

# Ethical Issues in Health Care in Kenya. A Critical Analysis of Healthcare Stakeholders

Githui Donatus (corresponding author)

School of Business, Kimathi University College of Technology

P O Box 657-10100, Nyeri –Kenya.

E-mail: [frdonatusmathenge@yahoo.com](mailto:frdonatusmathenge@yahoo.com)

Designation: A research paper on managing healthcare professionals in Kenya.

## Abstract:

The main aim of this paper was to examine and analyze the ethical and moral issues in the healthcare systems in Kenya, with special emphasis being given to physician performance, nursing care and professionalism. The research was carried out in 8 (eight) provinces of Kenya, due to their cultural similarity and findings established. Research questionnaires were prepared and hand delivered to top administrators, employees, students pursuing healthcare professions, religious leaders and patients as well as private cooperates, government officials in Kenya especially in research regions. The paper employed ethical theories such as virtue ethics theory, deontological ethics theory, ethical learning and growth theory. Teleological ethics, utilitarian theory and ethical principles such as autonomy, beneficence, non-maleficence, double effect, confidentiality and informed consent to build its content.

The research involved survey approach to get responses from the eight provinces. An analysis of the data was carried out using principal component analysis. A major finding was found to be the weakening influence of the healthcare institutions to instill ethical concerns on the physicians, nurses and other members of society on healthcare management in Kenya.

It was recommended that ethics should be employed to help in healthcare management and reinvent the affected parties especially the patients, nurses, physicians and healthcare institutions at large. This was to involve healthcare management aided by ethical theories and values of humane living, through establishment of ethical committees whose members live by ethical standards of honesty, integrity, commitments and accountability. This paper is purely ethical and first in its entirety in Kenya to focus on ethics as a tool of enlightening and controlling healthcare institutions in Kenya.

**Key Words:** Healthcare systems, physicians and nurses, ethical theories and principles, performance and professionalism.

## 1. Introduction

The health care and medical sections are the key pillars that any country can ever boost of because its greatest wealth is health. The life of the citizens will depend largely on how effective and efficient the healthcare and medical fields are handled and managed. Until recently, philosophers took little interest in medical practice or physicians' codes of ethics. Since the 1960's, however, they have joined physicians, theologians, and lawyers in founding journals, research centers, hospital and medical school committees, departments, programs, and special degrees in medical ethics and bioethics. This exponential growth invites differentiation of medical ethics (primarily, physician-centered) and health care ethics (including nurses and other healthcare providers), clinical ethics (focused on hospital case decisions with the aid of diverse

committees and consultants), and bioethics (including general issues of reproduction, fair distribution of organs and other scarce life-saving resources, and protection of the biosphere) as researched on by Holmes & Purdy (1992).

Developing countries like Kenya still face critical issues in its healthcare systems. Some of these issues include brain drain to fast developing countries like South Africa, Europe America and the Middle East, causing human personnel in the healthcare sector to be outweighed by the rising population of patients. In Kenya specifically, healthcare personnel especially the doctors and nurses work long hours before taking breaks, low emoluments with no job compensation. These often causes most of its qualified young doctors and nurses not only have low motivation and concentration in their vocational jobs but also great temptations to look for better well paying jobs in the private sector and foreign countries who have expressed either directly or indirectly their need for such doctors and nurses from many third world countries.

The management of healthcare systems in Kenya needs urgent reforms with respect to employee motivation, human relationship skills and performance rewards. This ought to start right away from the training institutions, where medical doctors and clinicians undergo their professional training. The relationship between the healthcare service providers and the patients in Kenya is still not well developed and many a times, most patients have been given wrong medical diagnosis and prescription because of lack of proper communication relationship.

The government of Kenya through the Ministry of health ought to find immediate solutions to healthcare facilities in public hospitals, as the private sector is largely setting up a competitive base both to the government and mission hospitals which have been giving complementally medical services and nursing care to Kenyans since the beginning of the 20<sup>th</sup> century. The role of the government of Kenya through the Ministry of health, being a public service, there is need to ensure that its benefits are afforded by the poor patients. With regards to compensation, the government ought to increase 'hardship and other employee benefits' ( Mwabu & Wang'ombe, 1998) in the public healthcare sector, so as to retain its well qualified personnel that are being offered good pay packages in some fast developing countries like Rwanda, Botswana, and South Africa.

Since the mission hospitals are also giving health services to Kenyans, the government through the ministry of health should rethink of the best ways to second medical doctors and nurses and also modern equipment and facilities in this sector. Contrary to the current situation, the mission hospitals physicians, nurses and drugs were donated by the mother churches. That is why the mission hospitals focus on service and not profit. Today, although the churches which built and managed them would like to continue with the health care services, they are facing a major crisis in terms of capital, human resources and modern medical equipments. Goodwill by itself is not enough in a modern competitive world especially when the government and private sectors have an advantage. It is common knowledge that mission hospitals are practically in all provinces of Kenya especially in areas where the common people are economically and financially disadvantaged coupled with poor infrastructure. Many times there are the only medical option for many people in the remote rural areas of the country.

Similarly, good compensation will increase service delivery in the public hospitals as more nurses, physicians and medical doctors will be satisfied and therefore well able to deliver. The rate at which doctors are setting up private hospitals in Kenya is alarming as some of these hospitals do meet the set standards in facility equipping, and some of its health service providers in these hospitals are permanent employees of the government, who because of low pay and drive for more money, refer patients to their hospitals for medication.

The 2002-2008 Kenya government development plans indicated that, the health targets attained in the past have been reversed by the impact of HIV/AIDS coupled with poor economic performance (GOK, 2002). Even where facilities exist, they suffer from shortages of trained personnel, inadequate supplies and poor

management, all translating to limited services (MOH, 2004). The high cost of western pharmaceuticals puts health care services out of reach of a big proportion of African population especially the poor.

Most abortion do not take place in public hospitals, rather they take place in private hospitals, which are driven by desire to make money using even illegal means like abortion. This has resulted in untold maternal abortion and deaths which have occurred because of lack of qualified personnel in the private hospitals. This is also against the Kenya's constitution regarding right to life, (Cap 4 Sec 26(4)). Therefore whatever professional training as discussed on by Kamunge (1993), which nurses, pharmacists and doctors undergo, there is dire need for ethical and moral integration in their courses to act as a guide in their careers.

Those physicians and nurses who work in mission hospitals are urged by their churches and religions to follow their consciences and continually educate these same consciences following the provided 'medical ethos' and terms of employment which state clearly that life begins at conception and ends in cardiac arrest and brain death, uphold sanctity of human life and that abortion is murder, (Monge 2003). Although all Kenyans of various persuasions may not agree on this aspect of abortion and sanctity of life, various churches and religious bodies have already made their position known especially during the recent referendum of the constitution where the majority of Kenyans voted against churches teaching on this matter.

It is true that the medical professionals and nurses are 'impatient with theoretical courses like ethics, psychology and philosophy' as argued by Kamunge (1993), but however, these very disciplines contain lessons about societal values that can be applied in any profession be it medicine, education or business. Focusing on the scientific researches in the laboratories is always the target for most clinical professions and in the process fail to complete, realizes the importance of disciplines such as ethics which in its values like responsibility, justice and fairness can be a great contributor to the outcomes of healthcare systems in Kenya and in any developing country.

