ETHICAL ISSUES IN THE MANAGEMENT OF HIV/AIDS PATIENTS IN NAKURU DISTRICT, KENYA

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DECLARATION AND RECOMMENDATION

Declaration

I declare that this Thesis is my original work and has not been presented for any degree in this or any other University.

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DEDICATION

I would like to dedicate this work to my late father Mzee Peter Joseph Were Juma and my late mother, Mama Anne Adhiambo Juma who always struggled to make us as a family receive formal education. My wife Rose and children Charlene Bena, Naville Were and Eileen Anne who gave me all the inspiration and encouragement I needed during the study. Lastly to the larger Were family who have kept the academic fire burning in their village. God bless them all.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
AIDSCAP	-	Aids Control and Prevention Project
BTS	-	Blood Transfusion Services
CBOs	-	Community Based Organizations
CEN	-	The Council of Ethics in Nursing
DASCOs	-	District AIDS Committees
FHI	-	Family Health International
FPAK	-	Family Planning Association of Kenya
GOK	-	Government of Kenya
GPA	-	Global Programme on AIDS
HIV	-	Human Immuno Deficiency Virus
KAIS	-	Kenya Aids Indicatory Survey
KDHS	-	Kenya Demographic and Health Survey
KEMRI	-	Kenya Medical Research Institute
MoH	-	Ministry of Health
NAC	-	National AIDS Committee
NACC	-	National AIDS Control Council
NACP	-	National AIDS Control Programme
NASCOP	-	National AIDS/STD Control Programme
NGOs	-	Non-Governmental Organizations
PLWHA	-	Person (People) Living With HIV/AIDS
PLWA	-	Person (People) Living With AIDS
STDs	-	Sexually Transmitted Diseases
STIs	-	Sexually Transmitted Infections
TAPWAK	-	The Association for People With AIDS in Kenya
UNAIDS	-	United Nations AIDS Programme
UNGASS	-	United Nations General Assembly on HIV and AIDS
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
WHO	-	World health Organization

ABSTRACT

The cure of HIV/AIDS has not been discovered, hence causing fear, discrimination and stigmatization to the victims. The general objective of this study was to establish whether healthcare professionals understood and adhered to different codes of professional ethics while treating HIV/AIDS patients, and whether lack of this contributed to fear, discrimination and stigma. The study examined this problem through the utilitarian ethical theory propagated by Jeremy Bentham and John Stuart Mill. The main goal of utilitarianism is to minimize pain, misery and suffering which is part of what Hippocratic Oath of doctors and other ethical codes of healthcare professionals' state. The population of the study comprised of doctors, nurses, clinical officers, laboratory technicians and HIV/AIDS patients. The sample size consisted of 11 doctors, 91 nurses, 13 clinical officers, 10 laboratory technicians and 120 HIV/AIDS patients. The total respondents were 245 from the total number of 340 healthcare professionals and HIV/AIDS patients. The study was carried out in the Rift Valley Province, Nakuru, district, covering district government hospitals, namely Naivasha, Gilgil, Nakuru and Molo. The computer based statistical package for social sciences (SPSS) was used in data analysis. Data was analysed using descriptive statistics, by using tables and means. The hypotheses were that the majority of the healthcare professionals do not understand and adhere to their codes of professionalism while treating HIV/AIDS patients, which the study established not to be the case. Chi- Square test was used to test the hypotheses of the study. Major recommendations were that, there was need for healthcare professionals to continually undergo short courses to remind them of their unique profession in society, and that healthcare workers should maintain high standards of ethical professionalism, should improve their skills and knowledge, in order to keep current with scientific advances in medical knowledge.

CHAPTER ONE
INTRODUCTION

1.1 Background Information

In December 2011, the world through the World Health Organization marked 30 years of AIDS and the Global theme for the years 2009 and 2010 World AIDS day was 'Universal Access medical and Human Right'. It was an occasion to acknowledge the fact that AIDS pandemic had turned out to be far worse than imagined. This fact has led governments, national AIDS control programmes, faith based organizations and individuals around the world to draw attention to the global AIDS pandemic and emphasize the critical need for universal access to essential care. The 2009 and 2010 World AIDS day theme was chosen by the World AIDS campaign to sensitize the public and the need to access medication which was the same theme propagated in 2011. It was intended to encourage the public to deepen their understanding, develop partnerships and challenge discriminatory laws, policies and practices that stand in the way of access for all to HIV prevention, treatment, care and support, UNAIDS,(2012).

Since the first case of HIV/AIDS was diagnosed in Kenya in 1984 it has had a rapid and dynamic socioeconomic effect on development and this made Kenya as a country to realize many commitments to protect human rights, The Declaration on Commitment on HIV and AIDS (2006). To achieve these goals, Universal Testing for HIV was key to accessing all the services provided whether at prevention, treatment, care or support level. The Kenya National AIDS Strategic Plan (KNASP III) which aims to achieve Kenya's Universal targets for quality integrated services at all levels, states that this objective cannot be achieved in total due to the fact that 80% of Kenyans do not know their status, while 57% of those infected with HIV and in need of attention cannot access treatment because they either do not know their status or there are no Anti-Retrovirals (ARVs). Availability of drugs, according to United Nations Report (October, 2010), is contributing to longer survival for those infected with HIV.

According to the above United Nations Report, Kenyans accessing Anti-Retrovirals (ARVs) jumped from as low as 11,000 in 2003 to 138,000 in 2007 and 850,000 by March 2010. Due to this rapid spread of the pandemic, many people have been infected and treated in both private and government healthcare institutions. The number of those admitted has steadily been increasing to the level where most of these healthcare institutions are full to capacity (USAID, 2006). By being in these institutions, patients need care from the medical professionals, who are

the doctors, clinical officers, nurses and laboratory technicians. As a matter of fact AIDS is a terminal disease and no cure has been discovered anywhere in the world so far, apart from anti retroviral which are used to prolong the patients' lives. This has resulted in a situation whereby HIV/AIDS patients are perennially in hospitals or clinics seeking care and support from the medical professionals, hence the core of this study is ethical issues that arise from medical practice or medical profession.

The healthcare personnel need to offer professional service and their professionalism should be guided by the ethical principles at all times, as stated in the Hippocratic Oath of Doctors and in other codes of conduct for other healthcare professionals. However, the issue of HIV/AIDS being a syndrome that presents itself in a range of opportunistic infections, creates room for those people diagnosed as seropositive or ill with AIDS to decide either by accepting or resisting treatment, thereby developing lay theories about AIDS and establish coping strategies for dealing with their illness, (WHO,1999). In Kenya, the disclosure of HIV status is further complicated by limited privacy and poor confidentiality in overcrowded public health institutions, and a low doctor/patient ratio.Lack of clear symptoms of HIV/AIDS, inadequate medical physical facilities, overcrowding, and high illiteracy levels, all are barriers to easy HIV status disclosure. This allows people diagnosed with HIV/AIDS opportunity to develop strategies of 'covering' for HIV and 'passing' for other diseases, Bedell (1998). The disclosure of HIV/AIDS is a delicate and time consuming exercise. The low doctor/patient ratio requires that paramedical staff such as social workers and counselors be trained in making disclosures of HIV diagnosis in public health institutions and to understand the Oath of Confidentiality which is taken by other healthcare professionals.

The background of this study therefore is based on moral philosophy, also called ethics. It is a branch of philosophy that systematically and formally examines good and evil, the rightness and wrongness of human acts, the logic used in ethical arguments and the assumptions upon which ethical decisions are based. Medical ethics employs a more interdisciplinary setting which deals with issues that relate to medical practice and policies related to healthcare. Aristotle gave us the principles embodying the ethics of virtue in the 3rd world before Pythagorean philosophical corpus that gave rise to the Hippocratic Oath which has guided physicians in the ethos of medicine for 2000 years, Jones, (1972).

To support the interdisciplinary setting of medical ethics, John Locke, (1632-1704), wrote *A Second Treatise on Government,* which was the basis for a libertarian ethics, McPherson (1980). The concept of autonomy came from David Hume, (1711-1776), *An Enquiry concerning the Principles of Morals*, (1777). Consequentialism, also called the utilitarian ethic, came from John Stuart Mill, (1806-1873) who wrote *On Liberty,* (1859). Immanuel Kant, (1724-1804), wrote on the categorical imperative, which was indebted to the ethics of duty and John Rawls, (1921-2002), wrote about the distributive justice, Rawls, (1971).

Due to the devastating effect of HIV/AIDS, the government in 1999 declared HIV/AIDS a national disaster and established National AIDS Control Council (NACC) to coordinate a multi sectoral fight against the pandemic. The Kenya government through NACC recognized the need to work collaboratively alongside other partners in the fight against HIV and AIDS. To this end, Kenya developed Kenya National AIDS Strategic Plans that have guided the response to the epidemic. Two of these plans have been implemented with considerable success and are guiding factors towards realizing the goal of universal access to all who are either infected or affected by HIV and AIDS. In areas of prevention, National AIDS Control Council (2009) indicates that there has been improvement in reducing prevalence rate from as high as 14% in the year 2000 to a rate of 6.7% in 2003, 7.1% in 2007 and 6.5% in 2010,(NACC,2011). Similarly, on issues of treatment for opportunistic infections, the government aimed at meeting the challenge of putting eligible people on treatment which has seen the rise of Kenyans accessing Anti-Retrovirals (ARVs). This has increased from as low as 11,000 in 2003 to 138,000 in 2007 and 850,000 in March 2010, (United Nations Report, 2010).

The government endeavoured to encourage everyone to take personal and collective responsibility to stop new HIV infections, provide care and support to those living with HIV and to ensure access to treatment for all people in need. The approach by the government has been participatory, which calls upon local communities to undertake several HIV and AIDS programs. It has implemented a number of projects under the Total War against AIDS (TOWA) program, Chukwu (2002). These projects have been tailored to meet needs of the entire country as well as the needs of particular regions as felt by specific communities.

The programs have been centered on prevention, treatment, care and support of those infected by HIV and AIDS which form the basis of this study. There has been an implementation of the HIV Workplace Policy and the HIV and AIDS Act of 2006, which was effected in the early

quarter of 2009. Although the Act is still under review, it provides a major milestone in the era of universal access by tackling issues such as discriminatory practices against all those infected with HIV. According to UNAIDS (2009) reports, 40 million people live with AIDS in the world. It is estimated that 35.3 million of these people live in Africa. Since its recognition in 1981 in USA and 1984 in Kenya, AIDS has claimed 21.8 million people of which 17 million deaths are from Africa. The report further states that Kenya loses 300 people per day and this has reduced the life expectancy from 65 years to 46years.

In December, 2011, the World marked 30 years of HIV/AIDS. The occasion focused on the fact that the epidemic has turned out to be far worse than earlier predicted by the medical professionals. Despite the successes recorded in the fight against HIV/AIDS, there are many challenges that impede successful fight against the scourge and these include new infections.

The fight against HIV/AIDS faces the challenge of new infections due to the youthful population and the fact that there are many people currently infected. Another challenge is that although HIV prevalence has reduced from 14% in the 1990s to 7 percent currently, the high HIV prevalence is currently causing death to over 140,000 Kenyans per year, leaving over 1.7 million orphans. There are currently 1.4 million people living with the virus and it is expected that a significant number may die from HIV/AIDS related complications in the consequent years, Edge, (1994). Another challenge in this fight is poverty. HIV/AIDS has a direct impact on poverty as productivity declines and individual's income is reduced due to high treatment costs. Poverty levels are worsened when a breadwinner succumbs to AIDS. As a result of decline in productivity and income levels, economic growth and development is negatively affected. It is estimated that HIV/AIDS will reduce per capita income by 14% and economic growth by 10% by 2014 if the current high HIV prevalence is not checked. The high cost of treatment is also a major factor in this fight. HIV/AIDS is a costly disease which has led to an increase in the cost of treatment in terms of the high cost of ARVs.

There are key regional dynamics, such as heterosexual intercourse which remains the epidemic's driving force in sub-Saharan Africa, with extensive ongoing transmission to newborns and breastfed babies. However, recent epidemiological evidence has revealed the region's epidemic to be more diverse than previously thought. Sex work continues to play a notable role in many national epidemics and in Kenya, sex workers and their clients account for an estimated 14.1% of new HIV infections, UNAIDS (2010). In Uganda**,** sex workers, their

clients and their clients' partners accounted for 10% of new infections in 2008. Seven African countries, Benin, Burundi, Cameroon, Ghana, Guinea-Bissau, Mali and Nigeria report that more than 30% of all sex workers are living with HIV. Several recent studies suggest that unprotected sex between men is probably a more important factor in sub-Saharan Africa's HIV epidemics than is commonly thought.

In a recent survey of men who have sex with men in Malawi, Namibia and Botswana, the HIV prevalences among the participants were 21.4%, 12.4% and 19.7%, respectively. Although common in sub-Saharan Africa, homosexual behaviour is highly stigmatized in the region. More than 42% of men who have sex with men surveyed in Botswana, Malawi and Namibia experienced at least one human rights abuse. Injecting drug users in sub-Saharan Africa appear to be at high risk of HIV infection. In the region, an estimated 221 000 drug users are HIV-positive, representing 12.4% of all injecting drug users in the region. In Nairobi, 36% of injecting drug users surveyed by Kenya AIDS Watch Institute (KAWI) tested HIV-positive.

Evidence suggests that HIV prevention programmes may be having an impact on sexual behaviours in some African countries but in southern Africa, a trend towards safer sexual behaviour was observed among young men and women between 2000 and 2007. The proportion of adults reporting condom use during their first sexual encounter rose from 31.3% in 2002 to 64.8% in 2008. As in the case of increased access to antiretroviral therapy, sub-Saharan Africa has made remarkable strides in expanding access to services to prevent mother to child HIV transmission, WHO (2010).

