Original Article

The major medical ethical challenges facing the public and healthcare providers in Saudi Arabia

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ABSTRACT

Background: Despite the relatively high expenditure on healthcare in Saudi Arabia, its health system remains highly centralized in the main cities with its primary focus on secondary and tertiary care rather than primary care. This has led to numerous ethical challenges for the healthcare providers. This article reports the results of a study conducted with a panel of practitioners, and non-clinicians, in Saudi Arabia, in order to identify the top ten ethical challenges for healthcare providers, patients, and their families. **Materials and Methods:** The study design was a cross-sectional, descriptive, and qualitative one. The participants were asked the question: "What top ten ethical challenges are Saudis likely to face in health care?" The participants were asked to rank the top ten ethical challenges throughout a modified Delphi process, using a ranking Scale. A consensus was reached after three rounds of questions and an experts' meeting. **Results:** The major 10 ethical issues, as perceived by the participants in order of their importance, were: (1) Patients' Rights, (2) Equity of resources, (3) Confidentiality of the patients, (4) Patient Safety, (5) Conflict of Interests, (6) Ethics of privatization, (7) Informed Consent, (8) Dealing with the opposite sex, (9) Beginning and end of life, and (10) Healthcare team ethics. **Conclusion:** Although many of the challenges listed by the participants have received significant public and specialized attention worldwide, scant attention has been paid to these top challenges in Saudi Arabia. We propose several possible steps to help address these key challenges.

Key words: Bioethics, ethical issues, ethics priorities, medical ethics

INTRODUCTION

Saudi Arabia is the second biggest Arab country, with a surface area of 2,150 thousand sq km, and a population of 25.5 million, about 7 million of whom are non-Saudis.[1-4] It is the leading Muslim country, as two of the most holy sites for Muslims (Makkah and Madina) where millions come to worship and work every year, are located here.

Compared to other countries in the Eastern Mediterranean Region, it has one of the highest gross national incomes per capita and expenditure on health (USD 22,300 and 6.4% (as percentage of gross domestic product (GDP)), respectively.[2,5]

Despite this relatively high expenditure on health (5% of GDP),[5] most of the facilities in the healthcare system remain largely concentrated in the three main and most densely populated cities,[4] namely: Riyadh, the political capital with18% of the Ministry of Health (MoH) hospitals and 18% of the Primary Health Care Centers (PHCCs) for 6.2 million people; Jeddah and Makah with 9% of the MoH hospitals and 7.5% of the PHCCs for a population of 4.9 million; and the Eastern Region, including Dammam and Qasim, which has 15% of the MoH hospitals, and 13.4% of the PHCCs for a population of 3.4 million.[4]

The development of the healthcare system in Saudi Arabia began in 1925, when a Public Health Department was established by a Royal decree. The first school of nursing

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was opened in 1926, followed by the School of Heath and Emergencies in 1927.

In 1951, the Ministry of Health was established. Since then, the health services have expanded immensely. From 1970 to 1980, the health services were predominantly curative. However, the concept of primary health care (PHC) became popular in the early 1980s; when the World Health Organization (WHO) slogan 'Health For All' (HFA) gained recognition. By a ministerial decree in 1980, the establishment of health centers was initiated. Currently, the Ministry of Health has 1848 PHC centers and 200 hospitals under its jurisdiction.

