Medical Ethics Education in the Niger Delta Region of Nigeria

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Abstract

Background: *Medical ethics has been described as a basis for sound and safe medical practice. However curriculum implementation as taught in Nigeria's medical schools has not shown it to be as described.*
Objective: This study sought to describe medical ethics education in the Niger Delta region and identify factors that affect its curricular implementation.

Method: *A cross sectional descriptive study was conducted between June 2016 and August 2017 in four medical schools. Structured questionnaires were administered to 105 final year students and 70 of their lecturers. The institutions and human participants were selected by convenient sampling. Nominal scale data were collected and analyzed on a Microsoft Excel spread sheet.*

Results: *Response rates for students and lecturers were 79% and 61% respectively. For correct meaning of medical ethics 21.4% students and 17.4% lecturers responded. Over 67% of participant groups were satisfied with the level of knowledge of medical ethics they had acquired and over 50% in each group was prepared to practice effective medicine from that knowledge. Opinion of the students shows that teaching method is limiting effective ethics education, while for the lecturers subject content is a limiting factor.*

Conclusion: *To derive satisfaction and practice confidence from inadequate knowledge of medical ethics calls for caution and care in medical practice in Nigeria. Similarly, not engaging appropriate medical ethics teachers, for example, moral philosophers, limits students' maximum benefit from medical ethics education. To didactic teaching, dialogic and case study methods should be considered in medical ethics education. Further studies are suggested.*

Keywords: Medical education; medical morality; reflective thinking, dialogic teaching

Introduction

Medical ethics is taught in medical schools in Nigeria and Clarke [1] described ethics as a reflection upon morality, morality having to do with right and wrong or good and bad conduct. Thus medical ethics can be said to enable medical practitioners reflect on their actions and inactions for effective practice of their profession. In 2012 stakeholders in the Nigerian health system observed that one of the major areas that needed improvement in the nation's medical education is medical ethics and jurisprudence.[2] Their aim was to ensure effective professional practice. In the USA the DeCamp Report which required all medical students to train in medical ethics was followed by the Romanell Report which addressed contemporary concerns of clinician's work life, cultural diversity and team-based health care coordination.[3]

Olukoya conducted a survey on attitudes of medical students to medical ethics in their curriculum [4] and found that 84% of the students rated medical ethics to be of high to critical importance to good medical care. Oye-Adeniran and colleagues adopted a curriculum for Sexual and Reproductive Health Rights and recommended that the six human rights instruments related to "right to health"

should be taught under medical ethics.[5] However, since 2012 only a few studies have examined medical and public health ethics. In their study Ogundiran and Adebamowo [6] reported that fresh medical graduates confessed that the ethics instructions they received from their normal curriculum did not sufficiently prepare them for the ethical challenges they came across in practice. Fadare and colleagues [7] found that though at induction graduating doctors are given the code of medical ethics and their practice license this does not translate to interest in medical ethics as 86% of the respondents said the curriculum they had at medical school was inadequate for good ethical practice of medicine. However the same number said the subject is very important for effective practice of medicine, suggesting a need for improvement in the medical school curriculum for medical ethics. Famuyiwa [8] examined the knowledge of public health ethics among doctors and found that despite 90.7% having had medical ethics at undergraduate level only 48.6% have a good knowledge of public health ethics. In medical schools less than 50% is a failure and so one can say that there is a failure of medical ethics education in Nigeria.

The problem in medical ethics education seems to be that curricular implementation is weak. For instance Umerah observed that it is either medical ethics is totally absent from medical school curriculum or it is poorly taught. [9] If medical ethics is not being adequately taught, the issue is to call for distributive justice in curriculum implementation. This is because if blame for errors in medical practice continues to be put on the practitioners, it would be unfair to also put the blame due to poor curriculum implementation especially in ethics education, on the practitioners as well. However Flethcer and Holt suggested that the problem of distributive justice occurs when there is a shortage of goods within society. [10] Indeed medical ethics education is being challenged by shortage of experts and other resources. Hence Ezeani asserted that the dearth of materials in medical ethics in Nigeria has also affected the teaching of the subject.[11] Even so, application of the theory of justice is necessary given that the teaching of medical ethics has become obligatory in medical schools elsewhere in the world. The theory of justice [12] would allow for fair implementation of the school curriculum. This is important for a unified approach [13] to the teaching of the subject. Being that previous studies were all done in the South West region of the country, and because more medical schools are being established in the Niger Delta region, this study provides baseline information for the effective implementation of medical ethics in the medical school curriculum.