Principal topics in medical ethics and healthcare according to Howard (1987) and Buchanan & Brock (1989) include: physicians' paternalistic deceptions and violations of patient confidentiality; the rights of patients or their surrogates to refuse life-sustaining treatments or request assistance in dying; drug experiments on children, demented or dying patients, and other incompetent or desperate patients; bias-free definitions of health, death, disease, and futility of treatment; removing viable organs from patients who are brain dead or in cardiac arrest; grounds for fetal testing, selection, and abortion; involuntary hospitalization and treatment of mentally disturbed people; conflicts of interest between physicians and their employers and third-party payers, public and private.

Physician-philosopher collaboration on this range of topics has posed meta-ethical questions about the role of professional codes, religious principles, ethical theories and principles, committee consensus, clinical experience, and moral intuitions in the analysis and decision of clinical cases. As clinicians increasingly share or preempt medical ethics teaching in medical schools, the issue of appropriate philosophical training has arisen. Clinical ethics like medical ethics, bioethics and healthcare ethics ought to be the daily lead in clinical and other healthcare service provision in Kenyan hospitals as inferred by Arras & Steinbock (1998).

The government has set laws and regulations regarding the conduct of public officers, however to be precise, sanity and success in healthcare service provision in Kenya cannot be achieved by a decree but by employing professional codes, religious principles as argued by John Paul II (1990), ethical theories and principles as argued by Gichure (1997) and Oruka (1990). Wisdom ought to be applied in the management of healthcare systems in Kenya as argued by Huang (2008), that 'a strategy without tactics is the longest road to victory. Tactics without strategy is the noise before defeat', hence the need for wisdom is relative to healthcare management and reinvention of its entire operations.

#### 1.1.1 Problem statement

Ethics ought to be a major component of the Kenyan healthcare system. As technology advances, laws are developed to govern the developments; however ethics are used to shape and influence the practical application of the processes before the laws are created. Even in fields that are dictated by legal guidelines, ethics are important contributors to the behavior of the professionals within the market. The development of law in a particular field narrows the discretion of providers in making ethical judgments as inferred by Fox *et al.* (2007). However, ethical behavior calls healthcare providers to conduct themselves in a manner that is beyond the demands of what is legal; it also asks them to behave in a manner that is ethical according to the guidelines of their profession.

Within the Kenyan systems, ethics and moral issues, especially within the healthcare field, are of major concern. These issues are regulated and assessed in many ways, including through legal mandates and laws, professional societies, and the clinical consultation of ethicists. Often, organizational mission statements help to guide the application of ethical concepts within the scope and practice of their services. There are many applications of ethical issues in the management and execution of healthcare that may be overlooked on the assumption that they are ethically neutral issues (Williams & Torrens, 2008).

However, despite the postulation that these issues do not have an ethical basis for consideration, they have a significant impact on the application and utilization of healthcare services, therefore having an ethical basis for consideration. It is important that these issues be regulated and correctly assessed and addressed in order to properly meet patient needs while maintaining appropriate levels of healthcare function. The failure to equate these issues with other matters of ethical importance would be detrimental to the successful management of a healthcare organization. This is what my research ought to propose that be inclined in the healthcare systems in Kenya.

#### 1.1.2 Research objectives

The research consisted of two categories of objectives, the general objectives and specific objectives.

##### 1.1.2.1 General Objectives

The general objective was to critically establish the ethical and moral issues in medical and healthcare systems in Kenya in tune with relevance to professionalism and performance delivery among the healthcare service providers in Kenya.

##### 1.1.2.2 Specific objectives

- (i) To identify the status, problems and the needs of medical service, nursing care and healthcare institutions in strengthening their role in protection of life through Meta ethics.
- (ii) To investigate how ethical theories, principles and values can contribute to healthcare management and ethical operation in the healthcare institutions and how these institutions can improve the fit between professional productivity and effectiveness.
- (iii) To establish some medical and clinical ethics that should be adopted by healthcare institutions towards nurturing an all round persons who are ethically and morally inclined to serve and deliver without seeking halls of fame.

#### 1.1.3 Justification and significance of the paper

Health of the people is important for national development, yet the poor are burdened by diseases. It is important to assess the performance of the healthcare institutions and advice on the health structures that support the health of the population towards their sustainable development, attainment of Kenya vision 2030 and millennium development goals.

With respect to relevance, the paper will have a greater benefit and use by the policy and law makers in the healthcare sector, to consider establishing ethical committees with hospitals that can act as a guide to management, operation and conduct of healthcare personnel. The government will find this paper of potential value especial with regard to clinical ethics in the healthcare systems in Kenya, and most importantly the government may adopt some of the proposals regarding the improvement of the working environment of healthcare personnel, restricting sprouting of unauthorized private health care institutions from being set up by individuals who may not be willing to save life but earn meager profits from poor and hopeless citizens and walk an extra mile in assisting non profit mission hospitals with qualified doctors, nurses and modern equipments

Similarly, with respect to training and education in the healthcare fields, the paper will be of benevolent use to trainers in integrating clinical ethics as other requirements for satisfactory and qualified health professionals. This, when applied in conjunction to ethical theories, religious principles and ethical values, then reformed but highly relied on healthcare professionals will be an edge for Kenya.

#### 1.1.4 Hypothesis formulation

The research had one main hypothesis denoted H

*H:* Applying ethical theories and principles in healthcare systems in Kenya will be a key driver towards improving the overall life and welfare of Kenyan population.

### 1.2 Literature Review

A physician's ethical response in all professional activities is necessarily coloured by the depth and breadth of his concept of health (Monge 1994). Morality is never a watertight compartment cut off from life; rather, it represents the whole meaning of human activity and relationship as argued by Kant in Stumpf & Fieser (2003). Such is the framework within which a number of health questions will now be discussed. Our attention turns to the physician-patient relationships, physician-society relationship, physician- institution relationship and meta-ethical and pedagogic issues in the health care operation in any opposition.

#### 1.2.1 Physicians and Patients relationship

In the interests of justice, efficiency and harmonious relationship, it is important for both physicians and the patients to appreciate their individual roles. Dunn (1994) argued that the doctor is the 'servant' of the patient but not the 'patient's slave'. Similarly the doctor does not have authority over the patient, but rather, only as an adviser to the patient.

Traditional medical oaths and codes, prescribe a physician's character, motives, and duties. Typically they portray ideal physicians as devoted to the welfare of patients and to advancement of the medical profession and medical knowledge, responding compassionately to the suffering of patients, humbly mindful of the limits of their curative powers and the harms they may unintentionally cause. The Hippocratic injunction "Strive to help, but above all, do no harm" is the ruling maxim as inferred by Dunn (1994). In current discussion, this maxim has been codified in oft-cited "principles of non maleficence and beneficence,"(Olafson 1994).

Although still supported by religious texts and medical tradition, this ideal physician is increasingly criticized as "paternalistic," too willing to act on judgments of a patient's best interests without the patient's knowledge or consent (Howard 1987). To treat without consulting a patient is to assume that a patient does or should share one's own assessment of the risks, benefits, and burdens of treatment. But current hospital specialists, it is said, rarely know their patients (or themselves) well enough to make this assumption without serious risk of ignorant arrogance. Given hospital hierarchies, such paternalistic physicians are seen to resemble Victorian patriarchs (Arras & Steinbock 1998).