In 2008, 45% of HIV-positive pregnant women received antiretroviral drugs, compared with 9% in 2004. Despite the improvements, the major challenge still remains in harmonization of activities and resource mobilization. The HIV Prevention Response and Modes of Transmission Analysis (2009) found out that the largest new infections, approximately 44%, occur among men and women who are in a union or in regular partnerships. Due to this rapid spread of the pandemic, many people have been infected and admitted in both private and government health care institutions. The number of those infected has steadily been increasing to the level whereby most of the facilities in these healthcare institutions have been over stretched and yet HIV/AIDS patients require treatment and care from these medical institutions, KAIS (2010). This disease is terminal and to date, no cure has been discovered anywhere in the world, apart from the anti-retrovirals that are used to prolong the patients' lives which has resulted in a situation where

HIV/AIDS patients are perennially in hospitals or clinics to seek care from the medical professionals.

While efforts to prevent HIV/AIDS infections are intensified, care, support and management to those infected and affected need to be made an integral part of these efforts. This should be carried out professionally by observing all the ethical codes that are demanded by each profession. There is need therefore to exercise professionalism in managing HIV/AIDS patients. The society has misconstrued the fact that many HIV/AIDS patients have died out of negligence and "I don't care attitude" from the medical professionals in medical practice, which implies that some healthcare professionals do not abide to the oaths they undertake after training.

Government hospitals in the Nakuru District have specifically been chosen for the study because unlike other districts in the province, the district has vibrant towns, namely Naivasha, Gilgil, Nakuru and Molo with many social activities because of their strategic locations. As such, they attract several sex workers from other towns, and this contributes to the spread of HIV/AIDS pandemic. These towns are located on the Great North Road, which traverses the country from the coast to the neighbouring African countries of Uganda, Rwanda, Congo (DRC) and Sudan. These are transit towns with many travelers who make stopovers on daily basis and as a result they are likely to engage into various social activities including having unprotected sex.

The effects of AIDS on individuals revolve around physical, socio-economic, moral and psychological perspectives and therefore, there is need to understand the importance of professional ethics for those who attend to the infected and affected people. In particular, doctors, nurses and other healthcare workers ought to be professional while treating HIV/AIDS patients. The prolonged illness tends to prevent an individual from going about his/her normal business and may cause disruption of family life due to frequent and prolonged hospitalization and eventually death. Being an expensive illness, families end up depleting their financial resources while the patient is still alive and this continues even after death.

As a result, those patients who are still under the care of health workers require proper management in terms of medical professionalism to avoid the patients being discriminated and stigmatized. The study shades light on the issues that contribute to lack of professionalism in healthcare practice, by investigating and analysing different oaths that these healthcare professionals undertake after their training and how they apply these oaths when attending to

their clients, specifically HIV/AIDS patients. Utilitarianism as an ethical doctrine is therefore a type of consequentialism which assesses actions on their outcome, with no consideration of the moral nature of the individual performing that action. The value of the action is assessed purely on the overall benefaction to utility, (happiness/goodness).

1.2 Statement of the Problem

The cure of HIV/AIDS has not been found hence causing wide spread fear, discrimination and stigmatization. This has remained a major challenge to Kenya as a country and to healthcare professionals in general. Lack of understanding, application and adherence to different ethical codes of conduct by healthcare professionals in treating HIV/AIDS patients, has caused fear, despondency and a sense of hopelessness to all communities living in Kenya. Those affected and infected have become unproductive members of society in terms of development. The patients become stigmatized and discriminated against by most people including healthcare professionals; hence the need to establish how the society can accommodate HIV/AIDS patients and how healthcare professionals can help reduce or eliminate the fear of being stigmatized and discriminated. There is a need to manage the patients professionally. The healthcare personnel as professionals, who are guided by the ethical principles at all levels of their operations are in a better position to encourage these patients to lead a more comfortable and affirmative life in society rather than feeling stigmatized, and rejected leading to living hopelessly. The study focused on whether healthcare professionals comprehend and adhere to their professional codes of conduct during treatment of HIV/AIDS patients.

1.3 Objectives of the Study

The study was guided by the following objectives:

1. To establish whether healthcare professionals in Nakuru district government hospitals understand ethical codes of conduct of their profession.
2. To establish whether healthcare professionals in Nakuru district government hospitals adhere to and are guided by professional ethical codes of conduct and principles in discharging their duties concerning HIV/AIDS patients.

1.4 Hypotheses

1. The Healthcare Professionals in Nakuru district government hospitals do not understand professional ethical codes of conduct prescribed in their training while handling HIV/AIDS patients.
2. The Healthcare Professionals in Nakuru district government hospitals do not adhere to and are not guided by professional ethical codes of conduct and principles in the discharge of their duties concerning HIV/AIDS patients.

1.5 Significance of the Study

Since HIV/AIDS was discovered in Kenya in 1984, the society, including the healthcare professionals, infected and the affected are still not conversant with relevant methods of managing, and offering care to those infected due to the complexity of this disease. As such, the study intended to come up with ways and suggestions on how healthcare workers can improve professionally and ethically on how to treat HIV/AIDS patients. These patients just like those suffering from diabetes or cancer can still live longer if well managed by the society in general and the healthcare fraternity in particular by helping them eliminate stigma and fear. It is assumed that some of these patients die prematurely purely due to lack of professionalism by the medical professionals handling them. Statistically, the Kenya Medical Association (KMA) report (2008), indicates that Nakuru district is among the leading districts in HIV/AIDS pandemic infection. This has been attributed to many factors, such as migrant workers who come to work on the big farms within this district, mobile workers such as salesmen/women and truck drivers who stop overnight in these towns. This attracts migrant and traffic sex workers who are likely to be HIV infected and who operate from one town to another. Finally, although there have been several studies done on HIV/AIDS, most of them have dwelt on prevention, care and treatment; hardly any major research has handled management and care of those already living with HIV/AIDS. The study therefore intends to come up with various solutions, suggestions and HIV/AIDS management strategies, which if well implemented by healthcare professionals, will result in the lives of those living with HIV/AIDS being prolonged, hence saving lives of those who would have died prematurely due to poor management.

1.6 Scope of the Study

This study was carried out in Rift Valley Province of Kenya, Nakuru district. The study intended to cover four government district hospitals, but it only covered three, namely Naivasha

district hospital, Gilgil district hospital and Molo district hospital. Rift Valley Provincial hospital was not covered due to the reasons stated under limitations. Naivasha district hospital is situated about 78 kilometres from Nakuru town, on the main Nairobi- Nakuru highway. Gilgil district hospital is also situated along Nairobi- Nakuru highway, about 50 kilometres from Nakuru town. Rift Valley Provincial hospital is about 5 kilometres from Nakuru town centre while Molo district hospital is about 60 kilometres off Nakuru-Kericho highway. These hospitals were visited and questionnaires were administered to doctors, nurses, clinical officers, laboratory technicians and HIV/AIDS patients. This was done with the aim of establishing whether the healthcare professionals understood and adhered to what their oaths and other ethical codes of conduct stipulated and whether they are guided by the same principles in their medical practice.

1.7 Limitations of the Study

A serious limitation was that the issue of HIV/AIDS is quite personal and sensitive. As a result, it is worth noting that the researcher encountered difficulties when trying to search for raw data from the patients, who were the real target of this study in order to give first hand information about the ethical behaviour of healthcare professionals. The study targeted four public district hospitals in the Nakuru district, namely Naivasha district hospital, Gilgil district hospital, Rift Valley Provincial hospital and Molo district hospital. However, the researcher encountered difficulties in all hospitals. General difficulties in all hospitals, apart from Rift Valley Provincial Hospital were that many staff members were not quite interested in filling the questionnaires and some persuasion and payment had to be done for them to do so. The researcher and the assistant had literally to be in these hospitals everyday in order to access some healthcare professionals who apparently report to duty on daily basis. This proved to be costly. It meant that the research assistant had to be paid on daily basis. A more serious problem however was that the researcher could not be allowed to administer the questionnaires to the patients directly since it was argued that it was a confidential medical issue. In all hospitals, questionnaires for patients were given to the nurses in charge of VCT Centres, who later administered them to HIV/AIDS patients.

Another obstacle initially was to get sufficient number of healthcare professionals to fill the questionnaire, but eventually, they turned up after some lobbying was done. Doctors proved to be the most difficult ones to access but those who were found, were very willing to fill the questionnaire instantly and many who took the questionnaires away returned them after filling.

This was attributed to the fact that most of them were visiting doctors who report on duty on different days and at different hours, which made it difficult to get the majority at once. The other limitation was that data was collected through a questionnaire rather than by direct observation of real life in terms of how the HIV/AIDS are handled when they visited these VCT centres. As indicted earlier, the researcher could not carry out any research at Rift Valley provincial hospital. After having been cleared by the hospital's research board, it was impossible to access the doctor who was in charge of VCT Centre, despite literally being in her office daily. The researcher had to use one clinical officer who tried to access staff and patients but it proved to be difficult to gather enough numbers. Due to this difficulty, only two questionnaires were administered to two healthcare professionals given that all the questionnaires had to be handled by the VCT office. Also ethically, problems of healthcare in managing HIV/AIDS patients or any other Sexually Transmitted Disease have traditionally been associated with immorality, hence making one shy and reluctant to talk about it. Another limitation which this study encountered is that the management of HIV/AIDS had not been emphasized before, compared to what is being easily talked about today like the prevention and cure, hence making it more difficult in terms of approach to those who are already sick or affected.

1.8 Definition of Terms

The following terms were defined as follows;

Act-Utilitarianism: Human action typically takes place within the fabric of our social existence. Thus an action performed by one person often affects not only the agent but also the lives of many others. The basic principle of act-utilitarianism is, "A person ought to act so as to produce the greatest balance of good over evil, everyone considered.

Rule-Utilitarianism: It is a theory which states that a person ought to act in accordance with the rule that, if generally followed would produce the greatest balance of good over evil, everyone considered.

Autonomy: The term implies that the patient has a right to refuse or choose their treatment, "voluntas aegroti suprema lex". The principle of autonomy recognizes the rights of individual's to self determination. This is rooted in the society's respect for individual's ability to make informed decisions about personal matters.

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.

Confidentiality: It is commonly applied to conversations between doctors and patients. This concept is commonly known as patient-physician privilege. Traditionally, medical ethics has viewed the duty of confidentiality as generally not negotiable tenet of medical practice.

Discrimination: Discrimination relates to action and behavior, treatment based on those negative attitudes. Treating different things or people in different ways.

Ethics: These are rules or standards governing the conduct of a person or the members of a profession like in medical ethics. It is also a branch of knowledge that deals with moral principles.

Ethical Code: It refers to a set of guidelines that guarantees and fosters the genuine ethos of a profession. These are rules guiding physicians and other healthcare professionals confronted with particular needs on the part of the patients. As codes of professional behavior, they provide guiding principles for the medical profession or particular medical bodies, which grant protection to the physician and assurance to the patient and the whole
of society.

Ethical Issues: Is a problem or situation that requires a person or organization to choose between alternatives that must be evaluated as right (ethical) or wrong (unethical).

Ethos: It comprises of the distinctive attitudes, which characterizes the cultural outlook of a professional group, in so far as this occupational subculture fosters adherence to certain values and the acceptance of a specific hierarchy of values, such as ethos of the priest, physician, a military officer, judges and lawyers who commit themselves to social values of the first order.

Informed consent: Doctors will give the patient information about a particular treatment or test in order for the patient to decide whether or not he/she could undergo such treatment or test. This process of understanding the risks and benefits of treatment is known as informed consent. It is based on the moral and legal premise of patient's autonomy. The patient has a right to make decisions about his/her own health and medical conditions.

Management: Management is the act of managing in terms of handling especially the skills in dealing with other people and particularly in this case, treating HIV/AIDS patients.

Non –maleficence; The concept of maleficence is embodied by the phrase "first do no harm' or the Latin " primum non nocere". That it is more important not to harm your patient, than to do them good.

Stigma; Refers to the realm of attitudes and perceptions. The word "stigma" has Greek origins referring to the marks of physical deformities. But in modern times, stigma has been defined as an undesirable or discreding attributes that an individual possesses, thus reducing that individual's status in the eyes of society.

Ethical committees: These are bodies which 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 in terms of deciding on complex issues that pertain to the management of patients.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

The main purpose of this chapter is to address critically literature regarding the study. It examines the Hippocratic Oath taken by doctors and other ethical codes of conduct taken by other healthcare workers in their profession. Internationally, there has been an interet to the response in HIV/AIDS related stigma and discrimination, which has brought about negative social responses to both the infected and the affected. Despite this, no serious policy has been formulated to the effect of reducing this phenomenon. Stigma has classically been formulated significantly as a discrediting attribute which is brought about by various factors. In this literature review, the study offers a framework to understand HIV/AIDS related stigma and discrimination effects. It highlights how the healthcare professionals are trained and their different ethical codes of conduct which they take after the training or in line with their duties. It is a philosophical assumption that when these different ethical codes of conduct are upheld, then stigma and discrimination can be alleviated. The chapter also discusses the patients' rights, autonomy, confidentiality, theoretical and the conceptual framework of the study.

