ORIGINAL ARTICLE

Barriers to Compliance with the Codes of Medical Ethics at Hospitals Affiliated with Jahrom University of Medical Sciences in 2016

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ABSTRACT

Background: Medical ethics are responsible for modifying behaviors and setting standards of occupational behaviorsamong doctors and medical staff. Knowing barrier of complianceofmedical ethic codes help health policy maker for planning to better patient care and their satisfaction .

Aim: To determine the barriers to compliance with the codes of medical ethics at hospitals affiliated with Jahrom University of Medical Sciences in 2016.

Methods: This is a mixed method(quantitative-qualitative) study conducted on the health care staff at hospitals dependent to Jahrom University of Medical Sciences in 2016. In the quantitative section, the stratified random sampling method was used to select 194 nurses and doctors from all the wards of hospitals dependent to Jahrom University Of Medical Sciences). The quantitative information collection tool was a two-part questionnaire consisting of demographic items andquestions in 3 parts (management, environmental and individual-healthcare) . In the qualitative section, data collected by in-depth semi-structured interviews, recording voices and taking field notes. The sampling process was carried on until the data were saturated..

Results: As a results, the prevalence of barriers concluded management barriers (75.17%) environmental barriers (80.2%) and the individual-healthcare barriers (65.73%) above average. The most important environmental barriers to compliance with professional ethics was the crowdedness of wards (70.2%), insufficient healthcare staff (nurses and doctors) (58.9%) and inaccuracy due to heavy workload (52.6%). There were not significantly different in compliance with the codes of medical ethics in different areas at those hospitals, sex, working history, educational level and fields (p-value>0.05) Finally,3 theme and 9 subthemes were obtained from qualitative part.

Conclusion: According to the research results, they should also eliminate most of barriers to medical ethics in order to implement standards of medical ethics in the best possible way.

Keywords: medical ethics, barriers, doctors, nurses, medical ethics cods .

INTRODUCTION

Medical ethics is a science studyinga series of acceptable or unacceptable behaviors with which medical staff should comply. In fact, their relationships and behaviors are compared to general ethics[1].

Maintaining patient respect and dignity, complying with patient rights, and adhering to ethical standards have significant effects on the treatment process of patients in medicine. On the other hand, since doctors deal with the lives of people, their behaviors and ethical decisions become more important. However, what is the criterion for knowing a moral action[2].

Thus, Western principles of medical ethics are accepted in Islam; however, the meanings of Western culture definitions are different from what we believe in[3].

With many developments in different areas of medicine and technology, there have been new ethical problems and subjects making it difficult and complicated to reach moral decisions in medicine. It is also necessary to have a systematic and comprehensive look at the ethical responsibilities of healthcare providers[4].

However, it is advised to pay attention to the fundamental differences between the ethical principles of Iran's religious culture and those of the Western secular society. In other words, it is necessary to pay heed to people's intention of providing medical services, soul purification, and moral virtues[5].

Unfortunately, doctors face some problems in certain communities, especially developing communities such as Iran, due to the fundamental

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defects of healthcare system. Such problems reduce the quality of services and decrease the physical and spiritual powers of doctors even if they do not lead to immoral and unprofessional directly[6,7].

Relevant studies show that the criteria for professional ethics are notcomplied appropriately at least by Iranian nurses[8].

According to Sokhanvar, the awareness and use of ethical principles were not evaluated to be satisfactory in clinical healthcare and decisions made by nurses as the medical staff of Shiraz University. In other words, nurses were not able to benefit from ethical knowledge in a real workplace[9].

A comparative study was conducted on how nurses understand ethical problems in China and Switzerland. According to the results, Chinese nurses were more nervous and upset during or after work. An unethical discomfort and incompliance with the principles of professional ethics, resulting from the inappropriate supervision of healthcare responsibilities, form another dimension caused by organizational barriers[7].

Some of the barriers to the solution for ethical problems include the lack of knowledge about ethical standards, material motives, perfectionism, fear of criticism and inspection, personality and professional immaturity, and the lack of an ethical decision-making model[2].

