭	⬭	⬭
13	If a patient wishes to die, health professional should be assisted in doing so	⬭	⬭	⬭	⬭	⬭
14	It is ethical to refuse a patient given a situation, a male health professional needs to examine a female patient and female attendant is not available	⬭	⬭	⬭	⬭	⬭
15	If patient refuse treatment due to belief, they should be instructed to find another doctor	⬭	⬭	⬭	⬭	⬭
16	Hospital staff can use patient pictures in public forum without the consent of the patient	⬭	⬭	⬭	⬭	⬭
17	Health professionals should refuse to treat patient who behave violently	⬭	⬭	⬭	⬭	⬭

E. Information related to practice questions

Ser. No.	Statements of ethics related to practice	Always	Mostly	Sometimes	Rarely	Never
1	How often do you obtain informed consent from a patient before rendering a service?	⬭	⬭	⬭	⬭	⬭
2	How often do you provide health service for your benefit that does not serve the needs of your patient?	⬭	⬭	⬭	⬭	⬭
3	How often do you work with or give any professional support to other health professional not licensed by appropriate organ?	⬭	⬭	⬭	⬭	⬭
4	How often do you render the same level of care to your clients in over-time and regular practice?	⬭	⬭	⬭	⬭	⬭
5	How often do you provide any preferential treatment to a client/patient by considering the relationship established with you in other health institution where you works?	⬭	⬭	⬭	⬭	⬭
6	How often do you use an apparatus or health technology or intervention which is proved up on investigation to be capable of fulfilling the claims made in regard to it?	⬭	⬭	⬭	⬭	⬭
7	How often do you refuse on ground of your personal belief to provide services such as contraceptive,legal abortion and blood transfusion?	⬭	⬭	⬭	⬭	⬭
8	How often do you sign and write your name on official documents relating to patient care such as laboratory and other diagnostic requests and results, prescriptions, certificates, patient records and other Reports?	⬭	⬭	⬭	⬭	⬭

9	How often do you administer or prescribe medicine or formulations about which you do not know about its composition and pharmacological action?	⬭	⬭	⬭	⬭	⬭
10	How often do you administer or prescribe medicine not registered in the National Medicine List without compelling reason?	⬭	⬭	⬭	⬭	⬭
11	How often do you report impairment in other health professional to the appropriate organ if you are aware of it?	⬭	⬭	⬭	⬭	⬭
12	How often do you report your own impairment to the appropriate organ if you are aware of it?	⬭	⬭	⬭	⬭	⬭
13	How often do you report any unprofessional/unethical conduct of another health professional to the appropriate organ?	⬭	⬭	⬭	⬭	⬭
14	How often do you assure your patient and respect the confidentiality of the information patient provided to you and the diagnosis?	⬭	⬭	⬭	⬭	⬭
15	How often do you preserve the privacy of the patient?	⬭	⬭	⬭	⬭	⬭
16	How often do you respect patient choices?	⬭	⬭	⬭	⬭	⬭
17	How often do you inform a Patient of any wrong doing?	⬭	⬭	⬭	⬭	⬭

F. Information related to knowledge questions

1. Ethical dilemma requires an individual to make a choice between two equal unfavorable alternatives?

Yes ☐ No ☐

2. Health professionals cannot use a medication or treatment that cures a disease or disorder or relieves its symptoms that is known by only a few people or professionals and intentionally withheld from general knowledge?

Yes ☐ No ☐

3._____ is an ethical principle that states communication between a patient and a provider must remain private.

a. Autonomy
b. Honesty
c. Consent
d. Confidentiality

4._____ is the major principle of medical ethics that states physicians and other medical professionals must act in the best interest of the patient.

a. Justice
b. Autonomy
c. Non-maleficence
d. Beneficence

5. The principles of _____ and _____ must be balanced to be certain that any risks involved in medical treatment or a procedure is outweighed by the benefit to the patient.
    a. Autonomy and Privacy
    b. Dignity and Justice
    c. Beneficence and Non-maleficence
    d. Ethics and Beneficence
6. _____ is the ethical principle most applicable to the highly publicized issue of universal health care.
    a. Justice
    b. Autonomy
    c. Non-maleficence
    d. Beneficence

7. One of the following is not included under the principle of Nuremberg code

a) The voluntary consent of the human subject is absolutely essential.

b) The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

c) The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

d) I will not be ashamed to say "I know not", nor will I fail to call in my colleagues.