2.2 The Effects of HIV/AIDS

According to UNAIDS report (2011), twenty-seven years after HIV/AIDS was medically recognized, it has become clear that it is more than just a medical issue. It pervades all spheres of live, be it social economic, political or cultural. It is also more than just an individual problem, for it affects families, disciplines, departments, governments, non-governmental organization and even community-based organizations (CBOs). The multi sectoral impact of HIV/AIDS has necessitated a multi-sectoral approach to its prevention, care and the mitigation of its impact. The approach calls for the mainstreaming of HIV/AIDS in all spheres and institutions of human lives.

The rapid progress made by medical technology has presented medicine and society with unprecedented ethical, legal and economic dilemmas. In other words, ethical principles apply across all fields of study such as in medicine, law and even in economic affairs. At a time when there seems to be an ethical collapse both in society and in the medical profession, there is a parallel upsurge in interest in medical ethics, Dunstan(1989). Twenty years ago, hardly any Kenyan medical school included this subject in their curriculum, but now, with the promulgation

of the new constitution, many medical schools have formal courses in ethics. This notion is applied worldwide, for instance in England, there is an Institute of Medical Ethics with its own journal, while in 1992, an International Association of Bioethics was launched in Melbourne, Australia, Ryan (2010). Currently, many books have been written on the subject and most hospitals now have an ethics committee to assess treatments and research projects. The World Medical Association has issued a series of ethical statements as guides to physicians and generally to all healthcare professionals. In Kenya, there is The Medical Practitioners and Dentist Board which is a statutory authority under cap 253 laws of Kenya. The board regulates the practice of medicine and dentistry in the country. It serves to check the ethical conduct of health workers and how they relate to patients.

Misconceptions, stigmas and discrimination have posed large barriers in Kenya's fight against HIV/AIDS. Those infected by the virus constantly deal with issues of discrimination and stigmatization because HIV/AIDS is viewed as a disease of the morally corrupt because of the ways in which it is transmitted. In many cases, if a person's AIDS status is revealed, they risk losing their jobs, housing and even social relationships. Lack of education and knowledge about the disease reinforce these discrimination and stigmatization, Chukwu, (2002).

2.3 Ethical Committees in Medical Practice

In response to the increasing number and importance of moral dilemmas in medical practice, hospitals have formed ethics committees to handle ethical issues that arise from the management of HIV/AIDS and other illnesses. These issues constitute an increasing concern for human rights, including the problem of informed consent before medical intervention and the increased strength of the consumer movement with demand for better information on healthcare and various aspects of treatment, Ryan (2010). The term 'ethics committee' under discussion should not be confused with ethics committees for research.

Ethical committees have been initiated by physicians themselves and have become common in medical institutions worldwide, including Kenya. They evaluate the objectives of intended research projects and protect patients from being used without their consent. It might be asked why medical practice alone among many professions has attracted fulltime attention of so many ethicists. An answer to this is that the public is more concerned with their body health than with their financial or political well-being. A more relevant explanation is the change in the doctor-

patient relationship, the affluence of the medical care system and the activities of the medical profession itself, Stroll (2010).

Shenken (1991) explains that up until the mid of twentieth century, the relationship between doctor and patient was always one to one and public health problems were in the domain of epidemiologists and state officials. As long as this form of relationship persisted, then the attention of the public and ethicists was not attracted to medical practice but the introduction of "third party payers" such as medical insurance plans and the government (Medicare and Medicaid) to pay medical bills altered the one to one relationship. Previously the cost of medical care was an individual responsibility and has now become a public concern which has led to a moral obligation, ethical principles and the need for medical ethics. This led to the public concern to get to know how hospitals operated and as well as how doctors practiced.

Another factor that has propelled ethics for medical practice a head of ethics or other professions has been the activities of physicians and other healthcare professionals themselves. Shenken (1986) states that in 1904, the American Medical Association (AMA) created a council on medical education which established "an ideal standard" for medical education. The council inspected medical schools and urged the state not to license graduates from inferior colleges to operate. Similarly in Kenya, there are various professional medical bodies that inspect medical colleges to ascertain whether they conform to the required professional standards or not, and such one body is Pharmacy and Poisons Board.

A final reason for the need of professionalism in medicine is the appointment of consultant ethicists as hospital staff. It has alerted many physicians and other healthcare professionals in general to be extra careful when making a medical judgment. This brings in utilitarianism debate that was developed by Jeremy Bentham (1749-1832) and John Stuart Mill (1806-1873). The deontological system was also expounded by Immanuel Kant, (1886). Deontology proclaims there are universal rules for behaviour, and intuitively understood by a rational man. By reflection, all rational persons know what is right or what correct conduct is. Kant (ibid) believed that there was one supreme moral law which states that all men should act only on those maxims capable of being willed as universal laws and no person should be treated as a means, but always as an end, since all people have intrinsic moral worth that needs to be respected. More contemporary deontologists have expanded this monistic approach to a pluralistic one. They state that our common moral convictions are composed of a plurality of principles that cannot be

reduced to one another as to some higher single principle. Ross (1980) believes that the so-called *prima facie* moral obligations (obvious on the face of it or at first sight) can be listed by reflection upon and analysis of our intuitions. Besides principles which apply to everyone as a rational being, there are also particular duties that apply to those with special roles as doctors. Physicians have a particular duty to their patients, to promote their health and respect their confidence to avoid stigma and discrimination.

2.4 Stigma, Discrimination, and HIV/AIDS

During the first few years of the 21st century, discussion of HIV and AIDS shifted to a greater focus on related issues, such as stigma and discrimination, gender, and development. Recognition of the significance of HIV related stigma and discrimination has put these issues at the forefront of strengthening effective responses to HIV. At long last, academics, researchers, activists, service providers, and people living with HIV/AIDS are beginning to understand and articulate the consequences of addressing and measuring stigma and discrimination. This study reviews the present understanding of HIV/AIDS related stigma and discrimination as they relate to vulnerability, and suggests approaches for stigma reduction. It explores and examines what constitutes stigma and discrimination, the effects it has on behavior, HIV/AIDS responses, and what the society has done to reduce these factors, Morrison (2006).

Stigma and discrimination, according to Delor and Hubert (2000), are recognized as two key factors that need to be addressed to create an effective and sustained response for HIV prevention, care, treatment, and impact mitigation. The effects of HIV-related stigma and discrimination can be felt on many levels: individual, family, community, programmatic, and societal. They represent obstacles such as preventing individuals from being tested; preventing persons from recognizing that they or family members are HIV positive; inhibiting people from seeking care, support, and treatment; causing people to mislead others; impeding people from using protection in intimate relations; preventing quality care and treatment; increasing social inequities; hindering the access of people living with HIV to housing, education, employment, and mobility; negatively affecting quality of life; and, eventually, leading to increased transmission, morbidity, and mortality.

Stigma and discrimination are interacting aspects that are common in all walks of life. While stigma refers to the realm of attitudes and perceptions, discrimination relates to action and behavior. The word “stigma” has Greek origins referring to the marks of physical deformities of

foreigners or persons deemed inferior, Strax, (2010). Christians gave this word a twist by using it to refer to the physical indications of the divine spirit. In modern times, stigma has been defined as "an undesirable or discrediting attribute that an individual possesses, thus reducing that individual's status in the eyes of society" Goffman, (1963). This led to a clear conclusion that the majority of those affected by HIV had one thing in common, that is, they were in some way or another marginalized within society. UNAIDS recognising the vital importance of reducing HIV related stigma and discrimination, and addressing HIV within a human rights framework, made this the theme of the world AIDS Day Campaign for both 2002 and 2003 years.

Parker and Aggleton (2003) provided a basis for action in this campaign by stressing that stigmatization is a process that works to produce and reproduce power relations and that HIV-related stigma reinforces existing social inequalities. This framework outlined four priority issues for action, which are as follows;

a) Improved understanding of stigma and discrimination, where they come from and what they do.

b) Increased appreciation of links to broader existing inequalities and injustices.

c) Better understanding of the complex stigma and Discrimination related issues that precipitate the epidemic.

d) Clear identification of objectives for results.

2.5 Morality and Happiness

Utilitarianism states that morality is determined by what maximizes happiness or what minimizes suffering or misery. Another description is that it is a doctrine which states that the rightness or wrongness of an action is determined by the goodness or badness of its consequences.

Smart (1995) argues that while some have interpreted utilitarianism to mean assessing the consequences of an action to the individual perpetrating it (egoistic utilitarianism), the majority of utilitarian believe the morality of action is dependent upon a calculation of its impact on society in terms of its producing the greatest happiness for the greatest number (universalistic utilitarianism). It is self-evident in this system that happiness is good and suffering is evil.

The most important division in utilitarianism was created between what is described as "act" and "rule" utilitarianism, Smart, (ibid). In the former "actions" mean particular actions and the

rightness or wrongness of an individual action is determined directly by the assessment of its consequences. When the word actions is interpreted to mean "sorts of actions", then it is rule utilitarianism that is invoked. Rule utilitarianism considers the consequences of each particular action but also it considers the consequences of adopting a general rule for actions. A rule for action is adopted if the consequences of all such actions are better than those of the adoption of some alternative rule. In a sense, rule utilitarianism can be considered deontologic or Kantian, since one has a duty to act in a certain way, based upon a theory, which is to produce the best consequences, implying the greatest happiness or the best welfare of society.

Modern utilitarians have advanced their theory to state that the best way to maximize overall happiness is to maximize the satisfaction of individuals by favouring their personal preferences. This provides a basis for the rights of individuals, their autonomy and their freedom.

Utilitarianism, particularly egoistic utilitarianism seems to override moral principles that are widely accepted such as respect for honesty and openness, promise keeping, justice and individual autonomy. Indeed, Mill (1863) had started to respect the autonomy of the individual, in so far as compatibility with autonomy for all is a fundamental component of utilitarianism.

Applied philosophers, ethicists and lawyers have devoted considerable energy to exploring the dilemmas emerging from modern health-care practices and their effect on the practitioner-patient relationship. Beyond healthcare, other groups have begun to think critically about the kind of service they offer and about the nature of the relationship between the provider and recipient in many areas of life. Social political and technological changes have challenged both traditional ideas of practice and underlying conceptions of what professions are. Competing trends towards "professionalization" on the one hand and the proliferation of codes of ethics or of professional conduct and towards challenging the power of the traditional liberal professions on the other hand, has raised great concern as to how healthcare personnel relate to their patients, George (1975).

Professional ethics is now acknowledged as a field of study in its own right; much of its recent development has resulted from rethinking traditional medical ethics in the light of new moral problems, arising out of advances in medical science and technology. Professional ethics therefore seeks to examine ethical issues in the professions and related areas both critically and constructively. These addressed issues are relevant to all professional groups, such as the nature of profession and the function and value of codes of ethics which give guidance as to how

professionals ought to relate to others. The study specifically dealt with the relations between the patient and the healthcare professional in line of his/her duty.

2.6 The Hippocratic Oath and Other Ethical Codes of Conduct

The ethical codes of conduct attempt to formalize values and standards by raising a number of questions about profession and the consequent moral implications for behaviour which touches on professionalism. This study points out that unethical behaviour of healthcare professionals contributes to the suffering and pain of HIV/AIDS patients and yet medicine is supposed to be a life of service to the patients, to their families and to society. The ideal motto for the physician is *caritas et justitia*, which means "love and justice". Expressed in another way, the purpose of medicine is sometimes to cure, often to relieve, and always to console, Dunn (1999).

The first and most succinct formulation of the duty owed by a doctor to his patients is contained in the Hippocratic Oath written in Greece sometime in the 5th century BC by Hippocrates, the man who was recognized as the father of western medicine. Hippocrates states "I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone", Jonsen (1990). Although the language of the oath has evolved through the ages, its essence remains the same and continues to guide modern medical ethics throughout the world. This duty has been recognised by law as a doctor's (and other medical practitioners') 'duty to take care' and applies irrespective of whether he has signed a contract of service with the patient, incorporating or excluding such duty.

The underlying assumption is that a person who offers medical advice and treatment implicitly states that he has the skill and knowledge to do so, to decide whether or not to take the case, to determine the nature of the treatment and to administer the treatment. If, therefore, in his treatment, a doctor deviates from accepted standards of practice and causes injury to or death of a patient, he is guilty of professional negligence and liable to pay damages to the patient or his/her next of kin.

The law on medical negligence has been developed considerably in the West where doctors maintain professional liability insurance to offset the risk of claims brought against them for professional negligence. In all instances, however, a doctor can only be held liable if the person suing him succeeds in proving or the situation is so clear that it speaks for itself that the doctor is guilty of a failure that no doctor with ordinary skills would be guilty of if acting with reasonable

care. Doctors cannot, nor are they expected to, guarantee either their skill or the outcome of the treatment. All they can do is act with reasonable care.

One solution is to enable persons to seek redress through consumer courts, as is being done in India. These courts are located in smaller districts and a person may appear before them without a lawyer. Here too, however, he would still need to establish that the injury or death was a result of an act or omission of the doctor. It is unlikely that a layperson would be sufficiently savvy or have access to necessary materials, to make the legal connection between the outcome, of which he complains, and the treatment he was given.

In any event, redress through the courts is a remedy after the fact and offers little comfort to a person facing the prospect of losing a limb or his life. Therefore, more important than allowing greater access to courts and enhancing the penalties for negligence are to take steps to prevent negligence from occurring in the first place.

While recognising not only that doctors owe a fundamental duty of care to their patients but also that there is need to reform the present legal framework of the profession, it is essential to ensure that the focus of all reform is on distinguishing those doctors that act in good faith and to the best of their ability from those that are negligent, rash or reckless and on punishing only the latter with appropriate and objective severity. A solution lacking this balance will drive out any good doctors that may still remain in the country and leave the field open to their less vigilant peers to play with the lives of patients according to their whims. This study points out that the unethical behavior of some healthcare professionals contribute greatly to the suffering and pain of HIV/AIDS patients. However, Pace and Dougall (1978), state that doctors and other healthcare professionals have a moral obligation to always act in the best interest of their patients, provided they keep within their own moral and ethical principles as stated in the Oath;

> I will maintain the utmost respect for human life from time
> Of conception, even under threat, I will not use my medical
> knowledge contrary to the laws of humanity.
> Geneva Declaration (1948).