Designing and understanding the codes of professional ethics can serve as a guide to ethical performance in ethical activities and determine certain responsibilities, the compliance of which can result in high-quality services[10].

Therefore, ethical codes are a very common tool used to enforce professional ethics in the medicalprofession. A method of enforcing professional ethics is to codify, teach, and monitor the compliance with the codes of professional ethics. It has become prevalent in many countries. National and international professional organizations have codified and approved some codes which are all meant for validation through clinical services despite some apparel differences in practice[11].

An important result of complying with the codes of professional ethics is the facilitated implementation of clinical governance. Other results include actions taken to mitigate dangers for staff and patients, in-time and impartial identification of complications and important events along with their reasons, paying attention to complaints made by patients, the use of best available evidence to make clinical decisions, self-evaluation of performance, and the results of clinical interventions[12].

Ethical codes can be classified as eleven principles: respecting patients, teaching patients, respecting colleagues of the therapeutic team, accountability, improving professional knowledge and empowerment, managing conflicts of interests, commitment to justice, improving the quality of healthcare, and commitment to the maintenance of dignity[13].

Therefore, the aim of this study was to investigate the barriers to compliance with the codes of medical ethics at hospitals affiliated with Jahrom University of Medical Sciences.

METHODOLOGY

This is a mixed method (quantitative-qualitative) study conducted on doctors and nurses at hospitals affiliated with Jahrom University of Medical Sciences in 2016. In the quantitative section, the stratified sampling method was used to select 194 doctors and nursesfrom all wards on different shifts atPeymanie and MotahariHospitals(hospital dependents to jahrom university of medical sciences . The quantitative information collection tool was a two-part questionnaire, the first of whichconsisted of demographic items (age, gender, name of ward, and work experience). The second part includedthe exclusive research question (11 management items, 4 environmental items, and 13 individual-healthcare items) designed to evaluate the barriers to compliance with the codes of medical ethics at hospitals affiliated with Jahrom University of Medical Sciences. The data were designed in a five-point Likert scale (1- no comments, 2- nothing, 3- low, 4- medium, and 5- high). The validity and reliability of this questionnaire were confirmed by Dehghani*et al*[14]

To collect data in the qualitative section, the key individuals were given in-depth semi-structured interviews by recording their voices and taking field notes. The purposive sampling method was used in the interviews to select a wide range of individuals including nurses and doctors having different work experiences in both genders to maximize the content validity. Then each participant was given a semi-structured interview for 30-45 minutes. To comply with ethical principles in this study, the interviews were recorded using digital devices by having the consent of participants and ensuring the confidentiality. During the research, a certain code was used instead of names for participants to comply with confidentialityand they were assured that the interview would be used solely for research purposes and would be extinguished after the end of the research.The sampling method was carried on until the saturation of data when no new responses were observed in the interviews. Lundman and Graneheim's conventional content analysis method was used to analyze the qualitative data[15].

In this method, the interviews are reviewed many times. Then data are divided into semantic units (codes) in sentences and paragraphs related to the main meaning. The semantic units are reviewed several times. Then the proper codes of each semantic unit are written, and codes are classified and compressed according to conceptual and semantic similarities. Finally, data are put into main classes which are more general and conceptual, and the themes are abstracted[16]. The accuracy criteria for content analysis are thought to be credibility, transferability, reliability, and confirmability[17].

The entire interview texts, codes, and classes were given to two experts of qualitative research to examine transferability. Moreover, a combination of methods was used to collect data from interviews and take field notes. Efforts were made to consider the necessary diversity in the selection of samples. Different individuals participated in the interview conducted in doctor, clinical, and nurse groups with different work experiences and ages. In this way, the content validity of data improved. Regarding the interplay between groups, a process was devised to record all of the activities accurately. Participators and external supervisors were then used to evaluate the strength of data. The written content was given back to the participators again to ensure the explanation of concepts and principles extracted from their comments. The comments of external supervisors were used to extract the themes and subthemes. In other words, the extracted codes and semantic units were given to three external supervisors. Then the consistency of codes, themes, and subthemes was evaluated, and the Holst's methodwasemployed to calculate the coefficient of agreement among individuals[18].

