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Common medical ethical issues faced by healthcare professionals in KSA

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المخلص

أهداف البحث: يهدف هذا البحث إلى تقييم معرفة مقدمي الرعاية الصحية في مستشفيات الرعاية المتقدمة في المملكة العربية السعودية بشأن القضايا الأخلاقية الشائعة التي يواجهونها في ممارستهم اليومية ومعرفة طبيعة هذه القضايا.

طرق البحث: هذه دراسة مقطعية تستخدم استبانة ذاتية استكملها الأطباء العاملون في مدينة الملك عبد العزيز الطبية، التابعة للشئون الصحية بوزارة الحرس الوطني بالرياض. تم اختيارهم بواسطة أخذ عينات مباشرة خلال الندوات والمؤتمرات.

النتائج: تم توزيع ما مجموعه ٢٤٠ استبانة على الأطباء، وكان معدل الاستجابة ٨٠٪ بين الأطباء، حيث كان ٦٨٪ (١٣٦) من الذكور و٨٢.٥٪ من السعوديين. وكان متوسط عمر المجموعة ٣٤.٠٨ ± ٠.٤٣ سنة.

تلقى ٦٩٪ فقط (١٣٨) من الأطباء تعليماً رسمياً في مجال الأخلاقيات البيولوجية. وشعر معظم الأطباء (٧٧.٥٪) أنهم بحاجة إلى إرشادات أفضل لمساعدتهم على تحديد القرارات الأخلاقية المناسبة بشأن عدم جدوى العلاج، كما شعر ٥٤٪ من الأطباء أنهم في بعض الأحيان بالغوا في علاج مرضاهم.

الاستنتاجات: وثقت هذه الدراسة أن هناك نقصاً في المعرفة في بعض القضايا الأخلاقية بنسبة كبيرة بين الأطباء. وأن هناك حاجة لتدريس أخلاقيات موحدة لمقدمي الرعاية الصحية، ليس فقط أثناء الدراسة الطبية ولكن أيضاً بعد التخرج وخلال الجولات السريرية.

الكلمات المفتاحية: الأخلاقيات الطبية؛ ممارسي الرعاية الصحية؛ الأطباء؛ المعرفة والتعليم؛ المملكة العربية السعودية

Abstract

Objective: There are growing concerns about ethical issues in the healthcare system. This study was conducted to determine the nature of common ethical issues faced by healthcare providers in a tertiary-care hospital in KSA.

Method: This cross-sectional study comprised a self-administered questionnaire given to the physicians working at King Abdulaziz Medical City Hospital-Riyadh, Ministry of National Guard Health Affairs (KAMC-RD, MNGHA). We used a convenience sampling technique during symposia and conferences.

Results: We distributed 240 questionnaires amongst the physicians and recorded a response rate of 80%; 68% (136) of the respondents were men, while 82.5% were Saudis. The mean age of the group was 34.08 ± 10.43 years. Only 69% (138) of the physicians had ever received any formal teaching in bioethics. Most physicians (77.5%) demanded clear guidelines to help them to take appropriate ethical decisions on therapeutic futility, whereas 54% felt that they sometimes overtreat their patients.

Conclusion: This study reported a lack of knowledge in certain healthcare-related ethical issues in a significant proportion of the physicians. There is a need for a standard educational agenda for medical ethics for healthcare providers, not only during medical school but also after graduation and during clinical rounds.

Keywords: Healthcare professionals; KSA; Knowledge and education; Medical ethics; Physicians

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Introduction

Healthcare professionals frequently encounter ethical dilemmas during their daily practice, such as the ones arising while treating terminally ill patients and disclosing medical errors.^{1,2} Unfortunately, for many decades, ethics teaching has been ignored in undergraduate as well as postgraduate medical programmes, more so in the non-Western world.^{3–5} This has resulted in a significant deficiency in the practice of healthcare ethics on a day-to-day basis by many healthcare professionals.^{6–8} Furthermore, lack of knowledge and practice of medical ethics has led to legal suits against healthcare professionals.^{9,10} This may reflect both increased public awareness of their rights as well as inappropriate practices by healthcare professionals. The basic principles of medical ethics—in particular autonomy, beneficence, non-maleficence, justice, and confidentiality—form the foundation for health professionals to guide themselves and decide what practices are ethical in daily clinical practice.^{11,12}