In San Francisco, for instance, the medical treatment was withheld to some patients and the main reason for not treating or stopping treatment were either futility of further treatment, extreme suffering or requests by the patients' families "DNR" (Do Not Resuscitate) orders which

preceded the actual withholding or withdrawing of further treatment and as per Hippocratic Oath, this is quite un ethical as it is stated;

> I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment and I will do no harm or injustice to them.
> I will neither give deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Lasagna (2001).

Medical understanding of these duties has been affected by three different currents of thinking as stipulated by Jonsen (1990). The first current is the one flowing from the origins of modern medicine in the Ancient Greek world, which has undergone various changes from time to time as indicated.

2.6.1 Original Version - Harvard Classics Volume 38, (1910)

I SWEAR by Apollo the physician, Aesculapius, and Health, and All-heal and all the gods and goddesses, that, according to my ability and judgement, I will keep this Oath and this stipulation.

TO RECHON him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look up his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others.

I WILL FOLLOW that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give a woman a pessary to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves.

WHATEVER, IN CONNECTION with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!

2.6.2 Modern Version of The Hippocratic Oath Harvard Classics Volume 38, (1910)

I SWEAR in the presence of the Almighty and before my family, my teachers and my peers that according to my ability and judgment I will keep this Oath and Stipulation.

TO RECKON all who have taught me this art equally dear to me as my parents and in the same spirit and dedication to impart knowledge of the art of medicine to others. I will continue with diligence to keep abreast of advances in medicine. I will treat without exception all who seek my ministrations, so long as the treatment of others is not compromised thereby, and I will seek the counsel of particularly skilled physicians where indicated for the benefit of my patient.

I WILL FOLLOW that method of treatment which according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is harmful or mischievous. I will neither prescribe nor administer a lethal dose of medicine to any patient even if asked nor counsel any such thing nor perform the utmost respect for every human life from fertilization to natural death and reject abortion that deliberately takes a unique human life.

WITH PURITY, HOLINESS AND BENEFICENCE I will pass my life and practice my art. Except for the prudent correction of an imminent danger, I will neither treat any patient nor carry out any research on any human being without the valid informed consent of the subject or the appropriate legal protector thereof, understanding that research must have as its purpose the furtherance of the health of that individual. Into whatever patient setting I enter, I will go for the benefit of the sick and will abstain from every voluntary act of mischief or corruption and further from the seduction of any patient.

WHATEVER IN CONNECTION with my professional practice or not in connection with it I may see or hear in the lives of my patients which ought not to be spoken abroad, I will not divulge, reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this Oath unviolated may it be granted to me to enjoy life and the practice of the art and science of medicine with the blessing of the Almighty and respected by my peers and society, but should I trespass and violate this Oath, may the reverse be my lot.

According to Collier, (1993), Hippocrates, the celebrated Greek physician, was a contemporary of the historian Herodotus. He was born in the island of Cos between 470 and 460 B.C., and belonged to the family that claimed descent from the mythical Aesculapius, son of Apollo. There was already along medical tradition in Greece before his day, and this he is supposed to have inherited chiefly through his predecessor Herodicus and he enlarged his education by extensive travel.

The works attributed to Hippocrates are the earliest Greek medical writings, but very many of them are certainly not his. Some five or six, however, are generally granted to be genuine, and among these is the famous "Oath." This interesting document shows that in his time physicians were already organized into a corporation or guild, with regulations for the training of disciples, and with the spirit of service and a professional ideal which, with slight exceptions, can hardly yet be regarded as out of date.

One saying occurring in the words of Hippocrates has achieved universal currency, though few who quote it to-day are aware that it originally referred to the art of the physician, Rebello (2003). It is the first of his "Aphorisms": "Life is short and the Art long; the occasion fleeting; experience fallacious, and judgment difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate. Collier(1993) continues to argue that the law of Hippocrates entails five characteristics which are as follows;

a) Medicine is of all the arts the most noble; but, owing to the ignorance of those who practice it, and of those who, inconsiderately, form a judgment of them, it is at present far behind all the other arts. Their mistake appears to me to arise principally from this, that in the cities there is no punishment connected with the practice of medicine (and with it alone) except disgrace, and that does not hurt those who are familiar with it. Such persons are the figures which are introduced in tragedies, for as they have the shape, and dress, and personal appearance of an actor, but are not actors, so also physicians are

many in title but very few in reality.

b) Whoever is to acquire a competent knowledge of medicine, ought to be possessed of the following advantages: a natural disposition; instruction; a favourable position for the study; early tuition; love of labour; leisure. First of all, a natural talent is required; for, when Nature leads the way to what is most excellent, instruction in the art takes place, which the student must try to appropriate to himself by reflection, becoming an early pupil in a place well adapted for instruction. He must also bring to the task a love of labour and perseverance, so that the instruction taking root may bring forth proper and abundant fruits.

c) Instruction in medicine is like the culture of the productions of the earth. For our natural disposition, is, as it were, the soil; the tenets of our teacher are, as it were, the seed; instruction in youth is like the planting of the seed in the ground at the proper season; the place where the instruction is communicated is like the food imparted to vegetables by the atmosphere; diligent study is like the cultivation of the fields; and it is time which imparts strength to all things and brings them to maturity.

d) Having brought all these requisites to the study of medicine, and having acquired a true knowledge of it, we shall thus, in travelling through the cities, be esteemed physicians not only in name but in reality. But inexperience is a bad reassure, and a bad fund to those who possess it, whether in opinion or reality, being devoid of self-reliance and contentedness, and the nurse both of timidity and audacity. For timidity betrays a want of powers, and audacity a lack of skill. They are, indeed, two things, knowledge and opinion, of which the one makes its possessor really to know, the other to be ignorant.

e) Those things which are sacred are to be imparted only to sacred persons; and it is not lawful to impart them to the profane until they have been initiated into the mysteries of the science.

The Hippocratic oath was an oath generally thought to be written in the 5th century BC by Hippocrates, who is considered by many to be the founder of modern medicine but some scholars now question Hippocrates' authorship of the Hippocratic oath, and certain scholars believe that instead, Pythagoras may have authored the oath, Rebello, (2003). It is also being assumed that the Hippocratic oath is still taken by all doctors and that the most important part of

the oath is a promise to " first, do no harm" , but the incoming physicians do not recite the Hippocratic oath in its original form, though many physicians recite a modernized version of the oath. The phrase derives from another part of Hippocrates writing and is not in the oath, Ludwig, (1943).

The classic Hippocratic oath swears first to honour one's teachers, take care of their family or children if need be, and offer free medical training to a teacher's children. The oath does describe a promise to try not to harm anyone and to prescribe medicines to the best of one's abilities, and to never give medications that could be used to poison someone or to cause a woman to abort a child.

The Hippocratic oath further promises never to cut anyone (perform surgery), which clearly is not valuable in modern applications. It enjoins that physicians keep their patients' conditions private, that they do not have sexual relationships with patients or a patient's family, and that they work always for the good of the patients, Curan, (1978). Certain modern versions of the Hippocratic oath are similar in construction. Some physicians upon taking the oath still swear not to perform abortions. Most tenants of the oath are promises, and do not carry the strength of the initial Hippocratic oath. Instead, any practices of physicians in most countries are legislated by governing medical boards. Breaking the laws can mean losing one's license to practice.

The original Hippocratic oath contains too many promises that have become increasingly morally challenging. For example, the Oath questions whether it constitutes harm for a doctor to perform abortions. Further, it questions whether physician-assisted suicide is a violation of the same oath. Thus the oath, like the marriage vows are promises that may not be kept, even if the oath is taken with due solemnity. Most would be surprised to learn that about 100 years ago, only 20% of American physicians took the Hippocratic oath, Ben, (2001). The number has actually increased steadily, with virtually all medical school graduates in the US now taking some form of the oath. The modern oath seems more of a rite of passage than an actual swearing of actions. The only promises a physician must keep are those that are made laws by governments, medical review boards, or hospitals in which a physician works.

Rabello (2003) argues that the current Oath is quite outdated and therefore he formulates one of what he calls the latest Oath for doctors and urges all physicians to read. According to him,

many doctors have forgotten their Hippocratic Oath or humanism and therefore, he administers the following oath to the doctors to serve as a reminder as to how important is their profession of which he calls the most modern;

I, ----------, do hereby swear on this solemn day that :-

I shall not prescribe unnecessary medicines and tests to my patients;

I shall not give false counseling

It shall not overcharge and accept cuts and gifts;

I shall not rape tiny tots with mercury laced innoculations or vaccinations, for they pollute the blood stream of small children leading to serious diseases like AIDS, Cancers, Autism, etc.;

I shall not prescribe lethal drugs, like anti-retrovirals, chemotherapy, or give ECT to my patients; I shall not indulge in human organ thefts to the detriment of my patients;

I shall not be afraid of any authority and fabricate medical records or give false evidence;

I shall not exploit students studying under me;

I shall not manipulate findings or results to win grants or awards.

I, ----------, further solemnly affirm that:-

If I cannot treat a disease, I shall not say that AIDS, cancers, diabetes has no cure. But will tell the patient to try other systems of medicine.

I shall treat health practitioners of other systems with respect and not tell deliberate lies to prove my importance. I shall study Holistic healing modalities to increase my knowledge and wisdom.

I shall not even by mistake say that "HIV=AIDS=death" or cancers cannot be treated. I shall not frighten my patients with unnecessary comments, opinions or advice. I still remember what Hippocrates said, namely, "Let diet be your medicine" and shall accordingly prescribe fresh fruits, vegetables and good diet to my patients, rather than tonics, syrups, synthetic multi-vitamins, especially to children.

I shall not perform surgery, unless it is absolutely a must and will not indulge in

rackets like amniocentesis, caesarian section, silicon implant or liposuction.

I shall work to ban the useless and cruel animal experiments in the name of medicine. I shall participate in periodic workshops, seminars, and conferences at my expense or on scholarship (no pharma funding) to educate myself and speak from my conscience if I am called upon to speak or preside.

Finally, I shall not consume alcohol, smoke tobacco, or take other narcotic and psychotropic substances. As far as possible, I shall also not take animal proteins.

I realize and ever that a great responsibility of people's well-being is upon my shoulders and I shall carry on my onerous task with utmost dedication.

This I swear in the name of God on this solemn Doctors' Day and I shall repeat this oath daily lest I forget that I am in a divine profession to heal the world.

When the Hippocratic Oath requires the physician not to harm but to help, it is against a background of Greek craftsmanship, that is, the craft of the carpenter is to work on wood according to the nature. The relevant portion of the Hippocratic Oath really indicates that there are constraints on the skill or art of medicine, and therefore it does not truly involve beneficence in the modern sense. However, beneficence in the modern sense enters the scene via the Samaritan tradition in medicine. It is known that St-Luke (10:29-37) was a physician and there is some evidence that Good Samaritan was meant to be a physician, who treated the man fallen by the wayside with an infundation of oil and wine which was a remedy for wounds in Greek medicine. That being the case, the idea of the Good Samaritan, as one who ministers to the sick despite inconvenience and danger to himself, was one which enormously affected the tradition of medicine, and it gave us the idea of beneficence in something like its modern form, and therefore the healthcare professionals should uphold medical beneficence as portrayed by St. Luke in the Bible.

Historians of medicine have debated the origins of this tradition, and it may have been in the religious orders that were founded to care for the sick and wounded during crusades. For example, the order of Knights Hospitallers was founded in the eleventh century to provide hostels for pilgrims to the Holy land and care for the sick, and later for those wounded in the crusades. The members of this order came mainly from noble families and were dedicated to serve "Our lords, the sick", which is a favourite phrase in medicine. This tradition 'continued'

in the religion's orders and it emerged in a different form in the eighteenth century when the status and education of doctors began to emerge. The opening words of the influential book on medical ethics, written by the British physician Thomas Percival (1803), bear witness in elegant language to the ethic of "noblesse oblige".

Physicians and surgeons should minister to the sick, reflecting that the ease, health and lives of those committed to their charge depend on their skills, attention and fidelity. They should study, in their department, so to unite tenderness with steadiness and condescension with authority, as to inspire the minds of their patients with gratitude, respect and confidence. These words echo the sentiments of the Knights Hospitallers of the crusades, and they were incorporated into the code of Ethics of the American Medical Association and stood unchanged from 1847 to 1912. Jonsen (1990) further contents that their spirit lived long after that, and is still influential and binding in contemporary medicine.

2.7 Principles of Medical Ethics for Healthcare Professionals

The International Code of Medical Ethics,(1964) was derived from the above principles and restates them in more direct terms, addressing the healthcare professionals as follows: -

a) To maintain the highest standards of professional conduct.
b) To practice uninfluenced by motives of profit.
c) To use caution in divulging discoveries, or new techniques of treatment.
d) To certify or testify only those matters with which the doctor has personal experience.
e) To ensure that any act or advice that could weaken physical or mental resistance of an individual must be used only in the interest of that individual.

