

ORIGINAL ARTICLE

ETHICS IN HEALTH CARE SETTINGS: PRACTICES OF HEALTHCARE PROFESSIONALS AND PERCEPTIONS OF PATIENTS REGARDING INFORMED CONSENT, CONFIDENTIALITY AND PRIVACY AT TWO TERTIARY CARE HOSPITALS OF ISLAMABAD, PAKISTAN

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Background: Medical profession works within thin lines of professionalism and trust. Faith of the patients often breached but less reported among the Low and Middle-Income Countries (LMICs). In Pakistan, though the Pakistan Medical and Dental Council (PMDC) have its own code of medical ethics but there isn't much evidence on regulating ethical misconducts. Apart from the gross violations of the code of conduct, the "insensible" misuse of informed consent, confidentiality and privacy is very common. This study is an effort to explore practices of informed consent, confidentiality and privacy among health care providers along with assessment of perceptions of patients about ethical practices in two tertiary care hospitals of Islamabad, Pakistan. **Methods:** We conducted eight homogenous Focus Group Discussions (FGDs), four each in both the public and private sector hospitals till the saturation was achieved. **Results:** Informed consent, in clinical practice, was found not being practiced. Confidentiality was not being uniformly applied in practices. Patients perceived the practices being contrary to the ethics. According to patients, ethical measures were found satisfactory in private hospitals. However, patients were not gratified fully with both the systems of healthcare delivery. **Conclusion:** There is insufficient adherence to the ethical principles in clinical practice, in both public and private sector hospitals in Islamabad, Pakistan. Informed consent, privacy and confidentiality are time and time again unheeded due to lack of robust system of monitoring and penalties by the responsible authorities.

Keywords: Medical examination; Discretion; Hospitals; Medical ethics

J Ayub Med Coll Abbottabad 2017;29(3):472-6

INTRODUCTION

The well-known "Hippocrates oath" is based on ethics, but in the contemporary society, this ideal oath is becoming restricted only to recital in convocations.^{1,2} Ethics has been applied in medical profession since ancient Egyptian times. Egyptian papyri dated 16th century B.C, are the first known official papers -dealing with ethics. In that period Hammurabi are set subscriptions according to the societal prestige of the patient and codes were placed down for physicians and surgeons.³ For health care providers, lawful and ethical standards of due care include proper training, expertise and carefulness. A physician is obligated to these standards.⁴ "Code of ethics" is essential in demarcation of a 'profession'.⁵ The problem of ethical violation is further transmitted by dearth of transparency in health care settings as well as inadequate efficacy of regulatory bodies.⁶ Although Pakistan Medical and Dental Council (PMDC) has its own code of medical ethics, still bioethics teaching curricula for undergraduate and postgraduate training programs, are virtually non-existent.⁷ Bioethics teaching needs special attentions in medical schools.⁸ Concrete knowledge of the current system of bioethics, prevalent situations, and patient's perception must be assessed and identified

in Health Care Professionals of Pakistan. Assessment of knowledge and attitude of health care professionals is first step to formulate ethics curriculum for the country.⁹⁻¹¹ A wide array of gap in knowledge and practice must be assessed as due to escalated need.¹² Another prevailing issue is lesser knowledge of code of ethics formed by PMDC; even Helsinki declaration is well-known to few persons. Doctors in Pakistan face ethical dilemmas due to lack of teaching resulting in difference in views between different cadres of doctors about patient's confidentiality and consent.¹³ Moreover, cases where patients are dying due to ill-trained staff are often seen.¹⁴ Dearth of knowledge, capability, professional reliability and pledge to medical ethics and poor accountability are all together hampering the situation on ethical grounds.¹⁵ A study published in Journal of Medical Ethics, argues that the four basic principles-beneficence, non-maleficence, respect for autonomy and justice- are "Good Medical Ethics". If properly understood, this can provide a set of basic moral commitments for the objectives and practice of medicine.¹⁶ PMDC should be more conscious about monitoring the code of conduct of health care professionals.¹⁷

This study was conducted in Islamabad to explore the practices of doctors and perceptions of

patients regarding informed consent, confidentiality and clinical practice in clinical setup. It identifies pertaining issues and then enabling factors that could lead proper implication and practice of code of ethics in health care settings.

MATERIAL AND METHODS

We conducted eight Focus Group Discussions (FGDs) with the groups of doctors and patients in both public and private sector hospitals. The analysis is a reconstruction of the discussion by different participants into richer, more condensed and coherent form. Content analysis was performed over the identified themes of ethical practices of doctors regarding informed consent, confidentiality and privacy.

The study was carried out in two tertiary care hospitals (one public and private, each) in Islamabad. Both hospitals had allied medical and surgical specialties providing 24-hour services. All doctors, male and female, available at medical Outpatient Departments (OPDs) of both the hospitals, and the patients visiting the OPDs from both genders were interviewed.