Some physicians reject such criticism as intervention by lawyers, philosophers, feminists, and other social critics ignorant of the realities of medical and hospital life. But the "neo-paternalists" admit that physicians should attend more carefully to a patient's desires and to give them greater weight in arriving at a treatment of choice (Buchanan & Brock 1998). Un-mollified critics, however, continue to insist that treatment choice belongs to the patient, however imprudent, and not to the physician, however 'attentive and knowing' (Rachels 1998). To curb Hippocratic paternalism they define a range of patients' specific rights to be told about, and choose among, alternative treatments, including a right to refuse all, even life-saving treatment as discussed by Gillon & Lloyd (1994).

These rights confer adult status on patients whom paternalists regard as children, replacing quasi-familial with quasi-legal relations. A patient's "free and informed consent" reflects an implicit therapeutic contract, defined and reviewed as treatment proceeds (Kamm 1996). A physician who treats without such consent is not a patriarch, but a batterer. Less litigiously, these rights define a "principle of autonomy" traced to Kantian notions of respect for persons and inherent human dignity (Olafson 1970).

The principle of 'autonomy' recognizes the rights of individuals to self-determination. This is rooted in society's respect for individuals' ability to make informed decisions about personal matters (Olafson 1970; Haring 1972 and Howard 1987). Autonomy has become more important as social values have shifted to define medical quality in terms of outcomes that are important to the patient rather than medical professionals. The increasing importance of autonomy can be seen as a social reaction to a "paternalistic" tradition within healthcare (Haring 1972. Some have questioned whether the backlash against historically excessive paternalism in favor of patient autonomy has inhibited the proper use of soft paternalism to the detriment of outcomes for some patients. Respect for autonomy is the basis for informed consent and advance directives (Howard 1987).

Psychiatrists are often asked to evaluate a patient's capacity for making life-and-death decisions at the end of life. Persons with a psychiatric condition such as delirium or clinical depression may not have the capacity to make end-of-life decisions (Arras & Steinbock 1998). Therefore, for these persons, a request to refuse treatment may be ignored. Unless there is a clear advance directive to the contrary, persons who lack mental capacity are generally treated according to their best interests (Williams & Torrens 2007). On the other hand, persons who have the mental capacity to make end-of-life decisions have the right to refuse treatment and choose an early death if that is what they truly want (Howard 1987). In such cases, psychiatrists should be a part of protecting that right although bioethicists and theologians in some religious traditions are totally against a patient or any person to choose an early death or any right for euthanasia. The society does condemn such inhuman acts. Just as other rights of psychiatrists can rationally have justification even those of such religious traditions must be respected by medical practitioners.

### 1.2.2 Physicians and Institutions relationship

These shifts reflect changes in medical practice from home and office to hospital and clinic. Physicians have become members of teams treating patients in institutions governed by internal routines and external guidelines from government, insurers, and corporate owners (and, secondarily, religious authorities in some instances). Increasingly decisions are delegated to "bioethics committees" which include nurses, lawyers, social workers, chaplains, philosophers, citizen representatives, patient advocates, and other non-physicians (Howard 1987). Even if physicians dominate these care teams and hospital committees, their moral virtues or religious faith no longer confer moral authority (John Paul II 1990). Any decisions must be articulate, defensible for both content and procedure and often, even in religious medical centers, by secular considerations (Pallegrino & Thomasma 1993).

Often, simple communication is not enough to resolve a conflict, and a hospital ethics committee must convene to decide a complex matter. These bodies are composed primarily of health care professionals, but may also include philosophers, lay people, and clergy - indeed, in many parts of the world their presence is considered mandatory in order to provide balance (Arras & Steinbock 1998). Members should include a

person with knowledge and experience in professional care, counseling or treatment of humans; a minister of religion or equivalent, e.g. Aboriginal elder; a layman; a laywoman; a lawyer and, in the case of a hospital-based ethics committee, a nurse (Pallegrino & Thomasma 1993). The assignment of philosophers or religious clerics will reflect the importance attached by the society to the basic values involved

### 1.2.3 Physicians and Society relationship

These clinical or micro-matters lead to larger issues of medicine as a public good, publicly supported and allocated. The increasing scope and costs of hospital medicine have prompted restraint and rationing in matters of drug prescriptions, elective surgery, in-patient hospital stays, out-patient services (Howard 1987). In response, philosophers have proposed contractarian and natural law rationales for age-relative distributions, as well as 'utilitarian' analyses of cost-efficient allocations of treatment and research funds (Olafson 1994).

These macro-issues raise questions about physician's social and political responsibilities. Most physicians recognize narrow public health and safety obligations to report a patient's communicable diseases, gunshot wounds, signs of child abuse, or serious violent intentions —socially motivated exceptions to traditional pledges of confidentiality (Holmes & Purdy 1992). But what of obligations is it necessary to work toward a more just system of healthcare? Such a system might well limit both physician income and professional choices even more than current corporate organization of medical care (Fox *et al.* 2007). Physicians might, for example, be less free to refuse poor or poorly insured patients. Physician autonomy would become subject to a redefined or renewed "social contract" between the profession and the society which educates, licenses, and grants its various privileges (Gregory 1993).

As these social issues emerge, medical ethics becomes less focused on the doctor at the bedside as they look for patients with lucrative diseases like hypertension, dialyses for kidney failure and heart surgery. Relationships between doctor and patient are increasingly linked with those between doctor and hospital, hospital and insurer or corporate owners and stockholders, and the ill and the healthy members of society, the rich and the poor. In short, the field has become less iatrocetric, expanding into the larger domain of health care ethics and clinical ethics (Gregory 1993; Kamm 1996 and Beauchamp & Childress 1994).

### 1.2.4 Metaethical and Pedagogic Issues

Medical centers are a primary context for medical ethics, as well as medical care. Whether physicians, philosophers, or theologians, most medical ethicists are primarily based in medical schools and teaching hospitals, and their principal audiences are (apart from one another) medical students and residents (Kamunge 1993). This setting partially explains the primary role of actual case analysis in medical ethics, by contrast with much ethical writing. Physicians and nurses have little patience with the theoretical dialectic or fanciful test-cases that constitute much current secular ethics (Buchanan & Brock 1989).

Nor do they readily accept the main theoretical alternatives. The Kantian ideal of persons as rational ends-in-themselves is hard to reconcile with the reality of patients whose mature judgment, sense of self and self-interests, and dignity are subverted by illness (Olafson 1994). Likewise, the scope of the Hippocratic maxim, "Strive to help but above all, do no harm" is far narrower than the Utilitarian principle, "Everyone counts for one and no more than one", (John Paul II 1990). Some physicians will give some weight to the welfare of a patient's family, hospital staff, or future patients (e.g. in drug trials unlikely to benefit current patients), but they will almost certainly ignore the friends, heirs or employers who may be seriously affected by treatment decisions (Pencel 1995).