In the quantitative part, the descriptive statistics (percentage & mean) and analytic statistics as a (Mann-Whitney U test and Kruskal-Wallis test) were conducted to compare the mean scores of participants. The data were analyzed in SPSS 18.0 at an 0.05 level of significance.

RESULTS

Quantitative Research: After deleting the participants who did not fill out the questionnaire completely, the information of 194 individuals was analyzed. Descriptive data reported in table 1.

According to results, the prevalence of management barriers was 75.17% above average with 37.37% at a high level. The prevalence of environmental barriers was 80.2% above average with 43.12% at a high level. Finally, the prevalence of individual-healthcare barriers was 65.73% above average with 27.38% at a high level.

According to the doctors and nurses working at the hospitals of Jahrom, the most important environmental barriers to compliance with professional ethics were the crowdedness of wards (70.2%) and unusual expectations of patients and their companions (49.5%). The most important individual-healthcare barriers were the insufficient healthcare staff (nurses and doctors) (58.9%) and long working hours (52.1%). Finally, the most important management barriers were time shortage (51.3%) and inaccuracy due to heavy workload (52.6%) (Table 2).

According to the results of the Mann-Whitney U test, men and women were not significantly different in compliance with the codes of medical ethics in different (environmental, management, and individual-healthcare) areas at hospitals affiliated with Jahrom University of Medical Sciences (p-value>0.05; Table 3).

According to the results of the Kruskal-Wallis test, different clinical wards were not significantly different in compliance with the codes of medical ethics in different (environmental, management, and individual-healthcare) areas (p-value>0.05) Table 4.

Qualitative part: Three main themes and nine sub-themes were extracted from 16 interviews and 110 resultant codes. In the table below, only the extracted themes and sub-themes are listed.

Inappropriate health care system: People believed that an inappropriate health care system, including poor rules, poor policies andpoormonitoring can provide grounds for violating and lack of compliance with ethical codes. Accordingly, sub-themes of Inefficient rules, inefficient monitoring, and inefficient infrastructure were extracted from this theme.

Inefficient rules: In interview No.1, An Anesthetist's Technician states that"*patient privacy and dignity were not complied with. Patients are not shown enough respect, either. For instance, patients are not covered properly in the operating room where they are defenseless and exposed. The doors may be open, and frequencies are not monitored. If the rules were taken seriously, ethics would not be violated*."

Inefficient Monitoring: In the case of Inefficient monitoring, people also believe that if there are specific indicators for monitoring compliance with ethical and professional codes, the issue will be more relevant and important. In this regard, in interview No. 2 one of the emergency supervisors believes that "*lack of monitoring is one of the factors that leads to violating codes being broken, this is so, because we do not have a clear indicator of this*".

Inefficient Infrastructure: According to individual's view point, inappropriate treatment infrastructure and failure to comply with professional standards is one of the themes which could provide violation of ethical codes.

In interview No. 4, an anesthesiologist says that "*one of the important and effective barriers is failure to provide sufficient information to staff and doctors, people's longevity, lack of facilities, and the most important reason is the scarcity of time and heavy workloa*d"

Nature and education: Individuals believed that the nature and the infrastructures of individual personality were factors that could affect the creation of professional commitment and the implementation of ethical rules. In this regard, the sub-themes of commitment, interpersonal communication and needs can be expressed in this theme.

Commitment: The first sub-theme of this section is commitment. Individuals consider commitment as responsibility for doing healthcare procedures that prevents violations of ethics and professionalism, and provides grounds for adherence to professional ethics. So that, in interview No. 6,an experienced operating room technician stated that "*A patient visited the emergency. The patient was reported to a relevant specialist. The patient was not examined before the operation. Upon the admission of the patient into the operating room, the doctor was present at the patient's bed. Therefore, there was a poor relationship between the doctor and the patient. This means not having commitment to the pt*."

Interpersonal communication: Communication is one of the elements that isdealt with in this section and in the theme of nature and education. By creating an inappropriate process of communication between the patient and the medical staff and then in the inter-professional relationship, inappropriate interpersonal communication can provide a ground for violating codes of ethics.