Over the last few years, interest in healthcare ethics and ethics codes has been evolving as a domain in the medical field.^{13,14} However, healthcare professionals' education, training, and understanding of healthcare ethics' principles and their application in daily practice is still inadequate and needs improvement.^{15,16}

Amongst Canadian physicians, 52% admitted that they never had any formal education in ethics, and 57% said they would seek support from the ethics committee, after its establishment, upon facing ethical issues.⁸ Similar findings were observed amongst physicians in other countries.^{17–19} Yousef et al. performed a cross-sectional comparative survey amongst physicians in different Asian countries, assessing knowledge and application of consent.²⁰ Although the theoretical knowledge was relatively high, its application in their daily practices was not certain.

Similar findings were observed amongst Saudi healthcare providers. Mobeireek et al. reported a clear violation by physicians of the principle of a patient's autonomy when it came to communication of serious diseases,²¹ while Saeed KS documented physicians' failure to recognize major ethical attributes they were assessed for.²² More recent work from KSA has shown increasing emphasis on teaching ethics to healthcare providers, particularly at the undergraduate level.²³ However, this is not enough, and it is important to consider not only teaching bioethics to undergraduate students during school but also after graduation.²⁴

The current emphasis on Western secular healthcare ethics, rather than formulating concepts within the context of individual socio-economic, geo-political, religious, and cultural backgrounds of each society, also may have contributed to the apparently diminished interest in healthcare ethics amongst so many professionals globally.

In this study, we assessed the common ethical issues faced by healthcare providers, how they deal with those in their

daily practice, the major dilemmas associated with each of those issues, and the factors influencing the physicians' decisions.

Materials and Methods

Study design

This was a cross-sectional descriptive study conducted using a self-administered questionnaire. The study objectives were explained to the physicians, and their agreement to complete the questionnaire was considered as consent to participate. The questionnaire was distributed directly during general symposia and conferences as well as at clinics amongst physicians working at King Abdulaziz Medical City Hospital-Riyadh, Ministry of National Guard Health Affairs (KAMC-RD, MNGHA).

We used the questionnaire developed by Donna L Dickenson.²⁵ It consists of eight sections—the first comprises questions about relevant demographic data (age, gender, nationality, religion, profession, and year of graduation); the second asks about the sources of ethical information; the third asks about the respondents' views on therapeutic futility and extraordinary/ordinary treatments; the fourth has questions focused on healthcare provider opinion in certain medical ethical situations (undertreatment, overtreatment, and withdrawing or starting treatment); while the fifth asks about disclosing information to the patient.

The level of healthcare providers' knowledge of and attitude towards advance directives is addressed in the sixth section, whereas the seventh assesses respondents' awareness of existing policy or guidelines at the institution regarding various medical issues, like policy on withholding or stopping mechanical ventilation and documenting reasons for DNR orders. The last section is on the potential sources of intra-staff conflict over different ethical issues, like determination of patients' capacity to take decisions and deciding who should initiate DNR discussions. The questionnaire distributed was in English.

Statistical analysis

The data analysis was performed by IBM SPSS version 24. Descriptive statistics, including means and standard deviations, and percentages, were used to describe the physicians' responses. The categorical variables were compared between the groups using the Chi-Square test, while the numerical variables were compared by t-test/ANOVA.

Results

We distributed 240 questionnaires; 200 physicians agreed to participate and completed the questionnaires, giving us a response rate of 80%. The mean age was 34.1 (SD ± 10.4 years); 68% were men and 82.5% were Saudis.

Two thirds of the physicians were trained in KSA, and 65% had more than 5 years of experience. Amongst the respondents, 79.7% had received formal teaching in bioethics in medical school, 22.5% were self-taught, and 17.4% had learnt bioethics by attending courses or symposia.