In the light of practitioners' resistance, some medical ethicists have forsaken ethical theories that have a single, dominant principle in favor of the jurist's tactic of "balancing" several unranked principles (Engelhardt 1996). Decisions are to be reached by "weighing" for each case the now canonical principles of autonomy, beneficence, and non-maleficence, and, when appropriate, veracity, sanctity of life, and

distributive justice (Percival 1975). The content and methods of medical ethics teaching varies with audience and locale. In philosophy department classes, cases are used to raise general, often abstract issues of moral reasoning and moral theory, the definition of central concepts (autonomy, death, causal connection), and metaphysical presuppositions (personal identify, body-mind relations) as argued by Reich (1995) and Veatch (1997) . In most medical schools, there is little appetite for such abstract matters, and too little curricular time to convince students and clinical co-teachers of their relevance to the pressing clinical issues and cases at hand. We should not be surprised there is no ‘Socratic dialogue with Hippocrates’ (Stumpf & Fieser 1994).

### 1.2.2 Operational framework of research variables

The operational framework was based on one broad objective of the ethical issues healthcare institutions and systems in Kenya as shown in figure 1 of the notes section.

Other specific variables included;

- (i) The relevance of ethical application in healthcare systems could foster effective delivery from the professionals.
- (ii) Professionalism in healthcare management can be improved if ethics is largely employed.
- (iii) The quality of performance by the physicians and nurses can be influenced if the systems are built on ethical theories and principles.(note)

## 1.3 Research methodology and Design

### 1.3.1 Instrument and Instrumentation

The survey instrument was pre-tested on groups of 20 healthcare institutions in each province of Kenya. Ambiguous questions were deleted or reworded for clarity. Demographic items included top administrators, employees, students pursuing healthcare professions, religious leaders and patients as well as government officials in Kenya. Eight hundred questionnaires were hand delivered to a cross section of top clinical heads, physicians and patients, from the accredited health institutions in Kenya. A total of 792 questionnaires were returned, netting a response rate of 96.2 percent. An attempt was made to include all the participants in the sample, and all of the returned questionnaires were usable in the final data analysis.

Quantitative data is analyzed by using descriptive statistics and other standard quantitative methods, which included Principal component analysis (PCA) and the Chi-square. Data collected from the survey was entered into the statistical package, SPSS (statistical package for social science) for analysis, discussion and presentation of the results in this research. To analyze the demographic information, the descriptive statistics are entered onto a Microsoft Excel sheet.

### 1.3.2 Findings and Results

From the responses of the demographics, the following results were established. Based on the results of the principal component analysis and multivariate analysis from the chi-square, a variance of 66% was deduced from the relevancy of the ethical programs to the needs of healthcare management as responded to by leading clinical heads, physicians as well as patients. Based on the professionalism and performance, each scored 50% as responded to by the clinical heads when assessing the performance of fresh graduates from colleges.

The employment of ethics in healthcare management in Kenya was after analysis by the principal component analysis found to score 67% variance. This proved the fact though there are rules and laws of existence, there is need to employ ethical values in managing health and medicine in Kenya.

#### **1.4: An Ethical Perspective of the Research**

The stability of any nation will depend largely not on well the citizens adhere to laws or daily regulations that have been codified, but on morality, values systems and ethics of their daily existence. Every society has values and morals which guide the way of its members.

Though a number of concerns have been discussed in the literature review section, they fall short ethical theories and values as the key pillars that can help redefine and reinvent the whole system of current medical and healthcare management in Kenya. Ethics though is taught as a discipline, it has its birth from the society's expectations and actions of the members that constitute that society. Hence no discipline can prove to be superior over others since the society is multifaceted with all the disciplines currently being administered in the current training and educational programmes.

Gichure (1997) defines ethics as 'the systematic study of human actions from the point of view of their rightness or wrongness as a means for the achievement of man's ultimate happiness'. Achola (1976) inferred that good actions means good ethics, similarly a good life means good ethics. Being moral agents, our actions are true picture of the society, and therefore any consequence or outcomes of the drinking culture on the society will be judged from ethical and moral standpoint.

We are all guided by ethical values which according to Gichure (2007) are; trustworthiness, honesty, integrity, reliability, loyalty, truthfulness, respect, caring, responsibility, accountability, transparency, diligence, perseverance, self-restraint, fairness, citizenship. This is what the current alcohol management and education should focus on if our society is to be restructured so as to become a better place for human existence.

##### 1.4.1 Ethical Theory

Ethical theories are tools for ethical guidance that can be adopted in analyzing the range of ethics that can affect societal culture, medical and healthcare management and individuals' growth and intellectual nourishment as claimed by Senge (1990). Our current meta-ethical and pedagogic training in healthcare management programs are not strictly married into action causing a gap in eventual management. There are theories, principles and values that could be applied this situation to help bring change in approach. These theories include; virtue ethics, ethical learning and growth, Deontological ethics and Teleological ethics.

##### 1.4.1.1 Virtue ethics

Aristotle was the proponent for virtue ethics in our daily ventures and undertakings. It is a stable quality in man; an internal principle or a habit. Plato, Aristotle's teacher had identified four virtues, those of wisdom, courage, self control and justice. When we say that a person is just, honest or prudent, we mean that in this particular person, there is stable quality of justice, reliability, trustworthiness, honesty or prudence (Gichure 1997). Fisher & Lovell (2009) infers that virtues are not the 'ends' rather they are the 'means'. They are personal qualities that provide the basis for individual to lead a good, noble or happy life (Debeljuh 2006).

##### 1.4.1.2 Deontological ethics

This theory as argued by Fisher & Lovell, (2009), was developed by Kant. Kant's philosophy was that actions must be guided by universalisable principles that apply irrespective of the consequences of the actions. An action can only be morally right if it is carried out as a duty, Kant's categorical imperative lays emphasis that one does 'duty for duty's sake.' not in expectation of a reward (Gichure 1997). Bowie (1999) in his organization, built upon Kantian principles, which provided a theory of moral permissibility for interactions. Interactions that violate the universability formulation of the categorical imperative are morally impermissible.

##### 1.4.1.3 Ethical Learning and Growth

An ethical organization cannot be achieved by a decree, (Fisher & Lovell 2009). The end has to be approached obliquely by encouraging process of learning that enable people to decide for themselves to act ethically. For Senge (1990, p. 13-14) learning is not simply an acquisition of useful information; it is simply a personal moral development, which could help in medical and healthcare management in Kenya. Covey (1992, p. 36) adopted the 'principle of process' of personal growth in the spheres of emotion, human relationships and character formation. These processes cannot, he argued, be short circuited; people have to go through the necessary stages of development to achieve greater effectiveness.

#### 1.4.1.4 Teleological ethics

According to Fisher & Lovell (2009), Teleological ethics means the rightness or goodness of an action is not intrinsic to that action but can only be judged by its consequences. They relied on the views of the Jeremy Bentham and John Stuart Mill, the initial proponents of this theory. The theory tends to combine an intention to work towards an end with a particular view of what institutions are necessary to achieve it. These institutions govern the way in which the appropriateness of an act to an end should be evaluated. Thus a person dealing in healthcare management will be judged as being irresponsible and therefore falling short of what is expected of him by the society.

#### 1.4.1.5 Utilitarianism

This theory is an extension of the teleological ethics, which focuses on the consequences of the action. The theory was developed by Bentham and further influenced by John Stuart Mill. The utilitarian ethical theory is built on the ability to predict the consequences of an action. To a utilitarian, the choice that yields the greatest benefit to the most people is the choice that is ethically correct. One benefit of this ethical theory is that the utilitarian can compare similar predicted solutions and use a point system to determine which choice is more beneficial for more people. This point system provides a logical and rationale argument for each decision and allows a person to use it on a case-by-case context.