Materials and Methods

The survey took place in the three core states of the nine states of the Niger Delta region of Nigeria. The states which are major oil producing states are Rivers, Bayelsa and Delta states. Four medical schools established by or before 2000 were conveniently chosen and as at the time of study all were fully accredited. The number of institutions involved means that the study is replicable since each of the previous studies [7,8] on similar topic focused on just one institution. In Nigeria universities are owned by three groups of authorities. Thus of the four schools, one is owned by the Federal Government, two are owned by two states and one is privately owned.

All the respondents are Nigerians and belong to the Faculty of Clinical Sciences. The questionnaires were administered to both lecturers and students but only teachers who had spent at least five years in the school were administered. The students who were all final year medical students at the clinical phase of their training have been studying in Nigeria for the past four years in the same school. In each school one to two assistants were recruited and trained. They administered the questionnaires, explained criteria for involvement, retrieved completed questionnaires and assisted the researcher in tabular presentation of data.

Convenient sampling was adopted to select both schools and respondents. For instance a minimum carrying capacity of 70 students for each school was chosen and convenient samples of 25 students and 15 of their lecturers were selected from each school. The target was to administer a questionnaire to a minimum of 100 students and a minimum of 60 of their lecturers in the four schools.

Two structured questionnaires were developed and administered, one for the students with 19 sets of questions and the other for the lecturers with 21 sets of questions. The questionnaires covered the demography of the respondents, their knowledge of medical ethics, factors affecting medical ethics education and impact of medical ethics education on medical practice. Nominal scale data was derived from the responses. Frequencies of the various response options were recorded, categorized and analyzed on a Microsoft excel spread sheet for descriptive (percentage) statistics.
The survey was completed in eight months between June 2016 and August 2017, outside the periods of strike by the Academic Staff Union of Universities (ASUU) and the Nigerian Medical Association (NMA). Apart from strikes being a hindrance to the exercise most times the lecturers were not readily available because they did not have clinics or lectures on the days of visit and most of the lecturers among private medical schools are not full-time staff. Ethical permission was obtained from all institutions involved. Theoretical application is based on the theory of justice.

Results

The response rate was 79% for the students and 61% for the lecturers. Most of the teachers had their basic medical education in Nigeria. For instance in one of the schools out of the 78 teachers on its staff list 74% of them trained in five major Nigerian medical schools. Only 8% of the teachers had their basic medical education overseas (the United States, United Kingdom and Russia). The rest trained in 13 other medical schools in Nigeria.

Table 3.1: Demography of participants

Institutional respondents / Characteristics	MADONA Students / Teachers	UPH Students / Teachers	DELSU Students / Teachers	NDU Students / Teachers	**TOTAL Students/ Teachers**
Gender					
Male	11/3	13/9	15/4	18/7	**57(67%)/23(53%)**
Female	9/1	7/11	5/3	7/5	**28(33%)/20(47%)**
Total	20/4	20/20	20/7	25/12	**85/43**
Age range in years					
21-30	20/--	18/--	16/--	17/--	**71(84%)/--**
31-40	--/1	2/2	4/3	8/5	**14(16%)/11(24.4%)**
41-50	--/2	--/7	--/6	--/4	**--/19(42.2%)**
51-60	--/--	--/9	--/--	--/2	**--/11(24.4%)**
>60	--/1	--/2	--/--	--/1	**--/4(9%)**
Total	20/4	20/20	20/9	25/12	**85/45**

In table 3.1 on both sides of students and teachers 67% and 53% respectively are males. 84% of the student respondents are in the age range of 21-30 years while 42.2% of their teachers are between 41-50 years.