Table 1: Socio-demographic data reported as proportions N (%).

| | |
|--|-------------------|
| Age (years) | |
| Mean \pm SD | 34.08 \pm 10.43 |
| Gender | |
| Female | 64 (32%) |
| Male | 136 (68%) |
| Nationality | |
| Saudi | 165 (82.5%) |
| Non-Saudi | 35 (17.5%) |
| Medical college graduation country | |
| Saudi Arabi | 140 (70%) |
| North America | 20 (10%) |
| India/Pakistan and other Asian country | 12 (6%) |
| Europe | 8 (4%) |
| Others | 20 (10%) |
| Received formal teaching in bioethics | |
| During medical school/college | 110 (79.7%) |
| Self-taught | 31 (22.5%) |
| Through courses or symposia | 24 (17.4%) |

Demographic details are shown in Table 1. To avoid presenting too many tables, we have fused a few categories together.

Medical futility and treatment withdrawal

Fifty-three percent of the physicians did not think that the distinction between extraordinary and ordinary treatments is helpful in taking termination of treatment decisions, and 77.5% agreed that there is a need for better guidelines to define futile therapy. There were uncertainties amongst physicians about what constitutes futile treatment or in providing treatment in futile cases, as per the patients' or their families' demands (Table 2).

Although 54% of the physicians felt that the treatment they provide their patients is sometimes overly burdensome, they considered it ethical to continue with that treatment. A clear difference of opinion was detected in the question on whether they have felt they are giving up too soon on their patients and whether or not this is an ethical issue (Table 2).

Table 2: Various questions on many ethical domains.

| Question | Disagree | Neutral | Agree |
|---|------------|-----------|------------|
| | N (%) | N (%) | N (%) |
| Domain: Acceptance of the concepts of medical futility and extraordinary/ordinary treatments—data reported as proportions N (%) | | | |
| The distinction between extraordinary (or heroic) measures and ordinary treatments is helpful in taking termination of treatment decision. | 18 (9) | 76 (38) | 106 (53) |
| Clinicians need better guidelines for help in determining when treatments are medically futile. | 14 (7) | 31 (15.5) | 155 (77.5) |
| Clinicians and patients generally agree about what constitutes as medically futile treatment. | 55 (27.5) | 67 (33.5) | 78 (39) |
| Clinicians are not required to provide medically futile treatment, even if a terminally ill patient or his/her family member demands it. | 84 (42) | 43 (21.5) | 73 (36.5) |
| Domain: Undertreatment, overtreatment, withdrawing or starting treatment—data reported as proportions N (%) | | | |
| Sometimes, I feel that the treatments I offer my patients are overly burdensome, but ethically, I have to continue. | 49 (24.5) | 43 (21.5) | 108 (54) |
| Sometimes, I feel that we give up on patients too soon, and this, for me, is clearly not ethical. | 84 (42) | 45 (22.5) | 71 (35.5) |
| There is no ethical difference between withholding (not starting) a life-support measure and stopping it once it has been started. | 124 (62) | 36 (18) | 40 (20) |
| Sometimes, it is appropriate ethically to give pain medication to relieve suffering, even if it may hasten the patient's death. | 46 (23) | 40 (20) | 114 (57) |
| To allow patients to die by forgoing or stopping treatment is ethically different from assisting in their suicide. | 66 (33) | 34 (17) | 100 (50) |
| To allow patients to die by forgoing or stopping treatment is ethically acceptable. | 98 (49) | 48 (24) | 54 (27) |
| Disconnecting the feeding tube is akin to killing the patient. | 70 (35) | 45 (22.5) | 85 (42.5) |
| All competent patients, even if they are not considered terminally ill, have the right to refuse life support, even if that refusal may ultimately lead to death. | 54 (27) | 34 (17) | 112 (56) |
| It is unethical for patients to let their caregivers decide what treatment is best. | 76 (38) | 58 (29) | 66 (33) |
| It is ethical not to tell patients they are dying, even if they want to know. | 153 (76.5) | 25 (12.5) | 22 (11) |
| It is not always unethical to hasten a patient's death upon his/her request. | 93 (46.5) | 64 (32) | 43 (21.5) |
| Patients should not be informed of different care alternatives as it may be distressing. | 165 (82.5) | 15 (7.5) | 20 (10) |
| Patients will not understand or remember the information they are told about their condition and treatment alternatives. | 144 (72) | 32 (16) | 24 (12) |
| Patients should get the help they need from their families to take decisions about care alternatives. | 17 (8.5) | 36 (18) | 147 (73.5) |
| Ethical issues in a patient's care should be discussed with the staff only. | 121 (60.5) | 47 (23.5) | 32 (16) |
| Ethical issues in a patient's care should be discussed with the patient or his/her family only. | 80 (40) | 45 (22.5) | 75 (37.5) |
| Domain: In your opinion, which of the following are sources of intra-staff conflict— data reported as proportions N (%) | | | |
| Determination of patients' capacity to take decisions | 58 (29) | 82 (41) | 60 (30) |
| Adequacy of the informed consent process | 73 (36.5) | 55 (27.5) | 72 (36) |
| Use of patients in research projects | 61 (30.5) | 85 (42.5) | 54 (27) |
| How information is given to patients and families | 52 (26) | 55 (27.5) | 93 (46.5) |
| Deciding when a treatment is medically futile | 39 (19.5) | 74 (37) | 87 (43.5) |
| What treatment alternative is best for a patient | 53 (26.5) | 52 (26) | 95 (47.5) |