#### 1.4.2 Ethical principles

According to Fisher & Lovell (2009), a principle is a 'standard that is to be observed', not because it will advance an economic, political or social situation, but because it is a requirement of fairness or justice or some other dimension of morality. In medical and healthcare management in Kenya, there are a number of principles which can be applied to help in effective and efficient operation that is ethically inclined and guided. These principles include: autonomy, beneficence, non malficence, double effect informed consent and confidentiality.

##### 1.4.2.1 The principle of autonomy

The principle of autonomy recognizes the rights of individuals to self-determination. This is rooted in society's respect for individuals' ability to make informed decisions about personal matters. Autonomy has become more important as social values have shifted to define medical quality in terms of outcomes that are important to the patient rather than medical professionals. The increasing importance of autonomy can be seen as a social reaction to a "paternalistic" tradition within healthcare (Holmes & Purdy 1994). Some have questioned whether the backlash against historically excessive paternalism in favor of patient autonomy has inhibited the proper use of soft paternalism to the detriment of outcomes for some patients. Respect for autonomy is the basis for informed consent and advance directives. (Haring 1974)

Autonomy is a general indicator of health. Many diseases are characterized by loss of autonomy, in various manners. This makes autonomy an indicator for both personal well-being, and for the well-being of the profession. This has implications for the consideration of medical ethics: "is the aim of health care to do good, and benefit from it?"; or "is the aim of health care to do good to others, and have them, and society, benefit from this?". Ethics - by definition - tries to find a beneficial balance between the activities of the

individual and its effects on a collective. By considering autonomy as a gauge parameter for (self) health care, the medical and ethical perspective both benefit from the implied reference to health (Monge 1991)

#### 1.4.2.2 The Principle of beneficence

The term beneficence refers to actions that promote the wellbeing of others. In the medical context, this means taking actions that serve the best interests of patients. However, uncertainty surrounds the precise definition of which practices do in fact help patients. Badi & Badi (2009) identified beneficence as one of the core values of health care ethics. Some scholars, such as Pellegrino & Thomasma (1993), argue that beneficence is the only fundamental principle of medical ethics. Some authors like, Monge (1991), argue that healing should be the sole purpose of medicine, and that endeavors like cosmetic surgery, contraception and euthanasia fall beyond its purview.

#### 1.4.2.3 The Principle of non-maleficence

The concept of non-maleficence is embodied by the phrase, "first, do no harm," or the Latin 'primum non nocere'. Many consider that should be the main or primary consideration (hence primum): that it is more important not to harm your patient, than to do them good (Haring 1974). This is partly because enthusiastic practitioners are prone to using treatments that they believe will do good, without first having evaluated them adequately to ensure they do no (or only acceptable levels of) harm. Much harm has been done to patients as a result. It is not only more important to do no harm than to do good; it is also important to know how likely it is that your treatment will harm a patient (Monge 1991). So a physician should go further than not prescribing medications they know to be harmful - he or she should not prescribe medications (or otherwise treat the patient) unless s/he knows that the treatment is unlikely to be harmful; or at the very least, that patient understands the risks and benefits, and that the likely benefits outweigh the likely risks (Olafson 1967).

#### 1.4.2.4 The Principle of Double effect

This principle as argued by Monge (1991), has frequent and multiple applications in the moral life; concretely, in relation to the imputability of the effects of human acts. When a human act has only one effect, it is not difficult to pass a moral judgment. The object, end, and circumstances of the same act can be adequately evaluated. Things, however, are not always this simple. Human life is often beset with conflicts of values because there are actions, which, aside from producing a good effect, cause an unwanted evil effect which accompanies the former inseparably (Monge 1991).

Double effect refers to two types of consequences which may be produced by a single action and in medical ethics it is usually regarded as the combined effect of beneficence and non maleficence (Monge 1991). A commonly cited example of this phenomenon is the use of morphine or other analgesic in the dying patient. Such use of morphine can have the beneficial effect of easing the pain and suffering of the patient, while simultaneously having the maleficent effect of hastening the demise of the patient through suppression of the respiratory system.

#### 1.4.2.5 The Principle of informed Consent

Informed consent in ethics usually refers to the idea that a person must be fully informed about and understand the potential benefits and risks of their choice of treatment. An uninformed person is at risk of mistakenly making a choice not reflective of his or her values or wishes. It does not specifically mean the process of obtaining consent, nor the specific legal requirements, which vary from place to place, for capacity to consent (Williams & Torrens 2008). Patients can elect to make their own medical decisions, or can delegate decision-making authority to another party. If the patient is incapacitated, laws around the world designate different processes for obtaining informed consent, typically by having a person appointed by the patient or their next of kin make decisions for them. The value of informed consent is closely related

to the values of autonomy and truth telling (Pencel 1995).

#### 1.4.2.6 The Principle of Confidentiality

Confidentiality is commonly applied to conversations between doctors and patients. This concept is commonly known as patient-physician privilege. Legal protections prevent physicians from revealing their discussions with patients, even under oath in court (Haring 1974). Confidentiality is also challenged in cases involving the diagnosis of a sexually transmitted disease in a patient who refuses to reveal the diagnosis to a spouse, and in the termination of a pregnancy in an underage patient, without the knowledge of the patient's parents. Traditionally, medical ethics has viewed the duty of confidentiality as a relatively non-negotiable tenet of medical practice (Veatch 1997)

### 1.5 Discussion and Recommendations

#### 1.5.1 Discussion

From the analysis of the literature review and the findings from the responses, various ethical issues are raised in healthcare and medical management in Kenya.

From the responses of the leading clinical heads, physicians and patients, there is a need for ethical integration in the management of healthcare service provision in Kenya. Most of them preferred ethical centers within all hospitals where physicians and nurses could be periodically oriented and therefore informed on the best clinical practices. Ethical principles and theories, as respondent to by the patients can be a guide to foster good relationship between the healthcare professionals and the society, with respect to life protection and healthcare management.

Some physicians run private hospitals, to supplement their incomes, and these part-time jobs have dire implications on the overall effects on the society especially if not careful monitored. Best practices in healthcare management and service delivery in Kenya would go a long way to involve various philosophical, theological and management professionals in the field on medicine and healthcare. This new dimension of interdisciplinary approach in management will help improve the performance and professionalism of doctors and nurses, who are often known to be impatient with theoretical literatures such as ethics and psychology.

The performance, professionalism and holding of ethical values and principles of the physicians and nurses in Kenya is a key factor that was largely discussed by the respondents especially the patients who are always the direct interact with such professionals. With regard to patient-physicians relationship, some patients especially those attending to antenatal and postnatal services prefer to be attended to by the local midwives because nurses cannot be patient with such patients. This is a clear indication of the current professional standards in healthcare systems in Kenya. That is to imply that if healthcare professionals considered ethical theories and principles then, patients will receive full cakes of medication in Kenya. Some respondents especially those who have been patients reported that some nurses were very sentimental and lacked human relationship skills which make such patients to seek alternative medical attention like herbal clinics as a result there is a proliferation of traditional herbalist who claims to cure all types of diseases including HIV/AIDS.