There is growing international literature that discusses the ethical issues relating to healthcare systems in industrialized countries, although these generally deal with specific specialities or a given group of patients. A leading study done by JM Breslin and colleagues identified the top ethical challenges that patients and their families in the healthcare system in Toronto, Canada, face. A modified Delphi study was conducted and the top ten ethical challenges that Canadians confronted within their healthcare were identified. The top three challenges in their study were: (1) disagreement between patients / families and healthcare professionals about treatment decisions; (2) waiting lists; and (3) access to needed resources for the aged, the chronically ill, and the mentally ill, respectively.[6]

Likewise, other studies were carried out to identify the national ethical problems related to the healthcare system,[7] the clinical situations doctors and nurses perceive as 'ethical problems',[8] and to describe the ethical issues deemed as highly important to oncology nurses.[9] The conclusions reached by these studies reflected the ethical issues close to those revealed by the Canadian study as frequently encountered, such as problems in the healthcare reform process, professional interactions, and doctor–patient relationships.[7,10] The top three priority ethical issues for oncology nurses were assisted suicide, end-of-life decisions, and pain management.[9]

However, the literature relating to medical / clinical ethics in Saudi Arabia remains limited in terms of volume and scope. Most of these studies focus on the Islamic perspective of some clinical practices such as organ donation,[11,12] do-not-resuscitate (DNR) orders, and end-of-life issues,[13,14] or other issues like patient satisfaction.[15] A study that is worthy of note was conducted by Kalid Bin Saeed, to compare the views of physician executives and clinicians on ethical issues in Saudi Arabian hospitals and the contributory factors leading to the presence of these ethical issues.[16] However, the ethical issues that confront the Saudi healthcare system and public were not adequately studied, nor was there any attempt to collate and prioritize them.

This study is aimed at defining, collating, and ranking the major ethical challenges encountered in the healthcare system in Saudi Arabia, as perceived by the healthcare providers and the public. It also proposes an approach to the management of these ethical issues in line with other international studies, especially the Canadian study by Breslin and colleagues.

MATERIALS AND METHODS

The study design was cross-sectional, descriptive, and qualitative. The study area included the three main Saudi cities of Riyadh, Jeddah, and Dammam, as well as other smaller cities (Taif (west) and Tabuk (north)). The study population included: Members of the ethics committees in the major health institutions (hospitals), who taught or had experience in medical ethics and medical administration, and academic staff from 10 hospitals in the selected areas [Table 1]. The data was collected from February to May 2010. Out of 110 participants, 90 replied in the study period, giving a response rate of 82%; and 83 (75.5%) provided their professional and contact information. The participants were male and female clinicians and medical doctors, 46 (55%) and 12 (15%), respectively; medical doctors in public health and community medicine 12 (14%); eight (10%) non-medical hospital staff; and five (6%) pharmacists and other paramedical technicians.

Participants from military hospitals were civilian staff without rank in the armed forces.

The justification for the use of a panel of clinicians and ethics committee members rather than community

Table 1: Hospitals included from each city and the sample size in each

City and hospitals	Participants (N)
Riyadh	34
King Fahad Medical City (KFMC)	
King Faisal National Guard Hospital (KFNGH)	
Military Hospital	
King Khalid University Hospital (KKUH)	
Jeddah	24
King Faisal Specialized Hospital (KFSH)	
King Abdul-Aziz University Hospital (KAUH)	
Dammam	8
Dammam Central Hospital	
King Faisal Specialized Hospital	
Others	24
Taif — Military Hospital	
Tabuk — Military Hospital	
Total	110

members was that it was expected that they would provide a better insight into the overall ethical challenges than community members, because of their work.

Data collection tools and analysis

A modified Delphi process was conducted in three rounds. In the first round, 110 participants were asked to write down a list of what they perceived as the top 10 medical ethical challenges to health care. These forms were then collected, listed, and ranked by the researchers. The ranked data was again sent in the second round to all the members. They were asked to rank the items from that list again as the top 10 ethical issues facing healthcare providers and return them to the researchers.

In the third round, after ranking the obtained ethical issues from all participants' responses, the list was sent again to the participants to indicate their agreement or otherwise to the ranking. They were requested to re-rank the items as they saw fit. If they did not agree with what they were sent, the re-ranked responses were returned by the participants to the research team.

On receipt of the participants' re-ranked forms, a meeting of experts of a select group of health professionals was held, to choose the top 10 medical ethical problems facing the Saudi population from the medical health professionals' point of view.