In this respect as Swash (1995) states, several modern attempts have been made to escalate the principles of ethical medical behaviour in a series of simpler statements. The declaration of Geneva, propounded by the World Medical Association in Sydney in 1968, represents a modern attempt to restate the Hippocratic Oath in terms acceptable to contemporary medical practitioners. Additionally on admittance to the medical profession, one is urged to adhere to the following principles: -

a) To solemnly pledge himself and consecrate his life to the service of humanity.
b) To practice his profession with conscience and dignity.

c) His priority should be his patients' lives.

d) To keep secrets confined in him by the patient even after death.

e) Should not be influenced by religion, race, nationality, party politics and social standing.

f) Respect human life.

2.7.1 Duties of Healthcare Professionals to Patients

Nicholas and Sheila (1976) have argued that the demand by the nurses to be consulted by the doctors while managing HIV/AIDS patients is likely to affect patient care in terms of decision making by the healthcare professionals. Yet, these changes in medical care should not interfere and cause harm to the HIV/AIDS patients while being managed. It should also be noted that the group decision-making involves group responsibility and, therefore, since nursing profession wants an equal claim to be heard, then nurses must be willing to be held responsible ethically for their decisions that affect these patients. The foundation for the Ethical Guidelines for Nurses is built upon trust and respect for people and an acknowledgement that individuals are unique but interact with their surroundings. People must be understood both in this relationship and in the actual situation. Ethical values find their expression in relations between people. The area of responsibility of the nurse is to carry out nursing care, to communicate, manage and develop nursing and this is directed toward people in need of nursing care. Nursing care includes health promotion and health maintenance, prevention and treatment of illness as well as rehabilitation and alleviation of suffering.

Nursing care is administered without any form of discrimination as stated in the UN Universal Declaration on Human Rights (1948). In the next section, the study focuses into Doctor's duties, principles of medical ethics, roles of nurses and other healthcare professionals, and finally patients' rights, autonomy and confidentiality.

From the time of Hippocratus, until 1960s, medical ethics were seen in terms of doctors' duties to patients. Medical ethics are the moral guidelines that help to prioritize a medical professional's responsibilities. The code of medical ethics outlines the proper conduct between medical professionals and their patients, communities, and colleagues. Each country has a different code of medical ethics, though most contain the same basic principles, and all share the same history of evolution, according to the World Medical Association, (2009).

The first basic guideline for medical ethics was introduced during the life of Hippocrates, a classical Greek physician who lived between 460 and 377 BC. Hippocrates' three-word phrase created the first code of ethics in the field of medicine. The phrase, now known as the Hippocratic Oath, began as the simple phrase, "Do no harm," and evolved into the 181-word vow recited at modern medical school graduation ceremonies, Daniels (2010).

A century after the time of Hippocrates, the cultures of India and China had established groundwork of morals and virtues to be exemplified by medical practitioners. These first guidelines established models of physician humility, concern, and compassion for patients, Daniels, (2010). Religions of that time influenced the creation of this code of behavior by establishing a basic understanding of the sacred relationship between medical practitioners and their patients.

During the intellectual revolution of the eighteenth century, numerous medical advances took place in the West, including the publishing of the first book discussing medical ethics. Thomas Percival, a British physician, published his book "Code of Medical Ethics," in the year 1803. At nearly the same time, Benjamin Rush, a physician, having seen the importance of medical ethics, began lecturing to medical students of the University of Pennsylvania. In 1847, the American Medical Association was formed in order to establish a definite code of medical ethics because no government laws established medical regulations, Blum (1964). The first code of ethics established the line between modern medical practitioners and homeopathic and faith-based healers, in addition to further defining proper medical conduct and relationships between medical professionals and their patients.

Modern codes of medical ethics are revised and replaced when ethical issues arise and create concern, Daniels (2010). Because medical ethics are an important area of study for medical professionals, more than 25 universities across Canada and the United States provide graduate degree programs in the field of medical ethics while in Kenya there is only one. Modern codes are published yearly with later editions including the most current guidelines. The books are written and revised by the Council on Ethical and Judicial Affairs of the American Medical Association, Jonsen (1990). These duties have traditionally been thought of as those of not harming the patient (non-maleficence) but of helping the patient (beneficence).

By virtue of their profession, doctors and nurses have more stringent obligations of beneficence than most of other professions. They have obligations to a specified group of

persons (their patients) that nonmedical personnel have no obligation to help. The term "duty of care" refers to these special obligations. In its bare form, however, the phrase gives no indication of the precise nature of the duty, nor of its limits. Its definitional vagueness, combined with its rhetorical appeal, may be used to justify actions without the need for rational deliberation. Used in this manner, the term may become a subtle instrument of intimidation, pressuring healthcare workers into working in circumstances that they consider morally, psychologically, or physically unacceptable. The phrase duty of care can thus be ethically dangerous by giving the illusion of legitimate moral justification.

2.7.2 The Role of other Employees in Government Hospitals

It is the duty of public bodies and their employees to promote equality. Personal feelings about patients must not interfere with the standard of any work. By law, one must provide all patients with high-quality care which reflects their individual needs, whatever their race, sex, sexuality, age, religious belief or disability. This means that you owe patients a 'duty of care' and they can expect a 'reasonable' standard of care from all workers. And, it is important to maintain clear boundaries when caring for patients. You should always have a 'professional' relationship with your patients. If you have any strong feelings about a patient's religious, social or cultural beliefs, you should tell the in-charge as soon as possible so they can take appropriate action. It should not matter to you what the patient is like as an individual, what colour or religion they are or how they live their life. You should see all patients as worthy of your respect.

According to Edge and Grove (1994) the code of conduct means that, as a health-care support worker must have a responsibility to work to standard. This means that you must do the following:

a) Only do what your job description or specification allows you to do. If you do something, or accept an instruction from another healthcare worker to do something, that is not within your job description or specification or level of skill, you could be putting the safety of the patient at risk and you could be disciplined. Let your manager or supervisor know if you feel you are being asked to do something you do not know how to, or something you know is not in your job description or specification.
b) It is within the code of conduct of all health-care professionals not to delegate tasks unless they are sure that the person they are delegating to have the skills and is happy to perform the task. The person who delegates will remain professionally accountable for

delegating the task. However, if you accept the task, you will be accountable for how well you perform it.

c) Make sure that you always follow the standard procedures for carrying out tasks and duties.

d) Make sure that you obtain consent, in line with your organisation's policies, before doing anything to a patient.

e) Follow the rules on 'duty to care'. This means you must always make sure patients and colleagues do not come to harm because of something you've done or something you have not done, or because you've been careless or taken risks.

f) Making notes and keeping patients records up to date and accurate is an essential part of care. You should only write down information relevant to the care you have given to patients, and get an appropriate person to sign the record in line with your organisation's policy. If you are not sure, ask for advice. As you are accountable for anything you write, no matter how informal it might seem, what you write can be used as evidence in any enquiry by your employer or the courts in the future.

g) Raise issues you are concerned about with your line manager where these relate to:
   i. how care is delivered
   ii. the personal health, safety and security of patients or
   iii. harm and abuse of patients

2.7.3 Duties of Doctors to the Sick

The International Code of Medical Ethics, (1964), stipulates the doctor's duties to the patient as follows: -

a) A doctor must always bear in mind the obligation of preserving human life from conception. Therapeutic abortion may only be performed if the conscience of the doctors and the national laws permit.

b) The patient is owed complete loyalty, and all the resources of medical science. Whenever a treatment or examination is beyond the capacity of the doctor, the advice of another doctor should be sought.

c) A doctor must always preserve absolute secrecy concerning all he knows about a patient because of the confidence trusted in him.

d) Emergency care is a humanitarian duty, which must be given, unless it is clear that there are others better able to give it.

2.7.4 Duties of Doctors to Each Other

A doctor must observe the principles of The Declaration of Geneva, (1948) approved by The World Medical Association (1949). The principle states as follows;

To other colleagues, the Code states the following: -

a) That a doctor must behave to his colleagues, as he would have them behave to him.

b) That a doctor must not entice patients from his colleagues.

c) That a doctor must observe the principles of the Declaration of Geneva.

The Declaration of Helsinki (1975) sets out recommendations for the guidance of doctors wishing to undertake bio-medical research involving human subjects. The problems raised by the interaction of modern medical practice with government and society as a whole, require much thought and analysis as a way of making ethical principles in medical practice a must, and any negligence in medical professionalism must be punished, to save the innocent patients who perish under the hands of these healthcare professionals who are not observant due to bad attitudes that do not subscribe to ethical principles.

2.7.5 Unethical Practices of Doctors

A doctor must always maintain the highest standards of professional conduct and must practice his profession uninfluenced by motives of profit. Accordingly, the following practices are deemed unethical:

a) Any self advertisement except such as is expressly authorized by the national code of medical ethics;
b) Collaborate in any form of medical service in which the doctor does not have professional independence;
c) Receiving any money in connection with services rendered to a patient other than a proper professional fee, even with the knowledge of the patient.

Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest. A doctor is advised to use great caution in divulging discoveries or new techniques of treatment and he should only certify or testify only to that which he has personally verified.

2.8 Nurses as Healthcare Professionals

In the early 1900s, doctors dominated the ranks of the healthcare profession, aided by a small number of nurses and other professional health workers, Fitzhugh, (2002). Today, doctors are dwarfed by the number and variety of other healthcare workers with overlapping boundaries among the licensed domains of individual healthcare professions. As well as the regular nurses, there are specialized nurses, physician assistants, clinical officers, psychologists, social workers, optometrists, and podiatrists, categories of healthcare professionals who didn't exist in the early 1900s.

Technological innovations in every field are changing the way medicine, and nursing, are practiced, Fitzhugh, (2002). Computerized information systems aim to standardize patient records and bring all patient data together in one place for instant retrieval. Although advanced technology requires specialists in specific areas, generalists will be required to provide practical, working interpretations of the results which can be passed on and be utilized. Patients will still require primary care, and help with the complicated decisions necessitated by the results from the new technology. As technologies blur the limits of knowledge distribution, legislative contests over ranges of practice for physicians, nurse anesthetists, nurse practitioners and others, is likely to heat up.

The concept of doctoral degrees for nurses may emerge as the use of nurse practitioners in anesthesiology, mid availability, reliability, and security, Simpson, (2003). Computerized Provider Order Entry (CPOE) systems are designed to prevent potential medical errors, checking the order for incorrect drug dosages, drug-allergy interactions, drug-drug interactions, drug-food interactions, and other possible causes of error. It monitors treatment processes to ensure nurses administer the correct drugs to the correct patient at the correct time, reducing errors and stress levels, and improving productivity by reducing paperwork. Virtual reality can be used in teaching nursing students so they get a realistic view of their future working conditions. Electronic Healthcare Records (EHRs) are a way for nurses to document their contributions to healthcare. In an example of the use of advanced technology, the Virginia Commonwealth University Health System has been using computerized information system technology for communicating patient care plans for more than 20 years, Szabo and Lockhart, (2003).

2.8.1 The Ethical Guidelines for Nurses

The foundation for the Ethical Guidelines for Nurses therefore is built upon trust and respect for people and an acknowledgement that individuals are unique but interact with their surroundings. People must be understood both in this relationship and in the actual situation. Ethical values find their expression in relations between people. The area of responsibility of the nurse is to carry out nursing care, to communicate, manage and develop nursing and is directed toward people in need of nursing care. Nursing care includes health promotion and health maintenance, prevention and treatment of illness as well as rehabilitation and alleviation of suffering.

In order for the nurse to be able to take an ethical responsibility, the nurse must be professionally well-founded. Nursing care is based upon caring and conscientiousness. The Ethical Guidelines for Nurses, (2000), require maintaining professional knowledge to provide guidance in various situations in which ethical decisions are necessary. The Council of Ethics in Nursing (CEN) intends that the guidelines contribute to:

a) Promoting ethical discussions and considerations among nurses
b) Supporting nurses in situations in which they must make ethical decisions
c) Promoting good judgment with the intention of developing the professional quality of nursing
d) Draw focus on ethical dilemmas so as to make ethical choices visible

2.8.2 The Nurse and the Profession

The Ethical Guidelines for Nurses are not prioritized but numbered for practical reasons and they demand the following;

a) The nurse must take responsibility for applying Ethical Guidelines for Nurses in nursing.
b) The nurse, in his/ her work, must recognise and acknowledge the ethical, professional and personal responsibility of own assessments and actions.
c) The nurse, in his/ her work, must use professional judgement, critical thinking, courage and thoughtfulness.
d) The nurse must contribute to creating a good working environment and supporting colleagues in difficult situations.

e) In co-operation with other disciplines, the nurse must show respect for co-workers. In situations in which a conflict of interest arises, the patient's interests must be safeguarded.

f) The nurse must contribute to developing the profession and protecting its credibility.

2.8.3 The Nurse and the Patient

a) The nurse must demonstrate care and strive toward protecting and preserving life.

b) The nurse must ensure that treatment with no prospect for recovery is terminated or not begun

c) The nurse must strive toward alleviating suffering and ensuring a dignified death.

d) The nurse cannot contribute to treatments which have the sole aim of hastening a patient's death.

e) The nurse must ensure that patients receive and understand the information that is needed to make choices. The information that is provided must be adapted to the individual patient's wishes and needs, as well as the patient's situation in life.

f) The nurse must respect the patient's choice including the patient's right to decline the right to choose.

g) The nurse must seek to preserve the patient's dignity and integrity.

h) The nurse must protect patients against abusive actions, including situations that involve the use of force, detention or other restriction of rights.

i) The nurse, in conflicts of interest between the place of employment and the ability to carry out responsible nursing care, must strive to safeguard the patient's interests.

j) The nurse must protect confidential information about the patient.

k) The nurse must demonstrate respect and care for the patient's relatives. If a conflict of interest arises between the patient and relatives, the patient's interests must be safeguarded.