Table 3: Awareness amongst healthcare providers of institutional policy, reported as proportions N (%).

| Question | Physicians (yes) |
|---|------------------|
| Obtaining DNR orders | 143 (71.5) |
| Documenting reasons for a DNR order | 131 (65.5) |
| Requests for organ donation | 94 (47) |
| Recording a patient's wishes in the medical record | 88 (44) |
| Obtaining informed consent | 174 (87) |
| Determining a patient's capacity to participate in decisions | 105 (52.5) |
| Withholding or stopping mechanical ventilation | 72 (36) |
| Withholding or stopping artificial nutrition and hydration | 63 (31.5) |
| How to proceed when ethical concerns about a patient's care arise | 101 (50.5) |
| What to do in case of conflict between the family and healthcare professional regarding a DNR order | 94 (47) |
| Who should initiate DNR | 147 (73.5) |

Regarding withdrawal of treatment after initiating it, 62% had ethical concerns, 20% did not, and 18% were neutral.

When asked if they would prefer to relieve patients' suffering even if this hastened death, 57% said yes. Amongst the respondents, 42.5% equated discontinuation of the feeding tube to killing the patient, but 50% thought that allowing the patient to die by stopping the treatment is different from assisted suicide (Table 2).

The majority of physicians (76.5%) did not think it unethical to not tell the patient s/he is dying even if s/he wants to know.

Patients' participation in decision-making

Seventy-two percent of the physicians thought patients remember what they are told about their condition, while 82.5% considered not telling the patient about alternative therapy to decrease distress unethical; only 10% thought it is ethical, while 7.5% were neutral. Fifty-six percent agreed on patients' right to refuse treatment even if it might lead to death, but they had different opinions on caregivers taking the decision on behalf of the patient. However, most physicians (73.5%) thought that patients should get help from their families to optimize their care (Table 2).

Sources of intra-staff conflict

Regarding the main sources of intra-staff ethical conflict, there were differences in opinion amongst physicians regarding determination of the patient's capacity to take decisions, adequacy of the consent process, and use of patients in research projects. How to deliver information to patients and families, deciding when a treatment is medically futile, and what treatment alternative is best for the patient were not considered factors of intra-staff conflict (Table 2).

Knowledge of local policies

There was a significant deficiency in the physicians' knowledge of the institution's policies governing various ethical issues. Only 44% knew of an existing policy requiring them to document the patient's wishes in the medical chart, and less than 40% were aware of existing hospital policies addressing withholding mechanical ventilation and stopping artificial nutrition and hydration; 47% knew how to deal with the family in case of a DNR order (Table 3).