"In interview No. 10, *another hospital supervisor says that, "misbehaving with the patients, especially those in the obstetric ward, is not suitable . They treat a patient like an animal*".

Needs: Of other sub-themes is the need of medical staff who have financial needs and lack of support and attention are some of the prominent issues that can obscure professional ethics & ethical codes of conduct.

In interview No. 11 one of the nurses believed that "*crowdedness was one of the reasons depriving patients of the necessary period of time. The lack of financial motivations, insufficient information, and too many shifts are also effective…*

Poor Educational structure: Of the main themes of this research were the weakness in the educational structure, which includes sub-themes of ineffective education, weaknesses in monitoring and weakness in the culture of education. The people believed that poor educational structure, along with weakness in education, monitoring and the culture of internalization of ethics, could play an effective role in defect ofethical codes.

Inefficient Education: Inefficient education is one of the issues that, along with the incompetencyof medical personnel and of educates of different fields of medicine, can provide grounds for violation of the codes of conduct. In interview on No. 13, another pediatrician stated that "*ethics training in education is weak. Each of us has taken some course of ethics, but we have never given us a proper way how to behave properly*. "

Poor Monitoring: In interview No. 14, one of the participants from anesthesiologists said "*problems are more frequent in cases where the doctor is inexperienced or unable to control stressful situations. so thatappropriate people are selected for these disciplines, both mentally and physically. also need to evaluate staff in clinical wards ad their care*

Poor Educational Culture: The weakness in Educational culture is also one of the issues that little has been done in training and internalizing it.

In interview No. 16 an old-handed nurse believed that "*in larger cities, customers are completely familiar with their rights. They even know about their legal affairs. They are aware of what time they can defend themselves. However, this occurs less often in the hospitals of smaller towns. Therefore, the patients must demand these codes and become acquainted with their right*s."

Table 1: The Descriptive Statistics of Demographic Variables in the Study

Variable	Subgroup	Frequency	Percentage
Gender	Female	143	73.7
	Male	51	26.3
Hospital	Peymanie	132	68.0
	Motahari	62	32.0
Ward	Surgery	52	26.8
	Internal	40	20.6
	Emergency	36	18.6
	Women	36	18.6
	CCU	17	8.8
	ICU	16	8.2
	pediatric	5	2.6
	Eye	5	2.6

	Neurology	1	0.5

Table 2: Compliance with the Codes of Medical Ethics at Hospitals Affiliated with Jahrom University of Medical Sciences