At the experts' meeting, an open session was held to: (1) unify the definitions of the problems; (2) select the top 10 ethical problems; and (3) re-rank these problems using a scale that depended on the following four items: (1) Size of the problem; (2) seriousness of the problem; (3) feasibility of solving it; and (4) status of public awareness of it. Each one of these items was put on a scale of one (+; the lowest score) to 4 (+s), the highest score.

Later, the experts were put into two groups and each group was given a list of the ranked items and asked to rank the top 10 ethical problems facing the Saudi care providers. At the end of these sessions, the top 10 ethical problems that the Saudi providers faced were formulated and approved.

RESULTS

Out of 110 participants, 90 replied in the study period giving a response rate of 82%. Following the first round, 32 ethical issues were identified, the top three of which were: Patients' rights (55; 61%), confidentiality of patients' information (41; 46%), and medical negligence / error (31; 34%). The least important were: Language barrier, private sections in public hospitals, and nursing practices (2, 2, and 1%, respectively).

The participants' ranking in the second round was identical to the first round. Patients' rights, patient confidentiality, and medical negligence / error were ranked the highest of the ethical issues.

The third round and the meeting of the panel of participants resulted in the underlisted top 10 medical ethics problems facing the Saudi population, from the participants' point of view [Table 2].

DISCUSSION

The presence of a centralized healthcare system in a culturally diverse population and healthcare providers may give rise to a set of ethical issues. For example, the ethical issues related to patients' waiting time for medical attention, lack of comprehension resulting from cultural differences, the language barrier between the healthcare providers and the patients, and issues relating to eligibility to health care. For instance, Saudi patients in many peripheral areas have to travel to one of the main cities to seek healthcare. Therefore, the introduction of an organized approach to handle these ethical issues, among others, is needed.

Table 2: Top 10 medical issues facing the saudi public from the health professionals' point of view

Items	Size of the problem	Seriousness of the problem	Feasibility of solving the problem	Status of people's awareness	Total
Patients' rights	4	4	4	3	192
Equity of resources	4	4	3	4	192
Confidentiality of the patients	4	4	3	3	144
Patient safety	4	4	2	4	128
Conflict of interests	4	4	2	4	128
Ethics of privatization	4	4	2	4	128
Informed consent	4	4	3	2	96
Dealing with opposite sex	4	3	2	4	96
Beginning and end of life	4	4	2	2	64
Healthcare team ethics	3	3	3	2	54

In addition to the results of rankings [Table 2], the panel members' comments during the meeting were taken as the basis for this discussion.

The highest ranked medical ethical challenge within the public in the healthcare system was the issue of *patients' rights*, whereas, in the Canadian study, the first priority was the disagreement between patients / families and healthcare professionals on decisions of treatment.[6]

The only known national document is the 'Manual Guide for Medical Practitioners' issued to provide guidance to practitioners in Saudi Arabia. This clearly states the right of patients to: the access of 'good' treatment; give consent for any medical intervention; confidentiality of his / her medical information; and the right to refuse treatment against medical advice.[17] Since it is only a document that 'guides', the onus has been on the main hospitals to develop their Patients' Bill of Rights. Unfortunately, this is still in the process of being formulated, finalized, and endorsed.

The second highest ranked ethical challenge facing the public in the healthcare system is *equity of access to resources*. The equity of distribution of health resources is a major issue in the Saudi healthcare system, as most of the resources are primarily in the main cities. Besides, there are inequities even within the cities and among Saudis and non-Saudis. Few exceptions are made for patients with some serious diseases, such as, tuberculosis and dengue fever, who should have access to free management, regardless of their legal status. This is an issue that needs to be addressed, for it is unlikely that an illegal resident would dare seeking medical treatment in a governmental hospital. Bin Saeed also draws attention to the more sensitive issue of, 'favoring patients based on their race or gender', which is considered an important ethical issue by 83.6% of the clinicians in his study.[16]