Discussion

In this study, only one fifth of Saudi physicians agreed that there is no ethical distinction between withholding and withdrawing treatment. Most Western ethicists as well as Western physicians would not distinguish between withholding and withdrawing treatment.^{26–28} In the study by Dickenson,¹⁹ 50% of the attending US physicians agreed that there is no ethical distinction between withholding and withdrawing treatment. This finding amongst our physicians could either reflect the existence of a different ethical perspective from the Western physicians or that our physicians have not fully and deeply considered and thought about the issue.²⁹ The majority of our respondents were not sure when to provide futile therapy, and 78% wished to have a clear guideline for help in determining when treatment is futile. Unfortunately, many practising physicians find it difficult to determine when the treatment is futile, and perception of futility is heterogeneous amongst practising physicians, particularly when the disease prognosis is not clear.³⁰

Fifty-four percent of our physicians felt that the treatment they provide their patients is sometimes overly burdensome. In contrast, Dickenson reported corresponding percentages of 45% for US attending physicians and 78% for US house officers.¹⁹

Another finding highlighting the difference in our physicians' take on existing ethical principles was pain management in a dying patient and what constituted medically futile treatment. When asked if giving pain medication to patients that could hasten their death was ethically acceptable, only 57% of our physicians agreed, as opposed to over 90% in the study by Dickenson.¹⁹ Amongst our respondents, 42.5% equated discontinuation of the feeding tube to killing the patient, as opposed to only 11% amongst the US attending physicians, according to the study by Dickenson.¹⁹

Only 39% of our physicians agreed on what constitutes medically futile or how to handle patients or their families demanding treatment in futile cases. These issues are important and sometimes difficult to handle in view of lacking local guidelines. Therefore, this study highlights the need for local consensus amongst healthcare providers, policymakers, and religious scholars, addressing all the ethical and religious concerns of this difficult issue; in particular, 77.5% of our respondents expressed the need for local guidelines in treating terminal and futile cases.

Most of our respondents had received theoretical teaching on ethics during medical school, which does not address the practical ethical dilemma faced during daily practice after graduation. Furthermore, there is a clear lack of knowledge and awareness amongst healthcare providers of institutional

policy—most are aware about the existing policy on DNR decision, and who will initiate DNR orders and documentation, but there is a lack of awareness of other existing policies; for example, 66% are unaware about organ donation regulations, and 70% are unaware about withholding or stopping mechanical ventilation, or what to do in case of conflict with family, or when to seek advice from the ethics committee. This is very concerning; healthcare regulators should take appropriate measures not only to lay down different policies and procedures related to patient care but also to ensure awareness amongst healthcare providers of such policies and sharing of the information with trainees. Furthermore, such policies should be taken up for discussion during institutions' educational activities and included in resident and trainee curricula.

Most of the exposure to healthcare ethics for our respondents occurred in medical school, and became limited after graduation. This study was done in a tertiary-care university hospital in the capital of KSA, where one would expect availability of educational sessions and materials on practical healthcare ethics issues.

This study affirms previous national and international findings of much needed continuous education on medical ethics, especially after healthcare providers' graduation from medical schools.^{15,19–21,24,25,31–34} The finding of healthcare providers' deficiency in various work ethics domains is not unique to KSA. Many studies show a similar lack of knowledge amongst healthcare providers on several ethical issues in daily practice.^{7,15,19,32,35–38} Our findings indicate that healthcare providers need more teaching and training in ethics. In a study from the USA, it was reported that medical students and residents supported ethics teaching initiatives in various topics and clinically-based teaching.³⁷ The situation in other parts of the country and other institutions may throw up more deficiencies, and therefore, a national assessment is needed. Another major problem in teaching ethics is the lack of faculty development and a scarcity of qualified ethics teachers.³⁹

Conclusion

The current study affirms the need for more educational sessions to practise healthcare ethics for healthcare providers in KSA. It also calls for national guidelines addressing end-of-life issues.

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Conflict of interest

The authors have no conflict of interest to declare.

Ethical approval

This study has been approved by King Abdullah International Medical Research (KAIMRC) ethics committee RR11/169.

Authors contributions

FA, AA, and YA participated in the study concepts, design of the study, development of the questionnaire, and data acquisition and entry. HA, AA, and AA contributed in data analysis and statistical analysis of the data, participated in the intellectual content, reviewed and summarized the published literature and clinical studies, and participated in outlining the result themes and manuscript preparation, editing, and review. Corresponding author HA takes responsibility for the integrity of the work as a whole. All authors have critically reviewed and approved the final draft and are responsible for the content and similarity index of the manuscript.

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