Area		No Comments	Nothing	Low	Medium	High	Above-Average Total Weighted Mean	High Total Weighted Mean
Environmental(4)	Crowdedness of Wards	1(0.5)	2(1)	8(4)	48(24.2)	139(70.2)	80.2%	43.12%
	Circulating Shifts	3(1.5)	9(4.5)	51(25.8)	91(46)	44(22.2)		
	Unusual Expectations of Patients and their Companions	1(0.5)	7(3.5)	21(10.6)	71(35.9)	98(49.5)		
	Lack of Knowledge about Criteria for Professional Ethics	9(4.5)	10(5)	35(17.6)	84(42.2)	61(30.7)		
Management(11)	Time Shortage	1(0.5)	5(2.6)	18(9.2)	71(36.4)	100(51.3)	75.17%	37.37%
	Inaccuracy due to Heavy Workload	3(1.5)	4(2.1)	22(11.3)	63(32.5)	102(52.6)		
	Doctor-Nurse Distrust	5(2.6)	11(5.7)	52(26.9)	89(46.1)	36(18.7)		
	Unusual Behaviors of Patients	3(1.5)	2(1)	39(20.1)	88(45.4)	62(32)		
	Negative Attitudes towards Criteria for Medical Ethics	11(5.8)	17(9)	50(26.5)	83(43.9)	28(14.8)		
	Dealing with Infectious Patients and Fear of Infectious Diseases such as AIDS and Hepatitis	2(1)	17(8.7)	50(25.6)	70(35.9)	56(28.7)		
	Lack of Motivation and Interest in Job	7(3.6)	34(17.4)	56(28.7)	54(27.7)	44(22.6)		
	Dissatisfaction of Basic Needs such as Income or Breaks	5(2.6)	10(5.1)	41(21)	74(37.9)	65(33.3)		
	Dissatisfaction with the Ward	3(1.6)	28(14.6)	38(19.8)	70(36.5)	53(27.6)		
	Lack of Technical Skills	4(2.1)	18(9.4)	62(32.5)	72(37.7)	35(18.3)		
	Lack of Critical Thinking and Ethical Decision Making	9(4.6)	17(8.7)	55(28.2)	81(41.5)	33(16.9)		
	Lack of Effective and Appropriate Relationships with Patients	4(2.1)	30(15.4)	53(27.2)	71(36.4)	37(19)		
	Disbelief in Compliance with Ethical Codes	6(3.1)	31(16.1)	39(20.2)	79(40.9)	38(19.7)		
Individual-Healthcare(13)	Imbalance between Working Hours and the Number of Shifts	1(0.5)	8(4.1)	25(12.8)	85(43.4)	77(39.3)	65.73%	27.38%
	Insufficient Medical Staff (Doctors and Nurses)	0(0)	6(3)	6(3)	69(35)	116(58.9)		
	Long Working Hours	1(0.5)	4(2.1)	16(8.3)	71(37)	100(52.1)		
	InsufficientRetraining and Training Courses	6(3.1)	9(4.6)	43(22.1)	83(42.6)	54(27.7)		
	Lack of Written Policies or Standards Related to Medical Healthcare	11(5.6)	10(5.1)	33(16.8)	80(40.8)	62(31.6)		
	Insufficient Experience in Ethical and Legal Problems of Education	5(2.5)	17(8.6)	44(22.3)	72(36.5)	59(29.9)		
	Insufficient Necessary Trainings in Ethics	5(2.6)	16(8.2)	30(15.4)	81(41.5)	63(32.3)		
	Inappropriateness of Job and Educational Degree	11(5.6)	34(17.4)	47(24.1)	56(28.7)	47(24.1)		
	Insufficient Ethical and Legal Support by Managers	6(3.1)	17(8.7)	27(13.8)	76(39)	69(35.4)		
	Lack of Appropriate Equipment and Facilities in Wards	6(3.1)	8(4.1)	42(21.4)	65(33.2)	75(38.3)		
	Biological Changes of Body in Night Shifts	5(2.5)	10(5.1)	25(12.7)	75(38.1)	82(41.6)		

Table 3: Comparing the Scores Men and Women in Different Areas

Area	Gender		p-value
	Male	Female	
	Median (IQR)	Median (IQR)	
Environmental	13 (12-14)	13 (11-14)	0.178
Individual	38 (33-41)	37 (32-42)	0.901
Management	33 (28-37)	34 (30-38)	0.172

Table 4: Comparing the Scores of Different Areas in Clinical Wards

Area Ward	Environmental	Management	Individual
	Median (IQR)	Median (IQR)	Median (IQR)
Internal	13 (11-14)	34 (27-38)	36.5 (30.5-41)
Surgery	12.5 (11-14)	31 (29-37)	36 (30-40.5)
Neurology	12 (9-15)	26.5 (17-36)	32 (32-32)
CCU	13 (11-14)	36 (31-37)	39 (35-42)
ICU	13.5 (11.5-14.5)	35.5 (33.5-38.5)	40 (33-44)
Emergency	13 (12-14)	35 (33-39)	37 (35-39)
Women	13 (12-14)	32 (26-37)	37 (32-45)
Eye	13 (12-15)	33 (33-39)	40 (40-40)
Post CCU	11 (11-12)	29 (33-24)	41 (25-43)
p-value	0.922	0.090	0.412

Table 5: Main themes and sub-themes

Themes	Sub-themes
Inappropriate health care system	Inefficient rules
	Inefficient monitoring
	Inefficient Infrastructure
Nature and education	Commitment
	Interpersonal communication
	Needs
poor educational structure	Inefficient education
	poor monitoring
	poor educational culture

DISCUSSION

According to the research results, 71.55% of doctors and nurses believed that there were above-average barriers to compliance with the codes of medical ethics at the hospitals affiliated with Jahrom University of Medical Sciences. Moreover, only 37.94% of them believed that there were many barriers to compliance with the codes of medical ethics. In a study conducted by Borhani*et al.*, it was observed that all of the participants (students) stated a kind of positive feeling and enthusiasm toward professional ethics[19].