Some sick people travel throughout Kenya to Tanzania to look for such herbalists or witchdoctors, either because of faith in herbalist and witchdoctors, or because of lack of money to meet the requirements of professional medical hospitals or as the case may be, because of the perceived or the reality of negative treatment by nurses. This is a signal to the government and all the stakeholders that something urgent must be done to mitigate this need if Kenya has to achieve vision 2030, millennium development goals and also to implement the new constitution dispensation to the full.

The performance and employee motivation is a necessary ingredient, which physicians and nurses reported

in the questionnaires, to have been denied by their employers and supervisors. This is totally unethical and against the holdings of ethical theories and principles. In many hospitals whether public, private or missionary, there is no organizational structure for medical doctors, nurses and other workers to voice their grievances especially at this error of new constitutions and the rights and responsibility therein. In such a structure, the danger of victimization of whistleblowers is very eminent and alive. This has forced good qualified professionals to seek for better opportunities in other countries like South Africa, Botswana and currently Rwanda. In order to prevent employee turnover and to increase their productivity, the government, through the ministry of health will need to develop mechanisms of motivation such as introduction of hardship allowances and other employee benefits.

With reference to mission hospitals which gave quality medical and nursing care in the past, the Kenyan government through the ministry of health should assist them by seconding qualified and morally upright medical doctors and nurses, and also modern equipments so that they can ably compensate the government services to the sick Kenyans in a very competitive world. On the other hand, the mission hospitals must reciprocate by developing policies aimed at safeguarding the welfare of all medical professionals and workers and also implement the rights and responsibilities given to their colleagues in government hospitals as regulated by the ministry of medical services, and ministry of health and sanitation. If this is not done, complains and go slows may scare those who would be patients even those who have cherished high regards for such hospitals because of the well known goodwill in health care. This is one of the basic suggestions from the interviewed focused groups who hold dear the commitment and service of the church hospitals to the sick and thus ethical theories and principles can be a remedy.

From the literature review and focused study groups, it emerges that, sensitization programs about the benefits of ethical theories and principles in healthcare, should be held constantly and regularly between all stakeholders in the healthcare services and management systems. This will remove misconceptions from all sides and clarify the goals of the government and churches for the welfare of the patients. Communication is the key to the improvement of any service delivery.

It is our contention that in order to have an economy that is thriving towards highest levels of economic status, then moral and ethical thinking, aided by ethical theories of intellectual nourishment, should play a larger role in guiding and sharpening the thoughts and reasoning of young members of the healthcare society to exercise high levels of integrity, self control, moral theories and principles of ethics especially when it comes to establishing good relationships with patients. Based on the meta-ethical and pedagogic orientations in the current medical training curricular, there will be a boost and a change of training to if ethics is included in medical and nursing training.

This is a major contribution enhanced by most focused groups who responded to the questionnaires

#### 1.5.2: Recommendations

From the analysis of our research based on the general and specific objectives, with responses from Government officials, healthcare heads, physicians, nurses, patients and the variables of the research, such as, relevance of ethics, professionalism and performance and the adoption of ethics in healthcare management in Kenya, the study has led to the following recommendations.

Recommendation 1: Establishment of ethical committees and medical centers of excellence.

(i) Often, simple communication is not enough to resolve a conflict, and a hospital ethics committee must convene to decide a complex matter. These bodies are composed primarily of health care professionals, but may also include philosophers, specialized and experienced counselors, lay people, and qualified clergy (mostly chaplains seconded in hospitals) - indeed, in many parts of the world their presence is considered mandatory in order to provide balance. Members should include a person with knowledge and experience in professional care, counseling or treatment of patients; a priest or minister of religion or equivalent, e.g.

societal elder; a layman; a laywoman; a lawyer and, in the case of a hospital-based ethics committee, a nurse. The assignment of philosophers or religious clerics will reflect the importance attached by the society to the basic values involved. This is the holding of virtue ethics on values.

(ii) Virtue ethics and deontological theory will be very much adopted by religious leaders who have proved to be great counselors in psychological and spiritual anchoring. Thus by having such leaders in the ethical committees and centers will help speed up the processes of guiding and counseling. Through their proven success in guiding and counseling married couples, religious leaders will again gain an edge in management of healthcare if greatly considered. They also improve their knowledge of healthcare through the profession of medical doctors, nurses and other stakeholders. The administrators of the hospitals should coordinate these initiatives so that they are not sidelined or separated from the core role and mandate of the hospital.

(iii) More evidently, there are increased cases of abortion and maternal deaths due to lack and absence of ethical committees to monitor and evaluate the actions of physicians who are sometimes driven by excessive desire for money as opposed to saving life. Ethical committees ought to be established in public healthcare institutions, mission nursing homes and private sector healthcare institutions, and be coordinated by the ministry of health. This according to teleological and utilitarian theories will be a remedy of reducing and therefore preventing sinful human actions such as illegal abortion and euthanasia.

(iv) In order to foster research and health improvement in Kenya, the government through the ministry of Health and Medical services, ought to set up medical centers of excellence in every county and within each province in Kenya. These centers may be differentiated in terms of specialization, with respect to crude disease like cancer, HIV/AIDs, Diabetes etc, but however, they will be instrumental in creating professionals who are committed to the overall welfare of the society. Doctors and nurses and other physicians may attend these centers weekly to be updated on the developing trends in their respective fields and this will improve their delivery and performance.

Recommendation 2: Restructuring human resource management in the healthcare systems.

(i) Healthcare ethics starts with organizational culture. If an organizational culture is based on shortcut-taking and cronyism, which culture will ultimately become part of daily life at the hospital. Cronyism exists when administrators put their own interests above those of the organization, and start to see the office as a vehicle for extracting benefits for their friends. If cronyism exists at a hospital, doctors and other professionals may be hired for political reasons rather than for skills, which can result in low-quality service. A generally lazy organizational culture may result in a hospital where, for example, cancer treatment equipment is not maintained properly. This can lead to unnecessary loss of life. Thus as ethics holds in the deontological ethics, there is need to ensure that the cultures of healthcare institutions work towards improving the overall welfare of their employees, who when properly motivated will work effectively and ethically and further still the chief executive officer and board of directors should be people of high moral integrity and should be given their jobs and membership through competitive vetting knowledge, experience, welfare of the patients, medical doctors and nurses and their concern in sanctity of human life. At the end of the exercise those who qualify should be given terms of reference, job descriptions with special reference to the implementation of the code of ethics and the performance of their duties during their time of office. They should also be people ready to work with the government and at the same time commit themselves to putting into practice the ethos of the hospitals they are called to administer. Relevant arms of the government should receive their reports since they are serving the people of Kenya. This does not mean that the confidential report which bind them with owners and managers of their specific hospitals are done away with. This is the true meaning of respecting the chain of command which is also an ethical value.

(ii) The treatment of employees at hospitals can become an ethical issue. For instance, verbal abuse against nurses by any stakeholder can be a serious problem. Other healthcare employees, such as receptionists,

pharmacists, and some paramedical are often asked to work very long hours for little pay. Doctors, while extremely well compensated, often work "on call," meaning that they are expected to come into work on short notice whenever they are needed. When hospital staff is pushed too far, it becomes an ethical issue for which administration is responsible. Thus there should be fairness and justice in the treatment of employees in hospitals which should be inscribed in hospital manuals, policies and letter of employment. Such actions are widely argued by the utilitarian theory of ethics, which might help create good consequences on the conduct of the physicians and good environment for the treatment of the patients.