8. One of the following is not included under the principle of Helsinki declaration

a) The physician's knowledge and conscience are dedicated to the fulfilment of this duty.

b) 'A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.

c) I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge

d) It is the duty of the physician in medical research to protect the life, health, privacy, and dignity of the human subject.

9. One of the following is not included under the Hippocratic Oath

a) I will prevent disease whenever I can, for prevention is preferable to cure.

b) The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

c) I will remember that I remain a member of society, with special obligations to all my fellow human beings.

d) I will apply, for the benefit of the sick, all measures which are required.

10. A nursing instructor is teaching nursing students about principles of ethics in health care, and she tells them that the most important principle to observe while taking care of patient is doing no harm. The principle of Ethics she described here is?

a) Beneficence

b) Justice

c) Non-maleficence

d) Respect for autonomy

11. A public hospital of developing country is having a large number of unreported incidents of needle stick injuries and workplace violence and no reporting system and compensation for health care providers is in place for such incidents. As contrast patients are well protected against harassment and spread of Hepatitis B and C infections.

Victims of maleficence here are:

a) Communities

b) Employees

c) Families

d) Patients

12. The overarching, most important consideration regarding the information in informed consent is:

a) It be understood by the patient

b) It must be communicated free of emotion

c) It must be technically accurate

d) It must be delivered in writing

13. The concept Paternalism conflicts with

a) Patient duties

b) Physician duties

c) Patient autonomy

d) Physician autonomy

14. The classification of people as children, intellectually disabled or “pleasantly confused” tells us

a) They can never be guilty of negligence

b) Little about their ability to give informed consent

c) Nothing about their ability to give informed consent

d) Healthcare workers are sometimes cruel

15. According to the ethical principles, the benefits we are obliged to provide as healthcare professionals are specified in part by...

a) Our upbringing and personal values

b) Our relationship, role, and agreements

c) Our employer, the law, our conscience

d) Our contract with the hospital or clinic

16. Which of the following is not relevant to a physician’s determination of who should go first in a triage or emergency prioritization situation?

a) Patient bone injuries

b) Patient blood loss

c) Patient tolerance for pain

d) Patient responsibility for their condition

17. What should you do if you recognize a conflict between the known wishes of a patient and the decision of their surrogate (the patient has recently become incompetent)

a) Immediately call the police

b) Refer the matter to superiors

c) First, do no harm; be ready to seek court intervention

d) First, do no harm, then contact parents or guardians

18. The professional's standard of care and skill establishes the point at which a professional:

a) May or may not charge a fee for services

b) Has the duty to apply "reasonable care"

c) May be judged negligent in the performance of services

d) Has met the minimum requirements for registration

19. To effectively reduce liability exposure, the health professionals should:

a) Pursue continuing educational opportunities

b) Work under the supervision of a senior health professionals

c) Maintain professional standards in practice

d) Provide patient with frequent progress reports

9.3. Annex 3. Questions for in-depth interview

1. What do you think of practice of clinical ethics in your institution look like?

2. Which ethical principle you think health professionals obey most?

3. Which ethical principle you think health professionals violate most?

4. What do you think of factors that affect practice of clinical ethics?

5. Do you think that attitude can affect practice of clinical ethics? What the attitude of health professionals towards ethics look like in your institution?

6. Do you think that knowledge can affect practice of clinical ethics? What the knowledge of health professionals towards ethics look like in your institution?

6. Is there any intervention your institution took to promote practice of ethics?