Table 3.2: Knowledge and practice preparedness from knowledge in medical ethics

Institutional respondents/Characteristic	MADONA Students/ Teachers	UPH Students / Teachers	DELSU Students / Teachers	NDU Students / Teachers	**TOTAL Students/ Teachers**
Meaning of medical ethics					
Right thing	**4/-**	**2/3**	**5/1**	**6/1**	**17(20.2%)/5(10.9%)**
Right and Wrong thing	**5/--**	**6/5**	**4/--**	**3/3**	**18(21.4%)/8(17.4%)**
Adherence to Code of professional practice	**10/4**	**12/14**	**11/7**	**14/6**	**47(56%)/31(67%)**
Don't know	**---/--**	**---/--**	**---/2**	**---/--**	**---/2(4.3%)**
Total	**19/4**	**20/22**	**20/10**	**25/10**	**84/46**
Preparedness to practice knowledge					
Yes	**6/3**	**11/8**	**12/12**	**18/7**	**47(57.3%/30(66.7%)**
No	**6/1**	**10/7**	**8/5**	**3/2**	**27(33%)/15(33.3%)**
Don't know	**8/-**	**--/--**	**--/--**	**--/--**	**8(9.7%)/---**
Total	**20/4**	**21/15**	**20/17**	**21/9**	**82/45**

In table 3.2 whereas 56% of the students and 67% of the teachers identified medical ethics as relating to adherence to code of professional practice, almost the same number feel prepared to practice safe and sound medicine from that knowledge.

Table 3.3: Scope of knowledge in medical ethics and duration of course delivery

Institutional respondents/ Scope and duration of course	MADONA Students / Teachers	UPH Students Teachers	DELSU Students / Teachers	NDU Students / Teachers	**TOTAL Students/ Teachers**
Scope of the course					
Topic	9/8	19/13	18/7	20/8	**66 (77.6%)/36 (78.3%)**
Course	4/--	1/3	2/2	5/2	**12(14.1%)/7 (15.2%)**
Don't Know	7/--	--/2	--/1	--/--	**7 (8.2%)/3 (6.5%)**
Total	20/8	20/18	20/10	25/10	**85/46**
Duration of Course					
Hours	8/3	18/11	17/6	20/10	**63(81.8%)/30(65.2%)**
Part Semester	3/--	--/3	--/1	2/2	**5(6.5%)/6(13.0%)**
Whole Semester	2/--	--/--	--/--	1/--	**3(3.9%)/---**
Part posting	1/1	¼	2/1	2/--	**6(7.8%)/6(13.0%)**
Whole posting	--/--	--/1	--/--	--/--	**--/1(2.2%)**
No response	--	2	1	--	**3(6.5%)**
Total	14/4	19/21	19/9	25/12	**77/46**

In Table 3.3 over 75% of both respondents studied the subject as a topic. Majority opinion also indicates that ethics education is given in few hours of lectures, within the medical school curriculum.

Table 3.4: Department of course delivery and Class/level of instruction in medical ethics

Institution/ Characteristic	MADONA Students/ Teachers	UPH Students/ Teachers	DELSU Students / Teachers	NDU Students/ Teachers	**TOTAL Students/Teachers**
Department					
Medicine	--/--	5/4	8/1	5/2	**18(25.7%)/7(17.1%)**
Surgery	3/--	2/--	3/1	2/--	**10(14.3%)/1(2.4%)**
Public Health	¼	10/11	8/5	11/7	**30(42.9%)/27(65.9%)**
Family Medicine	--/--	--/--	1/--	--/--	**1(1.4%)/--**
Others	6/--	2/2	2/--	¼	**11(15.7%)/ 6(14.^%)**
Total	10/4	19/17	22/7	19/13	**70/41**
Class/level					
100L	1/--	--/3	--/--	9/--	**10(12.8%)/3(7.3%)**
200/300L	6/--	--/3	--/--	3/--	**9(11.5%)/3(7.3%)**
400L	--/--	7/5	14/1	4/5	**25(32.1%)/11(26.8%)**
500L	5/1	11/--	5/4	4/3	**25(32.1%)/8(19.5%)**
600L	--/1	2/2	¾	4/2	**9(11.5%)/9(22%)**
PG	--/2	--/2	--/1	--/2	**--/7(17.1%)**
Total	12/4	20/15	22/10	24/12	**78/41**

In table 3.4 it is the opinion that the Department of Public Health (Community Medicine) should provide the teaching personnel for medical ethics. Both respondents agree that ethics should be taught at the clinical science phase in the 400/500 class levels.