(iii) Motivation of employees in hospitals in Kenya is a need that should be addressed. This will go a long way to ensure that top administrators obtain relevant human management skills besides holding medical proficiencies. This should happen in government, private and mission hospitals. Sometimes poor delivery and services occur due to lack of adequate training, experience and choice of managers who do not have the hospital service at heart. Poor treatment and demotivation of physicians and nurses has been a good cause for some of them to seek employment opportunities in other countries. Thus with regard to ethical theories and principles, there should be equality in promotion and employee appraisal. This calls for quality assurance service which is trained and efficient in its appraisal work following the set standards and policies.

**Recommendation 3: Reinvention of the meta-ethical and pedagogic issues in healthcare training.**

(i) Medical centers are a primary context for medical ethics, as well as medical care. Whether physicians, philosophers, or theologians, most medical ethicists are primarily based in medical schools and teaching hospitals, and their principal audiences are (apart from one another) medical students and residents (Kamunge 1993). This setting partially explains the primary role of actual case analysis in medical ethics, by contrast with much ethical writing. Physicians and nurses have little patience with the theoretical dialectic or fanciful test-cases that constitute much current secular ethics. This norm should be changed by employing ethics in the curricular training programmes offered by medical training institutions as discussed by ethical learning theory and growth.

(ii) To achieve this goal, it may be necessary to recast curricula, using new and appropriate methods, so as to go beyond cognitive mastery of disciplines by adopting ethical theories and principles. New pedagogical and didactical approaches should be accessible and promoted in order to facilitate the acquisition of ethical skills, competences and abilities for communication, creative and critical analysis, independent ethical and critical thinking and team work in multicultural contexts, where creativity also involves combining traditional or local knowledge and know-how with advanced science and technology. Academic personnel should play a significant role in determining the curriculum, by integrating philosophers, ethicists and theologians in their curriculum development.

**Recommendation 4: Improving relationship between physicians, nurses, institutions, society and patients.**

(i) The relationship between physicians and the institutions, reflect changes in medical practice from home and office to hospital and clinic. Physicians have become members of teams treating patients in institutions governed by internal routines and external guidelines from government, insurers, and corporate owners (and, secondarily, religious authorities in some instances). Increasingly decisions are delegated to "bioethics committees" which include nurses, lawyers, social workers, chaplains, philosophers, citizen representatives, patient advocates, and other non-physicians. Even if physicians dominate these care teams and hospital committees, their moral virtues or religious faith should confer moral authority (John Paul II 1990).

(ii) The relationship between physicians and the society has lead to larger issues of medicine as a public good, publicly supported and allocated. The increasing scope and costs of hospital medicine have prompted restraint and rationing in matters of drug prescriptions, elective surgery, in-patient hospital stays, out-patient services (Howard 1987). In response, philosophers have proposed contractarian and natural law rationales for age-relative distributions, as well as 'utilitarian' analyses of cost-efficient allocations of

treatment and research funds (Olafson 1994). This has been discussed by the utilitarian theory of ethics.

(iii) With respect to relationship between the physicians and the patients, and in the interests of justice, efficiency and harmonious relationship, it is important for both physicians and the patients to appreciate their individual roles. Dunn (1994) argued that the doctor is the 'servant' of the patient but not the 'patient's slave'. Similarly the doctor does not have authority over the patient, but rather, only as an adviser to the patient. As deontological and utilitarian theories hold on the happiness, this relationship will improve the overall happiness of both the physician and the patient.

#### Recommendation 5: Mainstreaming the relationship between the Government and mission hospitals

There has been good relationship between the government of Kenya and mission hospitals practically in all provinces. However, in the last decade, this relationship has met setbacks and made some players to apportion blame on both sides. Since the focus of the two institutions is to serve the Kenyan patients', mechanisms should be put in place so that the good relationship be cemented and be focused to service delivery for the Kenyan patients. This involves policy development, workshops, and seminars to widen areas of communications. If both parties minimize their differences and strengthen their common bonds, the Kenya nation will be attaining its greatest wealth which is health.

#### Recommendation 6: On going formation for nursing care providers

Many ethicists and professional doctors have acknowledged that ethical issues in nursing arises chiefly with the changing environment within the medical profession as well as the technological advancements that come with it. As the nursing profession begins to specialize into many different fields of expertise, several ethical dilemmas are encountered and often times overlooked. Such ethical issues occur based on the kind of technology involved. This highly depends on the clinical specializations whether in mental health, cardiology, oncology or rehabilitation. It goes without saying that the consequences that arise from these ethical dilemmas are most likely to be varied.

We recommend that the nurses take advantage of attending workshops, seminars and even improving their grades because this area is advancing technologically and thus posing crucial ethical issues including patients. The advancement of medical doctors in healthcare technology should go hand in hand with that of nurses in Kenya in order to improve nursing care services and overall improve the healthcare systems in Kenya.

#### 1.5.3 Conclusion

In order to develop and nurture a healthy and productive future generation, there is need to consider employing ethics in healthcare management in Kenya. Most stakeholders like; physicians, patients, healthcare institutions and other institutions should work and develop ethical committees and centers that are guide their members. Self control and responsibility values should be adopted through ethical application, by the physicians.

Physicians will be required to be people of high integrity to seem to convince the society that self discipline is worth in attaining high faculties in life not just in professional excellence but in health life and growth. Above all, ethics should be made part of everyday life and activities in healthcare institutions. Wisdom ought to be applied in redefining the performance and professionalism in healthcare management among physicians in Kenya as argued by Huang (2008), that 'a strategy without tactics is the longest road to victory. Tactics without strategy is the noise before defeat', hence the need for wisdom is relative to healthcare management. The greatest wealth we can ever have is health and a developing nation with good health is rich and therefore wealth. Having health population will enable Kenya to realize the vision 2030 and the millennium development goals.

#### 1.5.4 Research Limitations

This research was carried out following a Kenyan perspective and only applicable to its culture and way of life of her citizens. Therefore a major limitation is that it may not be applicable to other countries due to cultural differences and background.

#### 1.5.5 Future work

This research was carried out based on the ethical issues in healthcare in Kenya with a critical analysis of the healthcare stakeholders where discussion led to the aforementioned recommendations for the country for healthcare providers and stakeholders.

Greater emphases was put on ethical programs likely to improve the performance and delivery of physicians, nurses and hospital management and improved collaboration with the ministries of medical services, ministry of health and sanitation in Kenya. Future work may be carried out to investigate the effects of healthcare on economic growth, society-physician integration and overall, the effects of healthcare on future population.