2.8.4 The Nurse and Society

a) The nurse must stay informed with regard to social and political developments and participate in debate of such issues.

b) The nurse must work toward prioritising a fair and reasonable distribution of resources that benefits the groups of patients that have the greatest need for nursing care.

c) The nurse must contribute to demonstrating the consequences that political decisions have on nursing care.

d) The nurse must maintain a critical stance to developments in biotechnology and health care technology that have consequences for nursing care.

e) The nurse, in his/ her work, must assume responsibility for protecting the environment against pollution and avoid unnecessary use of resources.

f) When appearing at public functions, the nurse must be conscious of whether this occurs in the role of employee, as a professional or as a private citizen.

The nurse must protect the profession's reputation and standing in society.

Nurse practitioners all over the world are expected to follow strict code of ethics in nursing. The code of ethics helps nurses to ethically practice nursing and also to deal with all the ethical challenges that arise in their practice with communities, families, individuals and other public health care systems. Nurses must vow not to reveal patients private information to third party, do not cause any harm to them and most importantly help the patient recover fast. The general public is completely dependent on nurses when they are ill as they are in a very helpless stage so they must be assured that those who are responsible to take their care should look for their welfare.

2.8.5 Purpose of the Code of Ethics for Nurses

The Code of Ethics for Registered Nurses serves as a foundation for nurses' ethical practice. It provides guidance for ethical responsibilities, relationships, behaviors and most importantly decision-making. The Code of Ethics should be used in combination with the existing professional standards, regulations and laws that guide practitioners.

There is certain purpose behind these codes of ethics which is as follows:-

a) Every patient being admitted to hospital or any health care center has right to maintain privacy and they have to be contented with the fact that their private affairs which they share with any of the medical personnel will be kept confidential.

b) All the nursing practitioners should abide by the code of ethics. In nursing profession, the patient's well being and safety should always be given the first

priority. Nurses have to always do their best to maintain the trust and confidence laid on them by the patients.

The Code of Ethics serves the purpose of self-reflection and self-evaluation for principled nursing practice and it also forms the basis for peer review and feedback. It is a kind of ethics based on which all nurses can practice under quality work environments so as to support the deliverance of ethical, compassionate, safe and competent care. Nursing is very reputable profession and people involved in this profession have the opportunity of being part of a self-regulating profession and should value this responsibility. The Code of Ethics informs all the nurses, general public as well as other health-care professionals about the moral commitments and social responsibilities which nurses have to accept for becoming part of this self-regulating profession. According to the Code of Ethics for nursing, Primary Nursing Values involves tasks like:-

a) Providing competent, compassionate, safe and right care to all the patients.
b) Promoting and respecting informed decision-making of every patient
c) Promoting health and well-being of all the patients
d) Preserving dignity
e) Promoting justice
f) Maintaining confidentiality and privacy
g) Being accountable for their actions

2.8.6 Consequences of Disobedience to Code of Ethics by Nurses

When any of the nurse or nursing student disobeys the code of ethics in nursing homes, this can make patients as well as their families distrustful and very fearful of all the staff. This in turn causes distress and argument amongst the staff members of respective health care centre and has adverse effects on its functioning. Even the single disobedience from any of the staff member can leave a stain on all of their coworkers, Strax, (1994). The code of ethics in nursing signifies not only commitment and pledge, but also the devotion of individuals involved in this missions of mercy. The disabled, the elderly, the young and the weak are at the mercy of people engaged in the healing arts and nurses are more trusted than any of the caregivers, Strax, (1994). This is really a great honour and nurses must respect the trust and beliefs laid on them by public and always strive to do their best for patients.

The above mentioned specific values and ethical responsibilities are expected of each of the registered nurses as well as nursing students and they should abide by them. Apart from the Ethical Code of Doctors, the International Ethical Code for Nurses, adopted by the International Nursing Council (1973), gives the fundamental responsibility of the nurse in fourfold, that is,

a) to promote health,
b) to prevent illness,
c) to restore health and
d) to alleviate suffering.

The need for nursing is universal. Inherent in nursing is respect for life, dignity and rights of man. It is unrestricted by considerations of nationality, race, creed, colour, age, sex, politics or social status. Nurses render health services to the individual, the family and the community and also co-ordinate their services with those of related groups. Unfortunately, of late the role of nurses has become ambiguous. Originally, the nurse was the person most concerned with the caring for the patient and was in continuous contact with the patient. Davis and Arosker (1978) support this theory by saying that the patient care is the nurse's task and not that of a general practitioner, family specialist or others.

However, according to Ehrenreich (1973), nurses have been burdened with other tasks. Far too long, they spent much of their energy in housekeeping chores, such as making beds, carrying trays and so forth. This situation today is slightly changing because auxiliaries are largely relieving them of these tasks, but they are still much occupied with technical tasks, such as temperature taking, injections, medications, intravenous feeding and so on. Ehrenreich and English (1980) continue to argue that despite the reliefs by the auxiliaries, nurses are still oppressed by the sexism implicit in the notion that caring is a maternal role suitable only for women. This sexism is reflected in the fact that until recently, women physicians from the time of Hippocratus were a small minority. Unfortunately this trend is now reversing. The freeing of medicine from sexism would also be furthered if men were encouraged to enter the nursing profession in larger numbers.

Finally, the International Ethical Code of Nurses as quoted by Lobo (1973) states the following as regards the nurses' conduct:

a) The nurse's primary responsibility is to those people who require nursing care. The nurse in providing care respects the beliefs, values and customs of the individual.

b) The nurse holds in confidence personal information and uses judgment in sharing this information.

c) The nurse carries personal responsibility for nursing practice and for maintaining competence by continuing learning.

d) The nurse sustains a cooperative relationship with co-workers in nursing and other fields. He /she should be active in developing a care of professional knowledge.

There are however, other general rules that regulate the practice of the nurses, such as:

a) The nurse shall maintain at all times the highest standards of nursing, care and professional conduct.

b) The nurse shall hold in confidence all personal information entrusted to him/ her. He/she shall carry out the physician's orders intelligently and loyally; he/she is however justified in refusing to participate in illegal or unethical procedures.

2.9 The Role of a Clinical Officer as a Healthcare Professional

Clinical Officers are purely trained as healthcare professionals and who like the nurses are governed and bound by ethical codes of conduct. Clinical Officers, just like all other healthcare professionals must have good character and be accountable in, making sure that one can always 'answer' for his actions or omissions. To make sure you are happy with the things you do (actions) and the things you don't do (omissions) in your daily work and that you can justify them to patients, your supervisor, your employer and others, Vedder (2003). You must carry out only the tasks agreed in your job description or specification so that your employer knows what you are likely to be doing and, based on this, agrees to accept liability (known as 'vicarious liability') for your actions. Aras (1999), spells out what a clinical officer must fulfill in his or her profession as follows;

a) A clinical Officer must work to the standard of being honest with him/her and others about what he/she can do. Know yourself, what you can do and what you can't do. The safety of your patients is your first priority. Always ask colleagues for help if you have any worries or concerns about your abilities. The Clinical Officer needs to understand

that some procedures can only be carried out by people who have had special training, and that, in certain circumstances, he/she needs permission from qualified staff who is the doctor before he does certain things with patients. If asked to do something he has not been trained to do, and that he does not have the skills to do it, he will speak up.

b) Clinical Officer must have Integrity**.** Always to do what is right to protect the patient**.** Always to do his best to make sure nothing you or anyone else does, or does not do, will harm the patient's mental or physical health or delay their recovery, taking into account all aspects of equality and diversity. Clinical Officer must play the role of Advocacy**,** doing your best for patients and their relatives. This means being responsible for promoting and protecting the interests of patients, many of whom may not be able to protect their own interests. This could involve speaking up for patients to make sure that what is best for each individual is always taken into account. Putting patients' interests first at all times and making sure that you are meeting their wants and needs. All patients are individuals with different likes and dislikes and you must acknowledge their equality and diversity to make sure that you treat them equally and fairly.

c) Clinical Officer must be Sensitive by respecting the patient. Every patient is an individual with real feelings and emotions. When working with patients, think about how they may be feeling and what the most appropriate response to their situation is. Treating patients and their relatives politely while being aware of the situation they are in and their reactions to it. For example, they may be feeling confused, angry or frustrated. It is important that you are sensitive to this and do not take their reaction personally, Dworkin, (1991). Clinical Officer must be objective**,** treating all patients in the same way.

d) Clinical Officer must be considerate and respectful, making sure that patients are always treated with dignity. Consider and respect patients' privacy to make sure that neither you nor they are ever placed in an embarrassing situation. You'll protect patients to make sure that they are never unnecessarily exposed to embarrassing situations, whether in front of relatives, fellow patients or healthcare workers. The Disability Discrimination Act 1995 states you must make sure that disabled patients receive the same quality of service as all other patients. This may mean you have to treat disabled patients more favourably than you treat others to deliver an equal level of care.

e) Clinical Officer must seek Consent, telling patients what you intend to do and listening carefully to what they say about it. Working in partnership with the patient at all times is a basic principle that you must keep to at all times. Always explain to patients what you intend to do with them, even when it is basic care or routine procedures, and only continue with your planned work once the patient agrees to it. You must check that this agreement is written in the patient records, and you should report any concerns that the patient or a relative has to your supervisor. You'll be demonstrating that you will always make sure that the patient knows what you are planning to do and is happy with it. If the patient cannot give consent for themselves, because of their age or condition, you must always check with a relative or a senior member of staff. If the patient or relative has not agreed to what you plan to do, you must not do it. Always check with a senior member of staff if you are in any doubt.

f) The Clinical Officer must always be confidential, protecting the patient's privacy. Confidentiality is essential to protect the interests of patients. It is a main feature of any code of conduct and of most terms and conditions of service in a health-care environment. So you must make sure that you do not give out personal information about patients, or about their condition or treatment, to anyone other than colleagues in the team who need to know the information to help in the patient's care. If you do not protect the patient's right to confidentiality, you may be breaking data-protection laws. If you feel that a patient is at risk of harm, and that you need to speak out, you should tell your supervisor. You should not discuss patients with anyone out of work. You'll maintain a professional attitude at all times when handling patient information and you won't 'gossip' about patients to anyone at any time. When you do pass on information to a colleague as part of your job, you will take care to be accurate and clear in what you say or write.

g) Clinical Officer must always co-operate**,** working effectively with colleagues as part of a team. Value the part you play in the team and respect the part played by other members of the team. You'll be communicating effectively, sharing information and working to meet the team's shared goals in the best interests of the patient.

h) Clinical Officer must be protective, making sure you do not put patients and colleagues at risk of harm by making sure patients, visitors and colleagues are protected from

dangers and risks and that nothing you do, or don't do, results in harm or risk to others. You should know the dangers patients and colleagues face at work and will do what you can to reduce risks of accidents or harm. You will also make sure you report any concerns you have to a supervisor to reduce risks in the future.

i) Clinical Officer must be development conscious by trying to increase his/her own knowledge and skills by talking to patients and colleagues and looking for opportunities to learn. You must be interested in your work and feel comfortable using the knowledge you need to carry out your job, in order to be able to offer a better service to patients and feel more motivated as a result. He should take every chance to protect patient safety by improving the way you work. This could be by attending a course, shadowing a colleague or listening to feedback from patients. You'll continually monitor, evaluate and reflect on what you do at work and try to do it to the best of your ability.

j) Clinical Officer must be alert by observing any changes that could affect a patient's needs or progress. Always try to notice when patients are not doing what you expect of them and report your observations to an appropriate person.

2.10 Medical Laboratory Technologists as Healthcare Workers

The medical laboratory technologists as healthcare workers are also governed by ethical codes that are stipulated by different management Boards. In 2004, the Kenya Medical Laboratory Act required that all medical laboratory technologists were to hold a current practicing license. This is to ensure that public interest is served and protected by the Medical Laboratory Technology Act. The main objectives are as follows:

a) To regulate the practice of medical laboratory technology and govern its members in accordance with the Act and the regulations.

b) To establish, maintain and develop standards of knowledge and skill among its members.

c) To establish, maintain and develop standards of qualifications and practice for the practice of medical laboratory technology.

d) To establish, maintain and develop standards of professional ethics among its members.

e) To establish, maintain and develop standards of continuing education for its members.

f) To establish or assist in establishing continuing education programs for its members.

g) To administer this Act and perform such duties and exercise such as powers as are required by the Act.

2.10.1 The Code of Professional Conduct for Laboratory Technologists

The code of professional conduct for medical laboratory technologists (2004), demands that;

a) Medical laboratory technologists are dedicated to serving the health-care needs of the public. The welfare of the patient and respect for the dignity of the individual shall be paramount at all times
b) Medical laboratory technologists work with other health care professionals, to provide effective patient care.
c) Medical laboratory technologists shall promote the image and status of their profession by maintaining high standards in their professional practice and through active support of their professional bodies.
d) Medical laboratory technologists shall protect the confidentiality of all patient information
e) Medical laboratory technologists shall take responsibility for their professional acts.
f) Medical laboratory technologists shall practice within the scope of their professional competence.
g) Medical laboratory technologists shall endeavor to maintain and improve their skills and knowledge and keep current with scientific advances.
h) Medical laboratory technologists shall share their knowledge with colleagues and promote learning.
i) Medical laboratory technologists shall be aware of the laws and regulations governing medical laboratory technology and shall apply them in the practice of their profession.
j) Medical laboratory technologists shall practice safe work procedures at all times to ensure the safety of patients and co-workers and the protection of the environment

2.11 Patients' Rights and Autonomy

Despite having addressed the ethical codes of doctors, nurses, clinical officers and medical laboratory technologists, they are still seriously faced with other challenges. By the 18th and 19th centuries, medical ethics emerged as a more self-conscious discourse. For instance, authors such as Thomas Percival (1849) wrote about "medical jurisprudence" and reportedly coined the phrase "medical ethics." Percival's guidelines related to physician consultations have been

criticized as being excessively protective of the home physician's reputation. Jeffrey Berlant (1995) is one such critic who considers Percival's codes of physician consultations as being an early example of the anti-competitive "guild"-like nature of the physician community.