Table 3.5: Importance of ethics course and satisfaction with ethics knowledge

Institutional respondents/ Characteristic	MADONA Students/ Teachers	UPH Students/ Teachers	DELSU Students / Teachers	NDU Students/ Teachers	**TOTAL Students/ Teachers**
Importance of course					
V Important	10/4	13/16	13/6	19/12	**55(67.9%)/38(84.4%)**
Important	5/-	5/2	5/3	5/--	**20(24.7%)/5(11.1%)**
Unimportant	-/-	--/--	--/--	--/--	**---**
Very Unimportant	1/-	--/--	--/--	-1/--	**2(2.5%)/---**
Don't know	2/-	--/2	2/--	--/--	**4(4.9%)/2(4.4%**
Total	18/4	18/20	20/9	25/12	**81/45**
Satisfaction with knowledge of ethics					
Very satisfied	-/1	¾	6/1	12/2	**21(27.6%)/8(17.4%)**
Satisfied	4/2	9/9	8/4	9/8	**30(39.5%)/23(50%)**
Unsatisfied	6/-	4/6	4/1	2/2	**16(21.1%)/9(19.6%)**
Very unsatisfied	--/--	2/--	1/--	2/--	**5(6.6%)/--**
Don't know	2/--	1/3	1/3	--/--	**4(5.3%)/6(13.0%)**
Total	12/3	19/22	20/9	25/12	**76/46**

In table 3.5 both respondents regard the subject as very important, similarly over 65% of both respondents (adding very satisfied and satisfied together) are satisfied with knowledge from ethics they had been taught.

Table 3.6: Major factors affecting medical ethics education

Institutional respondents/ Characteristic	MADONA Students/ Teachers	UPH Students / Teachers	DELSU Students / Teachers	NDU Students / Teachers	**TOTAL Students/ Teachers**
Teaching Method	6/1	8/--	10/1	6/4	**30(39.5%)/6(13.0%)**
Appropriateness of topic	½	5/9	3/1	6/5	**15(19.7%)/17(37%)**
Duration of class	2/--	2/3	3/1	½	**8(10.5%)/6(13.0%)**
Content of subject	3/1	4/5	5/7	11/4	**23(30.3%)/17(37%**
Total	12/4	19/17	21/10	24/15	**76/46**

For both respondents the content of the subject in the curriculum is a major factor affecting the teaching and learning of medical ethics. The least factor is duration of class but specifically for students teaching method is most important factor while for teachers it is the appropriateness of topic.

Discussion

Although neither medical students nor their teachers described ethics as being about wrong things in practice, when the low figures of 21% students and 17% lecturers who got the correct meaning of the subject, are examined against the high figures of 56% students and 67% lecturers who feel satisfied to practice confidently from that meaning, caution and care are needed to practice ethical medicine. This is because whether it is by commission or by omission it is morally wrong to be doing the right thing from a wrong standpoint. According to John Patrick, a pediatrician, the primary responsibility of the doctor is a moral responsibility. Thus whereas adherence to professional code of conduct may have more to do with professional etiquette, medical ethics is about morality in medical practice. In 1893 the Lord Chief Justice Coleridge of England made it clear in the case R v Instan that "It would not be correct to say that every moral obligation involves a legal duty; *but every legal duty is founded on a moral obligation.* [14] Uzodike [15] supported the Lord Justice by indicating that it is morals that govern medical practice. The author emphasized this by calling for proper education and information of the practitioner's conscience as an indicator of moral.

Moreover since the medical duty of care is a legal one it means that to fulfill it must be based on the recognition of a moral obligation on the part of the practitioner. Thus in the teaching of medical ethics the conscience of the learner should be awakened to the realization of this moral

responsibility in the call to the duty of care. Didactic teaching alone cannot achieve this. There is need for a dialogic teaching approach to untangle the student's self will. The dialogic approach enhances the learner's moral reasoning capacity which May [16] described to involve a moral imagination by the teacher in the life circumstances of the learner, to unlock the student's freedom to perform or think in a new way.