#### References

- Ministry of Health (2004) Republic of Kenya Sessional Paper No. 2 of 2004 on National Social Health Insurance in Kenya May, 2004. Theme: *Providing Quality healthcare to all Kenyans*.
- Mwabu, G., & Wang'ombe, J., (1998). "Providing rural healthcare services in Kenya. *Population Research and Policy Review*, Vol 17 Pp 55-70.
- Badi, V., R., & Badi, V., N., (2009), *Business Ethics*, Vrinda Publications (P) Ltd. Delhi, India. <http://www.vrindaindia.com>.
- Huang, J., H., (2008). *The Art of War*. New York: William Morrow and Company, Inc.
- Kamunge, J. (1993). *Report on Presidential Working Party on Education and Manpower Training for the Next Decade and Beyond*.
- Olafson, A., F., (1970). *Principles and persons: an ethical interpretation of Extentialism*, The Johns Hopkins Press Ltd: London.
- Fisher, C., & Lovell, A., (2009). *Business Ethics and values: Individual, Corporate and International Perspectives*, (3<sup>rd</sup> Ed.). Edinburgh Gate, England: Pearson Education Ltd.
- Monge, A., M., (1991). *Ethical Practice in health and disease*. Manila: Sinag-Tala Publishers, Inc.
- Stumpf, E., S., & Fieser, J., (2003). *Socrates to Sartre and Beyond: A History of Philosophy*, 7<sup>th</sup> ed New York: McGraw-Hill.
- Haring, B., (1974). *Medical Ethics*. Slough, England: St. Paul Publications.
- Dunn, H., P., (1994). *Ethics for Doctors, Nurses and Patients*, Staten Island, NY, USA: Alba House.
- Fox, E., Myers, S., & Pearlman, R., A., (2007). "Ethics Consultation in United States Hospitals: A National Survey". *The American Journal of Bioethics*, 7 (2), 13-25.
- Williams, S., & Torrens, P., (2008). *Introduction to health services*, (7<sup>th</sup> Ed.). Clifton Park, NY: Delmar Cengage Learning.

Arras, J., D., & Steinbock, B., (1998). *Ethical Issues in Modern Medicine*, (5<sup>th</sup> Ed.) Mountain View, Calif.: Mayfield.

Beauchamp, T., L., & Childress, J., F., (1994). *Principles of Biomedical Ethics*, (4th Ed.) New York: Oxford University Press.

Howard, B., (1987). *Stories of Sickness: Recasting of ethical issues in terms of patients' narratives of illness and dialogues with doctors*, New Haven, CT: Yale University Press.

Buchanan, A., E., & Brock, D., W., (1989), *Deciding for Others: The Ethics of Surrogate Decision Making*, Cambridge: Cambridge University Press.

Callahan, D., (1987). *Setting Limits: Medical Goals in an Aging Society*, New York: Simon & Schuster.

Engelhardt, H., T, Jr., (1996). *The Foundations of Bioethics. Libertarian social analysis of autonomy and rights to abortion, infanticide, healthcare, treatment refusals*, (2<sup>nd</sup> Ed.). New York: Oxford University Press.

Gillon, R., & Lloyd, A., (1994). *Principles of Health Care Ethics: Criticisms and defenses of the canonical medical ethics principles of autonomy, beneficence, non-maleficence, and justice*. Baltimore: John Wiley & Sons.

Holmes, H., B., & Purdy, L., M., (1992). *Feminist Perspectives in Medical Ethics*. Bloomington: Indiana University Press.

Gichure, W., C., (1997). *Basic Concepts in Ethics*. Nairobi: Focus Publications Ltd.

Kamm, F., M., (1996). *Morality, Mortality*. New York: Oxford University Press.

Pellegrino, E., D., & David, C., T., (1993). *The Virtues in Medical Practice: An extension of Aristotelian and Scholastic analyses of virtue to physicians*. New York: Oxford University Press.

Oruka, O., H., (1990). *Ethics; A Basic Course for Undergraduate Studies*. Nairobi: University of Nairobi Press.

Paul II, J., (1993). *The Splendour of Truth*. East Africa Edition: The Paulines.

Senge, P., M., (1990). *The fifth Discipline. The Art and Practice of the Learning Organization*. London: Century.

Pence, G., (1995). *Classic Cases in Medical Ethics*. (2<sup>nd</sup> Ed.) New York: McGraw-Hill,

Percival, T., (1975). *Percival Medical Ethics*. Huntington, NY: Robert E. Krieger Publishing.

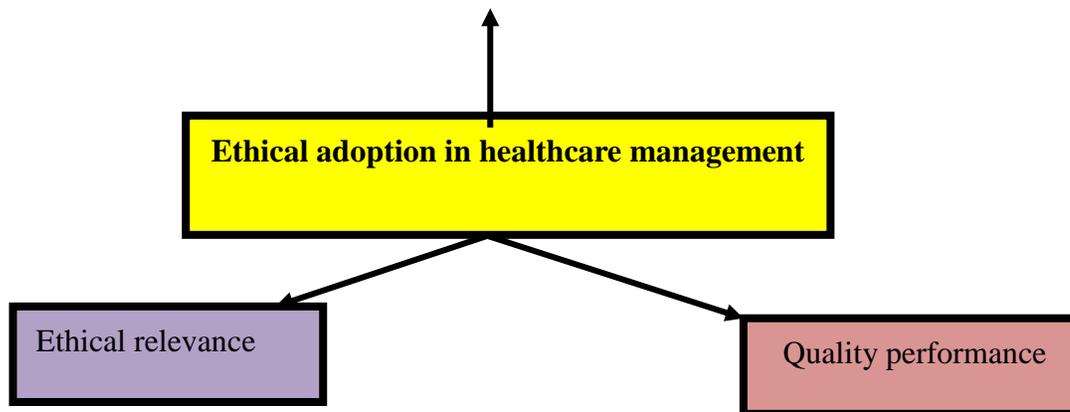
Rachels, J., (1998). *The End of Life: Euthanasia and Morality. A defense of euthanasia, active and passive when biological life is over*. Oxford: Oxford University Press.

Reich, W., T., (1995). *Encyclopedia of Bioethics*, (2<sup>nd</sup> Ed.) New York: Macmillan.

Veatch, R., M., (1997). *Medical Ethics*. (2<sup>nd</sup> Ed.) Sudbury, Mass: Jones & Bartlett.

**Notes:** Fig 1 the operational framework of the research variables

Professionalism



Sources: Kolb (1984) learning and Experiential Model

This academic article was published by The International Institute for Science, Technology and Education (IISTE). The IISTE is a pioneer in the Open Access Publishing service based in the U.S. and Europe. The aim of the institute is Accelerating Global Knowledge Sharing.

More information about the publisher can be found in the IISTE's homepage:

<http://www.iiste.org>

The IISTE is currently hosting more than 30 peer-reviewed academic journals and collaborating with academic institutions around the world. **Prospective authors of IISTE journals can find the submission instruction on the following page:**

<http://www.iiste.org/Journals/>

The IISTE editorial team promises to review and publish all the qualified submissions in a fast manner. All the journals articles are available online to the readers all over the world without financial, legal, or technical barriers other than those inseparable from gaining access to the internet itself. Printed version of the journals is also available upon request of readers and authors.

### **IISTE Knowledge Sharing Partners**

EBSCO, Index Copernicus, Ulrich's Periodicals Directory, JournalTOCS, PKP Open Archives Harvester, Bielefeld Academic Search Engine, Elektronische Zeitschriftenbibliothek EZB, Open J-Gate, OCLC WorldCat, Universe Digital Library, NewJour, Google Scholar