In 1847, The American Medical Association adopted its first code of ethics, which was based largely upon Percival's work, Laird (2009). While the secularized field borrowed largely from Catholic medical ethics, in the 20th century a distinctively liberal Protestant approach was articulated by thinkers such as Joseph Fletcher. In the 1960s and 1970s, building upon liberal theory and procedural justice, much of the discourse of medical ethics went through a dramatic shift and largely reconfigured itself into bioethics, (ibid). Since the 1970s, the growing influence of ethics in contemporary medicine can be seen in the increasing use of Institutional Review Boards to evaluate experiments on human subjects, the establishment of hospital ethics committees, the expansion of the role of clinician ethicists, and the integration of ethics into many medical school curricula, Annas (1993).

2.12 Values in Medical Ethics

In the History of Medical ethics, there are six characteristics or values that commonly apply to medical ethics, Haring (1995). These values are as follows;

a) Autonomy - the patient has the right to refuse or choose their treatment. (*Voluntas aegroti suprema lex*.)
b) Beneficence - a practitioner should act in the best interest of the patient. (*Salus aegroti suprema lex*.)
c) Non-maleficence - "first, do no harm" (*primum non nocere*).
d) Justice - concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality).
e) Dignity - the patient (and the person treating the patient) have the right to dignity.
f) Truthfulness and honesty - the concept of informed consent has increased in importance since the historical events of the Doctors' Trial of the Nuremberg trials and Tuskegee Syphilis Study.

Values such as these do not give answers as to how to handle a particular situation, but provide a useful framework for understanding conflicts. When moral values are in conflict, the result may be an ethical dilemma or crisis. Sometimes, no good solution to a dilemma in medical ethics exists, and occasionally, the values of the medical community (the hospital and its staff)

conflict with the values of the individual patient, family, or larger non-medical community. Conflicts can also arise between health care providers, or among family members. Some argue for example, that the principles of autonomy and beneficence clash when patients refuse blood transfusions, considering them life-saving; and truth-telling was not emphasized to a large extent before the HIV era.

2.13 Autonomy of the Patients

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. 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, Ryan (2010). Respect for autonomy is the basis for informed consent and advance directives.

Autonomy is a general indicator of health. Many diseases are characterised by loss of autonomy, in various manners. It makes autonomy an indicator for both personal well-being, and for the well-being of the profession, George (1975). This has implications for the consideration of medical ethics: "is the aim of health care to do well, and benefit from it?" or "is the aim of health care to do well 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 others. By considering Autonomy as a gauge parameter for (self) health care, the medical and ethical perspective both benefit from the implied reference to Health, Shenken, (1991).

According to Dunn (1999) for the sake of justice, efficiency and harmonious relationship, it is important for both doctor and patient to appreciate their individual roles. The doctor is the servant of the patient but not the patient's slave. Since each person has the primary obligation of caring for one self, each also has the obligation to seek and choose professional people to help advise them concerning healthcare. Professionals fail to realize how difficult it is for ordinary persons to select a physician or how uncertain in such persons are about their own rights in dealing with a healthcare institution. Healthcare professionals have an educational responsibility to help clients know how and where to seek health care and how to protect their own rights.

Blum (1964) argues that one out of three persons who need to see a doctor, fail to do so, not because of economic and educational obstacles, but due to fear, apathy, shame and self-punishment which is contributed to two factors: - mainly psychological moral factors and lack of confidentiality in medical professionalism.

Psychiatrists are often asked to evaluate a patient's competency 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. 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. 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. In such cases, psychiatrists should be a part of protecting that right, Kilner, (1990).

2.13.1 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. 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.

It is not only more important to do no harm than to do good but it is also important to know how likely it is that your treatment will harm a patient and therefore, 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 she/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, Shenken, (1991).

In practice, however, many treatments carry some risk of harm. In some circumstances, for instance, in desperate situations where the outcome without treatment will be grave, risky treatments that stand a high chance of harming the patient will be justified, as the risk of not treating is also very likely to do harm, Sagor and Brodskey, (1999). The principle of non-

maleficence is not therefore absolute, but it balances against the principle of beneficence (doing good), as the effects of the two principles together often give rise to a double effect.

2.13.2 Double Effect

Double effect refers to two types of consequences which may be produced by a single action Ayalew, (2001) and in medical ethics it is usually regarded as the combined effect of beneficence and non-maleficence, (McGraw-Hill Concise Dictionary of Modern Medicine 2002). 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.

2.13.3 Conflicts between Autonomy and Beneficence/Non-Maleficence

Autonomy can come into conflict with beneficence when patients disagree with recommendations that health care professionals believe are in the patient's best interest. When the patient's interests conflict with the patient's welfare, different societies settle the conflict in a wide range of manners, Annas (1993). Western medicine generally defers to the wishes of a mentally competent patient to make his own decisions, even in cases where the medical team believes that he is not acting in his own best interests. However, many other societies prioritize beneficence over autonomy, Ayalew (2001). Examples include when a patient does not want a treatment because of religious or cultural views. In the case of euthanasia, the patient, or relatives of a patient, may want to end the life of the patient. Also, the patient may want an unnecessary treatment, as can be the case in hypochondria. A doctor may want to prefer autonomy because refusal to please the patient's will would harm the doctor-patient relationship.

Individuals' capacity for informed decision making may come into question during resolution of conflicts between autonomy and beneficence. The role of surrogate medical decision makers is an extension of the principle of autonomy. On the other hand, autonomy and beneficence/non-maleficence may also overlap. For example, a breach of patients' autonomy may cause decreased confidence for medical services in the population and subsequently less willingness to seek help, which in turn may cause inability to perform beneficence. The principles of autonomy and beneficence/non-maleficence may also be expanded to include effects on the relatives of patients or even the medical practitioners, the overall population and economic issues when making medical decisions.

2.13.4 Euthanasia as a Medical Practice

Some American physicians interpret the non-maleficence principle to exclude the practice of euthanasia, though not all concur. Probably the most extreme example in recent history of the violation of the non-maleficence dictum was Dr. Jack Kevorkian, who was convicted of second-degree homicide in Michigan in 1998 after demonstrating active euthanasia on the TV news show for 60 Minutes, Tassano, (1999).

In some countries euthanasia is accepted as standard medical practice. Legal regulations assign this to the medical profession. In such nations, the aim is to alleviate the suffering of patients from diseases known to be incurable by the methods known in that culture, Tassano, (1995). In that sense, the *"Primum no Nocere*" is based on the realisation that the inability of the medical expert to offer help, creates a known great and ongoing suffering in the patient. "Not acting" in those cases is believed to be more damaging than actively relieving the suffering of the patient. Evidently the ability to offer help depends on the limitation of what the practitioner can do. These limitations are characteristic for each different form of healing, and the legal system of the specific culture. The aim to "not do harm" is still the same. It gives the medical practitioner a responsibility to help the patient, in the intentional and active relief of suffering, in those cases where no cure can be offered.

But a more radical challenge that medical practitioners face according to Pace and Sheila (1996) arises from the appearance of the patients' rights movement. This movement is not unconnected with the rise of nursing as a profession because many nurses see themselves as being "the patients' advocate", and support their patients' rights. However, this movement is also influenced by many other considerations and one broad influence has been the general democratization of society. In general terms, the public requires involvement in decisions that are going to affect them. This increasing openness and consultation has affected medicine as much as any other branch of society.

2.14 Confidentiality of Patients' Medical Information

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. Confidentiality is mandated in America by laws, specifically the Privacy Rule, and various state laws. However, numerous exceptions to the rules have been carved out over the years. For example, many states

require physicians to report gunshot wounds to the police and impaired drivers to the Department of Motor Vehicles. 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. Many states in the U.S. have laws governing parental notification in underage abortion, Appel,(2006).Traditionally, medical ethics has viewed the duty of confidentiality as a relatively non-negotiable tenet of medical practice. More recently, critics like Jacob Appel have argued for a more nuanced approach to the duty that acknowledges the need for flexibility in many cases (Tassano, 1999).

Another ethical factor in a patient choosing his or her physician or healthcare facility arises from the fact that, today there seems to be a wide spread doubt about the competence and the character of healthcare professionals. Illick (1971) has launched an attack on the whole system of healthcare professions, giving an example that in USA, healthcare professions do not live up to their professed standards, and this can probably be applied to some extent to the medical personnel in Kenya. Knight (1981) argues that among professionals, some medical personnel are also drug addicts, alcoholics and have psychological disorder. When this is added to the growing evidence that considerable percentage of healthcare professionals have an income well in excess to members of other professions, a patient choosing a reliable and competent physician to manage the his/her state of affairs is quite difficult. Nathaniel (1981) adds to this debate by stating that this income surplus contributes to some medical professionals becoming arrogant and unethical in their profession, more so when dealing with HIV/AIDS patients in government hospitals. In response to concerns about ethical improprieties and issues in medicine, various authors have expressed their feelings such as Freese (1984), Levin (1980), Annas (1990), Sagor and Brodskey, (1999).

The above works show the need for a careful and even aggressive attitude on the part of the patient toward the healthcare professionals and healthcare facilities. This seems to be in strong contrast to the attitude of trust, which has traditionally been regarded as the basis of every profession,Sagor and Brodskey, (1999). Patients need to be conscious of their rights, which are correlative to choosing professionals who are competent and ready to listen to them. Annas (1975) states that a patient is entitled to the following rights;

a) The right to the whole truth.

b) The right to privacy and personal dignity.

c) The right to refuse any test, procedure or treatment.

d) The right to read and copy medical records.

e) The right to obtain redress in the event of poor service.

Annas (1975) correctly argues that the above rights rest on the fundamental concept of informed consent.

2.15 Informed Consent in Medical Practice

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, Freese (1984). 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. Patients can decide 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. A correlate to "informed consent" is the concept of informed refusal. If a patient is to give a free consent, then the patient must also be able to refuse any test, procedure or treatment. He argues that the right to privacy and personal dignity amounts to the right of patients to refuse to be involved in any professional procedures which make them objects of study for the benefit or convenience of professionals or students, rather than for the patients' own therapy, Cohen, (2000).

Melum (1977) supports George (1975) by stating that the consent is not only free but also informed, hence the patient has a right to the whole truth, including reading and copying medical records. Many professionals deny patients these rights on the grounds that they cannot be able to understand the technical information known to the physician and that the patient may be harmed. Such difficulties should not disprove patients' right to know so that their consent may be fully informed, and it's a professional duty therefore to communicate this information in ways that are helpful and not harmful to the patient, based on some of the basic principles that are stated by Resnik (1998).

Another aspect which patients have the right to know is the competency and ethical integrity of the physician to whom they may entrust themselves. No matter how competent a health professional is, a patient should not hesitate to consult if doubt arises, Ryan, (2010). While retaining primary right and responsibility to give informed consent or refusal to any kind of professionalism, health service patients should also remember the commendatory words of scripture as follows;

Hold the physician in honor, for he is essential to you and God it was established who established his profession. From God the doctor has his wisdom, and king provides him access to those in authority. God makes the earth yield healing herbs, which prudent man should not neglect; was not the water sweetened by a twig, [when Moses sweetened the bitter waters in the desert] that man might learn his powers? He endows men with the knowledge to glory in his mighty works, through which the doctor eases pain and the druggist prepares his medicines; Thus god's creative work continues without ceasing in its efficacy on the surface of the earth. Sirach, (38: 1-8).

In continuation, Swash (1995) states that the fundamental principle underlying the concept of a medical ethic is that of the autonomy of the patient. This means that a patient has a right to decide his or her own medical destiny, the physician may advise, but the patient decides. Upon this notion, rests the concept of seeking consent for medical interventions, research and teaching. The physician, therefore, not only has a duty to advise but also to explain. The idea of "autonomy" of persons as self-determining, self-governing beings was first discussed with proper understanding from Kant (1781). He assumes that people are essentially rational, although their desires may at times blind them. Decisions that are made as a result of dominant or blinding desires he called them "heteronomous", of which he meant they are not fully the desires of the self, for they are caused by non-rational aspects of human nature. The Kantian tradition of moral philosophy as it affects medical ethics was modified by the liberal tradition of John Stuart Mill (1947). Mill states that we have a right to do what we want unless it is shown that we are harming others.

The difference between Kant and Mill's approach to autonomy is that Kant (1781) emphasises the rationality, while Mill focuses on preferences. For Kant, a decision is autonomous if it is rational, whether it expresses our preferences or not. These traditions have emerged and developed an "autonomy" which expresses informed preferences or consent to

whatever is done. No doubt the doctor-patient relationship always involves some sort of consultation and discussion, and the latest interpretation of autonomy is obtaining informed consent for all medical decisions, as an extension of and insistence on that process of consultation.

2.16 Doctor-Patient Relationship

The doctor-patient relationship is central to the practice of medicine and is essential for the delivery of high-quality health care in the diagnosis and treatment of disease. The doctor-patient relationship forms one of the foundations of contemporary medical ethics. Most medical schools and universities teach medical students from the beginning, even before they set foot in hospitals, to maintain a professional rapport with patients, uphold patients' dignity, and respect their privacy, Arras, (1999). A patient must have confidence in the competence of their doctor and must feel that they can confide in him or her. For most physicians, the establishment of good rapport with a patient is important. Some medical specialties, such as psychiatry and family medicine, emphasize the doctor-patient relationship more than others, such as pathology or radiology, Stroll, (2010).