The health resources are mainly distributed in favor of the specialist hospitals, that is, secondary and tertiary institutions, leaving the primary care and preventive care centers at a disadvantage. In the Canadian study, this issue was ranked the third most important because it was found that a major part of the funds was directed toward acute, live saving care, while long-term, rehabilitation, and mental healthcare were grossly underfunded.[6]

The third highest ranked ethical challenge facing the Saudi Healthcare system was *confidentiality of patient information*. The panel underscored the importance of this issue, which had to be given serious attention. There are no clear policies on the management of patient information, specifically the medical records, in many hospitals. The management of these records is usually left to the discretion of the clinician. This includes decisions on sharing any information about the patient without the proper consent of the patient. Unlike patients' rights, not much effort is being made to develop policies on information security. This was also a finding made by Kahlid Bin Saeed, who indicated that 80% of the clinicians in his study had stated that patient confidentiality was a major ethical issue in their hospitals.[16]

The most probable reason is that patients are unlikely to know that their confidential information has been shared, and therefore, are less likely to file a complaint against the treating doctor or the hospital. With an increasing number of patients suing their treating doctors in Saudi Arabia , the main hospitals have taken preventive measures, including the development of certain policies that mandate a physician to take an insurance policy against medical errors before registration in the Saudi Council for Health Specialties.

The fourth ranked ethical challenge was *patient safety*; this comprised their physical, emotional, and social safety. This issue was not considered one of the top 10 ethical challenges in the Canadian health care. The problem could be linked to the previous one, in that, a physician's feeling of insecurity made any potential source of 'doctor–patient' conflict an ethical priority. Despite the danger to themselves the moral responsibility of the doctors to look after their patients' safety, remains paramount.

The fifth ranked ethical challenge chosen by the panel was the *Conflict of Interests*. The panel dealt with many issues here. Included were, the relationship between the healthcare team and the pharmaceutical, medical equipment, and companies that traded in medical supplies, especially during the conduct of research in which patients were participants. It also included ethical issues relating to privatization and doctors practicing in both public and private hospitals. No sustained effort has been made to formulate a clear policy on the conflict of interests within the main hospitals where the study took place.

The sixth ranked ethical challenge facing the public in Saudi Arabia was the *ethics of privatization*. According to the panel members, this item comprised many important issues, especially as health insurance was going to be made obligatory in the next few years. The panel members also drew attention to the fact that some physicians worked in the private sector during their official working hours, when they were supposed to be at their posts in government

hospitals. This necessarily affected the time they had to devote to their patients in governmental sectors. Besides, their patients were sometimes advised to go to the private hospitals for their follow-up in order to avoid a long waiting list.

Other issues relating to the private sector included the concern that doctors were inclined to request more investigations for patients than was necessary, as also the problem of exorbitant fees charged by some private facilities. Moreover, employment by some private facilities of poorly trained health professionals, could affect patient safety. This issue was not considered an important ethical issue in the Canadian study, because of the nature of the Canadian health system, which depended almost exclusively on public funds.

The seventh challenge facing the public in Saudi Arabia was *Informed Consent*: There was a lengthy discussion on this matter for many reasons. The patient / family members tended to sign the form for informed consent hurriedly without carefully reading a document with many difficult medical expressions, which neither the patient nor his / her family member could comprehend. Language was another issue. As many of the personnel working in the Saudi health sector are foreign, and therefore, unable to speak Arabic well, communication with a patient and / or his / her family member, who had to sign the consent form, became a problem. It is estimated that Saudi nurses represent only 22% of the total working force of nurses in the country.[18]

The next ethical challenge in healthcare in Saudi Arabia is, '*How to deal with the opposite sex*', that is, when male doctors have to examine female patients and vice versa. As the practices of the Saudi community are based on Islamic ethics and rules, this is a sensitive problem, especially when a male healthcare provider has to deal with a female patient. It is worth mentioning that this is permitted in Islam only under special circumstances, for example, when no competent female doctor is available for a male doctor to examine a female patient.