It was also observed that doctors and nurses believed that the majority of barriers to compliance with the codes of medical ethics were environmental; however, the lowest rate of such barriers were observed in the individual-healthcare areas. Zareh*et al.* observed that environmental factors had the most significant role in incompliance with the codes of professional ethics compared with other factors[20].

The results of a study conducted by Dehghani*et al.* were consistent with the current research results. Accordingly, environmental factors were regarded as the most important dimensions affecting incompliance with the criteria for professional ethics in the eye of nurses[7].

It was also observed that the most important barriers to compliance with professional ethics were management, time shortage, inattention and inaccuracy due to heavy workload, and inattention to interpersonal relationships. Dehghani*et al.* also indicated that management, lack of personnel, and inappropriate working shifts were the most important barriers to compliance with the criteria for professional ethics in nursing performance.[7]

However, Benne*etal.*reported that time shortage and insufficient personnelwere the most important barriers which nurses had to overcome to use research evidence and comply with professional ethics in healthcare .[21]

According to Morocco *et al.*, nurses are usually in close contact and appropriate situation to support patients; however, they had not assumed such a role in Greece due to insufficient personnel, insufficient time, and the absence of appropriate training in such areas[22].

Other important barriers were insufficient nursing personnel, heavy workload, time shortage, and financial and organizational constraints. It was difficult for nurses to regard ethical performance and decisions as a priority in their daily healthcare activities[23].

According to Dehghani*et al.*, the most important environmental barriers to compliance with the criteria for professional ethics were the crowdedness of wards, unusual expectations of patients and their companions, and biological changes of body at night shifts[7].

In the present study, the role of inappropriate medical treatment and non-standard environment in violating ethical codes were addressed.

According to the results of a comparative study conducted on the nurse perceptions of ethical problems in China and Switzerland, Chinese nurses

suffered more from anger and discomfort due to heavy workloads and insufficient rest.

However, both Chinese and Swiss groups of nurses experienced inappropriate relationships with patients in this study[24].

These results are consistent with the findings of the present study about the importance of the relationship with the patient and the relationship between inappropriate profession in violating ethical codes. Therefore, providing doctors and nurses with more relaxation times can help them comply with professional ethics better and more effectively[24].

The expressed issues regarding not satisfying the needs of the medical staff were among the issues addressed to in the present study.

Marier *et al* indicated that compliance with professional ethics was not significantly related to variables such as age, gender, and work experience. However, an individual's performance is related to the type of ward[25].

According to other findings, inefficient education was another barrier to compliance with professional ethics among doctors and nurses. Grandtin conducted a study entitled Ethical Decision-Making Processes Used by Healthcare Providers and indicated that the inability of doctors and nurses to make the right ethical decisions and comply with acoherent pattern in this regard. It was mainly due to the lack of necessary trainings in ethical subjects[26].

In the present study, the weakness in teaching and internalizing ethical principles was mentioned as one of the important issues.

Poor monitoring of doctors and nurses was reported to be another barrier to professional ethics. According to Callahan, the absence of objective standards of testing ethical competencies is another barrier to qualifying such competencies[27].

Poor observation and monitoring was also mentioned as one of important factors in the present research.

CONCLUSION

According to the research results, environmental factors were regarded as the most important barriers to compliance with medical ethics in clinical healthcare in the eye of doctors and nurses. Therefore, it is essential that healthcare systems make accurate and appropriate plans to provide and balance environmental factors. They should also eliminate most of the barriers to medical ethics in order to implement the standards of medical ethics in the best way possible.

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