In total, we used eight FGDs, four each at both the public and private hospitals, each having 6–8 participants, till saturation was achieved, with the same male to female ratio of doctors in each hospital. During morning shifts after the OPD, doctors and patients were asked to come for the focus group discussions. FGD guide enclosed the relevant areas to be discussed on consent, confidentiality and privacy. FGDs had taken 35–40 minutes. Notes taken and audio recording were transcribed within 24–48 hours. Data was kept confidential by assigning codes to the session notes, and preventing unauthorized access.

We conducted content analysis of the FGDs. After every focus group discussion session, the moderator checked the recorded data and completed the notes. Data were further analysed manually using the scissor-and-sort technique. Different coloured fonts were used to mark different topics within the transcript text. After completing the coding process, apart and sorted so that all material relevant to a particular topic is placed together. On the bases of similarities and differences, the data were further categorized and analysed. Finally, more rich and coherent themes emerged from the dispersed data.

Internal Review Board (IRB) of Health Services Academy (HSA), Islamabad granted permission to carry out this research after evaluating the proposal. Written permissions from the hospital authorities and the participants were obtained.

Trustworthiness in this study has been achieved by Lincoln and Guba's Evaluative criteria. Credibility was safeguarded by including study participants of

different characteristics in terms of age, designation, with varied experience. Moreover, field notes, audio recording of the focus group discussions and auditing of transcripts provided the dependability of the data.

RESULTS

We derived following themes from results which shows that importance of informed consent is realized but not usually practiced, confidentiality and privacy of the patients are also wretched the most at public hospital. The said principles are, to some extent, followed by private hospital.

“Informed consent in clinical practice is ethically significant but not adroit”

When inquired about the need of informed consent, one of the strongest answers from the public hospital was *‘I think it is not necessarily needed because when patient comes to consult a doctor then definitely it is his/her wish to do so, that's why he came’*. Other respondent said that *‘In case patient is old and having a co morbidity along with, then his family must be informed and again in case if certain emergencies, it is not even possible to take consent.’*

On the other hand, one of the doctor from private hospital said that *‘Need of informed consent is there actually to assure the autonomy of patient and it increases the confidence of the patient as well.’*

“Priority area of informed consent”

During discussion views were taken about priority areas for necessarily taking informed consent then most of the doctors from public hospital were having the views that *‘it must be taken before all types of surgeries.’* Whereas other respondents said that *“we take it before CPR, CVP and Lumber Puncture. We do take it because for example in lumber puncture, patient's CSF pressure could be too high and after puncturing he can suddenly collapse”*. Interestingly none of them mentioned to take informed consent before examination. Few other responses were as follows *“When we need to expose a female patient then we usually take permission otherwise in OPD like during eye or throat examination, we don't take consent.”* Even in the ward we don't take permission before examination.” Whereas respondents from private hospital elaborated that they have good practice of informed consent before all surgeries, instrumentation and even examination.

“Language barrier while taking informed consent for examination”

During discussion, the doctors stated many difficulties they face during examination due to diverse culture and language. Sometime doctor doesn't know local language so they seek help from attendants, relatives to interpret or from any other colleague who knows that language. Thus, they don't take consent but try to reach to diagnosis only.

“Lack of informed consent results in Potential consequences”

When asked about the results if informed consent is not taken, then the most popular reply from both public and private hospital's respondents was conviction of legal process. The consequence of which is threat to doctor's life and his practice. High risks procedures like CPR, leading to patient's sudden death, were also highlighted as major consequences.

“Underline Problems in taking informed consent”

Various barriers associated in taking informed consent were being highlighted. Doctors stated some other problems as less human resource and more patients. They can hardly give one patient 1 and ½ to 2 min only. There was knowledge gap as well. *One of them said ‘ we cannot take consent in day to day practice due to knowledge gap. For instance, if patient is having plural effusion along with splenomegaly then he will never understand. Consent could be taken from patient only if he knows the benefits or adverse effects. We have low literacy level. To tell patients the whole detail will be wastage of time.* Another concern, while discussing the same issue from government representative was, like *“There are two types of patients, from lower socioeconomic class and from elite class or those who have got some influence at hospital. As patients from elite class want protocols so we usually fulfil the criteria and give them more time. At the same time people from lower socio-economic class, they don't want any protocol regarding procedure to be followed”*.

“Patient's Information (Confidentiality) must not be shared”

It is really important not to tell others about the illness of the patient. It can create psychological pressure on patients. Moreover, patient can feel ashamed and lose confidence.