In our contemporary society the inadequate understanding of what medical ethics means, makes it uncertain if current approach to medical ethics education can enable students to achieve the new way of thinking. For instance, although the department of public health is, unarguably the department for the teaching of medical ethics, in all the schools visited the departments are not adequately staffed. Although this may be because they lack 'medically qualified' experts in the subject, in the West African Bioethics Training Programme its membership includes priests, lawyers, philosophers and social workers. It is this group that gave the technical support to the Federal Ministry of Health in the production of the National Code of Health Research Ethics which suggests that these experts can as well be involved the teaching of medical ethics. In the Asian countries 48% of teachers of medical ethics are either philosophers/ethicists, theologians or lawyers/social scientists.[17]

Although a dearth of materials is affecting the teaching of the subject, not to look outwards to other relevant departments in the universities, such as those of Philosophy and Public Law, denies the students of the expertise in those departments. Teaching medical ethics today requires a teacher with interest in the subject or a specialist in the subject and knowledgeable in the health system. Veatch observed that because expertise in ethical decision making may reside in some members of a profession but absent in others shows that there is no evidence of a quantum difference between a professional and a layman. [18] Therefore teaching medical ethics should help the learner to learn by providing opportunity for learning (progressive series of behavioral change) [19] and reflective thinking.

Inadequate time is also affecting the teaching of medical ethics. In this study out of a list of time durations, 81.8% and 65.2% of the students and teachers respectively identified few hours as the time spent in the teaching of medical ethics. Fadere and Famuyiwa had reported median durations of 3 and 5 hours respectively. Muyasaka et al.[17] found that 60% of the schools in China, Taiwan and the Philippines devoted more than 20 hours to the subject. Meanwhile Macer [20] reported that at the 1st International Conference on Medical Ethics Education 25 hours was recommended for an undergraduate's first three years of medical school. Whereas in the UK regular teaching intervals and time for reflection are provided, in the USA Muyasaka et al cite Miles and colleagues who argued for conceptual coherence, vertical and horizontal integration of the subject. In fact in the study by Ogundiran et al. by not identifying what they were taught as formal the students suggested that ethical issues are treated inappropriately and inadequately. The danger in this is obvious. In the case of infamous professional misconduct charged against one doctor A.O.O [15] it was because he used 8 weeks to train a House Officer in Obstetrics and Gynecology instead of the appropriate and adequate time of 12 weeks.

As for course content although the 2006 version of the Red Book has medical ethics topics to include history and evolution of medical ethics, duties of the doctor, the doctor and the law, responsibility, confidentiality, negligence and misconduct they are not topics to be handled in a few hours. Even so these topics are still not sufficient to adequately prepare doctors for the duty of care they should render to the contemporary patient. WHO [21] core content goes farther to include philosophical principles of medicine, surrogacy, inter-professional relations, care for the dying, rationing and allocation of scarce resources and issues of children and young people. With that content it shows that medical ethics should be treated as a course and not just as topics as shown in this study. For teaching method as a factor, report writing and case study of issues arising from practice have been recommended.[20]

Furthermore despite technological development, majority of lecturers graduating from medical school at the age range of 22-26 years and having been in practice for 18 – 24 years the moral reasoning of the people has yet to change, supporting what Dr. Gyoh a former Chairman of the MDCN described as resistance to change by some in the profession in Nigeria.[22] However, since both teachers and students agree on the minimum class (400) level to teach medical ethics, which also is in line with MDCN standard, [22] applying the dialogic method of teaching would over time enable students and practitioners to become more reflective and self-evaluative on the knowledge gained from the classroom, clinics (bedside) and community practice. This is important because moral reasoning among undergraduate students has been found to increase with age and level of education.[23]

Conclusion:

Although medical ethics is a very important subject in medical education, the didactic method of teaching and the inadequate time given to the teaching of the subject are not producing the medical personnel with the appropriate ethical knowledge to meet the needs of patients. There is therefore a need to bring in specialists in medical ethics, policy studies, law or moral philosophy to support the teaching of the subject. In addition the dialogic, case study and report writing methods of teaching should be introduced. These methods are essential to enhance the moral reasoning capacity of the learners and more time should be given for adequate coverage of the subject content. This way medical ethics education would be fairly treated in relation to other subjects in medical school curriculum.

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