The ninth ethical challenge facing the public in Saudi Arabia was the matter of *the beginning and end of life*. This sensitive issue discussed by the panel has created much controversy between family members and the medical team. It has become more complicated because of the large amount of money used to purchase sophisticated equipment and supplies, which consequently have raised the expectations of patients and their families for a better quality of life as well as a longer life. Although mentioned in the Canadian study discussion, it was not one of their major ethical problems.

The tenth ethical challenge facing the public in Saudi Arabia was: The Ethics *Health Care Team*. This refers to ethical issues relating to disagreements, disputes, or even conflicts among the healthcare team members. The problems vary according to the attitudes of physicians and their colleagues toward one another and other professionals. This situation gets complicated because of the lack of clearly defined job descriptions, which lead to disputes or even conflicts within the health facility.

Apart from the top ten ethical issues, other important issues were raised, although not listed. These related to the language barrier and relations within the healthcare team, Islamic medicine, and ethics of Muslim doctors. The last issue is important in Saudi Arabia, which is a symbol of the modern Islamic state. Discussions revealed differences between the historical Islamic practice of medicine[19] and western teaching, which most of the Saudi doctors had undergone . Moreover, the differences between the ethical and practice standards in the western hospitals where they were trained and what was obtained in this country aggravated this divergence.

CONCLUSION

The major 10 ethical issues as perceived by the participants were: (1) Patients' Rights, (2) Equity of resource distribution, (3) Confidentiality of patients, (4) Patient Safety, (5) Conflict of Interests, (6) Ethics of privatization, (7) Informed Consent, (8) Dealing with the opposite sex, (9) Beginning and end of life, and (10) Healthcare Team Ethics. However, this list was not exhaustive. The results of this study were intended for comparison with those of the Canadian study. Differences were indeed expected because of the differences in culture and healthcare systems of Saudi Arabia and Canada. Unlike the Canadian study, this study included the opinions of administrators and legal representatives.

Although many of the challenges listed by the participants have received significant public and specialized attention worldwide, very little attention has been given to these top challenges in Saudi Arabia.

The higher authorities in the health delivery system hierarchy have to initiate more in-depth discussions on the ethical issues, in order to ultimately bring about changes in policies, particularly on resource allocation. Although a code of ethics need not lay down rules that are set in stone , it can provide guidance to deal with ethical issues as they arise.[16]

The top ethical issues reflected the national and cultural peculiarities of the Saudi population and health system. However, one can reasonably assume that the issues discussed will be applicable to other countries of the region that share the Arabic-Islamic moral values. Differences will, however, remain, as there will be issues that arise from different health delivery systems.

Limitations of the study

This study focused on major ethical issues without providing an exhaustive list. The results were intended for comparison with those of the Canadian study by Breslin and colleagues.[6]

The main limitation relates to the ability to generalize the results within or outside Saudi Arabia. First, the study did not include the smaller underserved rural hospitals that could have revealed another set of ethical issues, although the issue of equity in access to resources was listed among the top five issues.

Second, although the study tried to involve non-clinicians, the dominance of Saudi male clinicians in the selected sample could have given the results and conclusions a clinical bias. This also partly explains why no ethical issues dealing with paramedical staff and their relationship with doctors were mentioned. As the Delphi process was not stratified, the peculiarities of the different settings were blurred. For instance, in this methodology, regional and gender differences and those related to the type of the health facility were indistinct. In addition, it appeared that there was no definite consensus on the meaning of some terms used.

Finally, there was also the fact that communication with the participants of the study was basically electronically supported by some phone calls and faxes. Moreover, the modified Delphi model, presented the possibility of some members dominating the discussions in the face-to-face expert meeting. However, the organizers did their utmost to prevent this from happening.

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