“Confidentiality in certain situation”

Patient's instant relatives must be informed about the diagnosis, Likewise, another respondent said that *“ in our setup confidentiality cannot be maintained, so attendants of patients must be informed whatever the condition is ”*. Some other respondents were having the view to tell patient about his disease, if he is adult and oriented. If he allows telling others only then his information should be disclosed. Surprisingly one of the respondents said that *“I still don't know what to do in certain critical situation, for example, if a young lady comes who is unmarried as well and she is pregnant so I am surprised how to break this news or whether it should be shared with the family specially parents or not? ”*. Social issues can arise if female patient is from conservative family which was cited by one respondent, who reacted harshly to her

patient when it was found she has functional disorder. Respondents from private sector gave their opinion that instant relatives must be informed.

“Bottle necks for keeping confidentiality up to the mark”

While inquiring from doctors about the hindrance in maintaining the confidentiality in health care settings, most of the respondents from government setup claimed lack of cooperation. There isn't any strategy to get the names of only 3, 4 instant relatives. There was another important view that *“We do have poor health management information system (HMIS) which is less integrated as well”*. When the same question was asked from respondents from private hospital they stated that they have maintained confidentiality to some extent.

“Keeping patient's privacy is important”

When it came to sightsee the reason why it is essential that no one sees the patient when physical examination is being carrying out? Then it was concluded that patient's privacy is very essential

“Loopholes in ensuring privacy”

Focus group discussion moved on towards Major difficulties regarding maintenance of privacy in clinical settings. They don't have sufficient infrastructure, no screen is available in male OPD, though female side has at least one. In wards, there is usually only one screen. On other hand, private hospitals usually have separate consultation room and screens for examination.

DISCUSSION

The findings of this study indicate that there must be an extensive effort to explore the gaps and problems in implementation of code of ethics provided by PMDC. Representatives of government side had a common view regarding paternalism despite of remarkable ethical connotation of informed consent in clinical practice, compare to private hospital who considered it necessary to take informed consent before any procedure. Perceptions from the Patients, demonstrate lack of informed consent in public hospital before examination while in private hospital, patients were satisfied as for informed consent. In 2014, a study conducted at Jamshoro- Sindh, showed the similar results.²⁸ Language is one of the obstacle, though respondents from both public and private hospital stated that they can speak in their local language, if patient don't understand URDU. It was common concern that not taking informed consent can expose them to legal process. Knowledge gap exists among patients and acts as one of the major culprits. A similar Study conducted at South Africa, 2013 showed the same results.²⁴ Sharing patients information with others can cause lose confidence and feeling ashamed. It is clear that only young and

adult patients can be communicated, otherwise things are to be discussed with instant relatives. However, in our setup, female patients are not independent to take decisions about themselves, therefore above statement don't serve the purpose. Similar results found in the study regarding earnestly of code of ethics and confidentiality.²⁵ Respondents from government setup claimed that there is lack of coordination and functional record keeping system in the hospital which plays a major role in keeping confidentiality while private hospital stated that they have maintained confidentiality due to better patient record keeping system. Similarly, at private hospital, patients had a consensus that they were satisfied for maintained confidentiality. A study in 2010, showed the similar results Informed consent and confidentiality were better practiced in the private as compared to the public hospital.²⁷ Privacy of female patients can still be maintained perhaps due to our culture but there is dearth in case of male patients. Another notable cause for improper practice of privacy is over burdening of patients in public sector hospitals, patients are not examined behind the screen not to mention dearth of separate consultation room. Other patients around were listening to what they were talking, serious breach of confidentiality. In private hospitals, these facilities are available. Parallel results have been found in 2010, in a study conducted in Karachi. There has been an obvious progress as compared with the earlier practices of biomedical ethics by the doctors of this public-sector hospital but still much improvement is looked for.²⁶

CONCLUSION

This study has opened a vast window of opportunity to look at the deficits of our health care system, practices of doctors and perceptions of patients and to find the ways to improving it and ensuring the implementation of Code of Ethics by PMDC. During the recent years it has been felt that the knowledge and practice of ethical contemplation among doctors is inadequate. Factors that are linked with poor implication of ethics in health care professions are under the weather highlighted. Ethics teaching and professionalism haven't been a dispensable part of the medical curriculum at all levels. There isn't any visible authority of PMDC for proper implementation of these codes of ethics as per standard protocols. Markedly, there is less Human resource to tackle the flow of the patients. Moreover, there is tiniest awareness of the patients about their legal rights to informed consent, confidentiality and privacy.

ACKNOWLEDGEMENTS

We acknowledge facilitating the conduction of this study by the hospitals in Islamabad, Pakistan, and participants' wilful participation. We declare that there were no whatsoever conflicts of interest in conducting this study.

AUTHORS' CONTRIBUTION

SR: Study design, literature review, data collection, analysis, manuscript writing. EAK: supervising the study, manuscript editing and review. TJ: Manuscript review.

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Received: 11 April, 2017

Revised: 4 May, 2017

Accepted: 4 June, 2017

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