The quality of the patient-physician relationship is important to both parties. The better the relationship in terms of mutual respect, knowledge, trust, shared values and perspectives about disease and life, and time available, the better will be the amount and quality of information about the patient's disease transferred in both directions, enhancing accuracy of diagnosis and increasing the patient's knowledge about the disease. Where such a relationship is poor the physician's ability to make a full assessment is compromised and the patient is more likely to distrust the diagnosis and proposed treatment, causing decreased compliance to actually follow the medical advice, Pandya, (2010). In these circumstances and also in cases where there is genuine divergence of medical opinions, a second opinion from another physician may be sought or the patient may choose to go to another doctor.

A contractual doctor- patient relationship is established when the patient makes a request for medical examination, diagnosis, opinion, advice or treatment and the doctor undertakes to provide these. There are situations when a request by the patient is not necessary, Blum (1964). For instance, treatment of an infant where the parents make the request or that of a comatose victim of an accident. The sanctity of such a relationship safeguards the interest of the patient and the doctor assuming all responsibility for providing health care, Pandya, (2010).

The patient has every right to terminate a relationship with his doctor at any time and seek the help of another. A reciprocal right rests with the doctor. The formal relationship may be brought to an end when the patient gives notice of intent to terminate it or when the doctor withdraws his undertaking, Arras (1999). In the latter event, the doctor is duty bound to continue to offer all possible help to the patient till the patient establishes a formal relationship with another doctor. The General Medical Council of Great Britain for instance upholds the right of doctors to refuse to accept individual patients when a satisfactory relationship between the doctor and patient does not exist for want of commitment on either side, Annas, (1975).

A doctor can, at any time, request the help of a colleague or specialist in the best interests of his patient. Such a request must be specific and made in writing, all relevant medical details being provided to the other doctor. In an emergency, the request may be made and details provided orally on the understanding that as soon as time permits, a written note will follow. This step precludes any consultant misunderstanding of intention or fact by the consultant. The consultant, in turn, is duty bound to return the patient to the referring doctor with a note bearing details of facts elicited, diagnosis made and treatment advised, Cohen, (2000).

Ethical norms have traditionally discouraged shopping for opinions or therapy. Such a practice destroys the doctor- patient relationship established with the primary physician, thus arose the practice of not seeing a patient already under the care of another doctor without a specific referral, Carr, (2000).

2.16.1 Second Opinion for the Patient

The patient, in doubt despite detailed explanation by his doctor of the nature of his illness and treatment advocated, can ask for a second medical opinion. Medical ethics demands acquiescence based on the patient's right to such counsel. The doctor is obliged to write a referral note and provide all relevant details. If the doctor disagrees with the patient's choice of consultant for second opinion he is justified in terminating his relationship with the patient after writing the note of referral, Carr, (2000).

According to Maguire (2009), the rules that apply in a doctor/patient relationship are different to those which govern other social relations. These two people have just met, but within seconds one has begun to tell the other intimate personal details about his health. What is more, it is likely that, in a few minutes, he will be prepared to remove some of his clothes and submit to a physical examination. This is a one-way process, and it would be highly inappropriate if the

doctor started to discuss his/ her own bowel movements or if the patient asked his/ her personal questions. The interaction is shaped by their differing social roles and their different needs. The patient is seeking expert knowledge and access to treatment. The doctor is acting as the gatekeeper of the scarce social resource that is health-care and so is seeking information about the patient in order to assess his needs.

Finally, there is need to state that the issue of doctor-patient relationship is of paramount importance, in terms of managing any illness. The word management could be treated here as a compound term, not only involving manpower, services and related drugs, but the kind of rapport that the healthcare professionals enjoy with their patients, Daniels, (2009). To understand why this is so, Bennett and Erin (1999) state that there is need to explore the basis of medical confidentiality, and in particular the relation between individual autonomy and medical information. Allowing a person discretionary control over who should have access to his/ her medical information affirms, emphatically, the respect for individual autonomy. Vedder (2003) analyses the special character of personal medical information which reveals that the breaches of medical confidentiality which are sanctioned by the individual concerned may cause the patient emotional and material harm. Moreover it is the individual who is best positioned to judge the harm that may be done, and therefore the presumed probability that third parties will be put at risk is key to the success of arguments for the maintenance of medical confidentiality. However, where a patient makes it clear that he/she is not prepared to take any action to protect others from the risk of infection by him/her, here, perhaps, the patient can be looked upon as residing outside the moral community and thus not deserving of the moral privileges associated with membership of it such confidentiality hence society should be told about the patient's status, Appel, (2006).

2.17 Theoretical Framework

It is essential for healthcare professionals worldwide to appreciate the moral implications of the medical decisions they make. This is despite that philosophy and medical ethics is a topic which is to a large part neglected in many undergraduate medical curriculums, Goodin, (1995). The philosophical theory of utilitarianism examines this doctrine in the context of healthcare professionalism. The utilitarianism as an ethical theory is a type of consequentialism which assesses actions on their outcome. The value of the action is assessed purely on its overall benefaction to utility, based on goodness or badness of the action. The study used an ethical theory which provides a framework that can be used to determine what is right and morally

wrong regarding human actions professionally. It used theories of right and wrong that commanded the attention in the 20th century. This is frequently reflected in arguments advanced in biomedical ethics. It gives a framework with which a person can correctly determine on any given occasion, what he or she morally ought to do, either as a professional or as a rational Being and subsequently, Kant's philosophy of universal moral laws is evident in the physician's thinking, whereby throughout his/her training, he/she is taught to save life.

Ethical issues are grouped into two main classes, namely the teleological and the deontological. The teleological claims that rightness and wrongness of human action is exclusively a function of the goodness and badness of the consequences, resulting directly or indirectly from the actions while the deontological in contrast states that the rightness and wrongness of a human action is not exclusively a function of the goodness or badness of the consequences. The study used the teleological ethical theory, which is also known as utilitarian theory which was propagated by two scholars, Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873), who introduced what was called " felicific calculus", which was a form of calculation that was used to determine whether an act was good or bad depending on the happiness resulting from it. The two philosophers argued that the main goal of utilitarianism was to minimize pain, misery and suffering, which is part of what Hippocratic Oath of doctors and other ethical codes of healthcare state, namely "Do no harm".

The two scholars differentiated between act-utilitarianism and rule- utilitarianism, and in this regard, referring to healthcare professionals, rule-utilitarian theory becomes quite appropriate in that it refers to a code of conduct. It establishes a moral code by reference to the principle of utility whereby a person ought to act in accordance with the rule that if generally followed, then would produce the greatest balance of good over evil, everyone considered. The rule being referred to in this case is specifically the Hippocratic Oath of doctors and other ethical codes that are taken by professional healthcare workers.

2.18 Conceptual Framework

This study dealt with a healthcare system, which was made up of healthcare professionals and HIV/AIDS patients. This is illustrated through the model below, taking into account the dynamic nature of the interplay between Independent Variables and the Dependent Variables. It also considers the importance of Intervening Variables that are appropriate to research. The diagrammatic representation of the conceptual framework is as shown in figure 1.

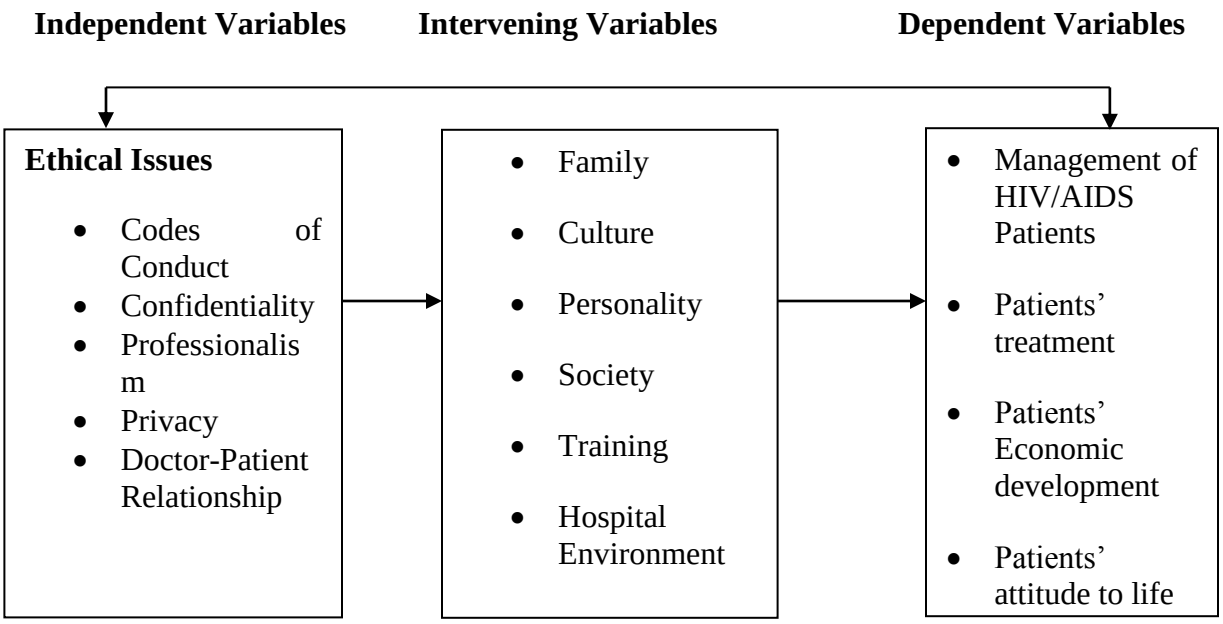

Figure 1: The Effect of Ethical Codes of Conduct to the Management of HIV/AIDS Patients

From figure 1, the first panel consists of Independent Variables. These variables include Codes of Conduct, Confidentiality, Professionalism, Doctor-Patient Relationship and Privacy. These are believed to have an effect on Dependent Variables. Intervening variables such as training, culture, personality, hospital environment, family and even the perception of society can influence the management of HIV/AIDS patients. These factors and others affect the patients' treatment, their attitude towards life which causes stigma and discrimination. However, when the codes of conduct are understood and adhered to, then positive results are achieved, whereby confidence is built contributing to long lives, economic developments, positivity in life and healthcare becomes effective. It is to be noted in Figure 1, that the arrows indicate a relational process between the variables. The literature review presented reveals that there is a relationship between the three variables.

2.19 Summary of Literature Review

In recent years, healthcare professionals and the public have become more conscious of the complexity of the moral problems that can be created by caring for other people. There is now growing awareness of the need to identify clearly what these ethical problems are and to arrive at possible solutions for the patients, nurses, doctors and other professionals concerned while taking into account wider social issues.

An initial complication is that problems in healthcare have traditionally been identified as "ethical" rather than "moral" and this has developed the mistaken idea that there are special kinds of expertise called medical "ethics" and "nursing ethics". As a result, there is a belief that those who have special claims to knowing or deciding what is right or wrong in health and illness and therefore ethical codes have been promulgated for physicians and other healthcare professionals since ancient times. Yet ethical problems in medical practice have never been of more concern or so widely discussed as at present.

The applications of innovative technologies have brought forth new moral problems and contemporary economic problems in the delivery of medical care. This has renewed discussion of ethical considerations. Not only are medical ethics now a concern of patients and doctors but in many instances, they have spilled over into political arena and the law courts whereby doctors are arraigned in court being accused of negligence, implying that they are going against their oath of office as stipulated in different codes of conduct which guide their profession. This is the trust that the society has given to healthcare professionals and therefore they should not betray it.

That knowledge and experience gives them some claim to be listened to, and it certainly affects their moral or ethical decisions; what is vital is that those who care for patients, should have some kind of familiarity with arguments and concepts that are employed in ethical discussions and should be knowledgeable about the Hippocratic Oath and other ethical codes of conduct.

Healthcare professionals are to take all due care, take necessary precaution, give proper attention while extending advice, treatment or when upon operating, Dwork, (1991). The general presumption is attracted that they have performed their duties to the best of their abilities and with due care and caution unless it is established through cogent evidence that they failed to take necessary precaution, due care and attention or acted carelessly and negligently, Curan, (1978). A judicial opinion only offers some hope to the patient and his heirs, if a person suffers at the hands of a doctor, or dies due to the treatment, he or his heirs may sue the doctor and claim damages either from the doctor or from the hospital or clinic that employs him. However, the rigours of litigation are such that only educated and reasonably affluent urban dwellers are likely to venture into it whereas others would find themselves at the mercy of doctors and, worse still, of quacks masquerading as doctors.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with procedures that were employed to carry out this research. The research survey method was used to establish the application of professional ethical issues by healthcare professionals, who were the doctors, nurses, clinical officers and laboratory technicians on HIV/AIDS patients. The chapter includes research design, location of the study, population, sampling procedure, data collection procedure and data analysis.

3.2 Research Design

The study employed the ex post facto research design. Qualitative analysis of variables was done. It was non- empirical which involved a philosophical analysis. This involved critical examination of the relationship between the variables under the study. The design was found to be appropriate for the study because the Independent variables were defined but were not manipulated. The dependent variables could not be influenced because the data for both independent and dependent variables were collected at the same time using questionnaires. The correlation analysis showed that as independent variables changed, dependent variables also changed, and this ensured that little or no control was exercised over any of the variables.

3.3 Area of Study

The study was conducted in the Rift Valley Province of Kenya, which is the largest among the eight Provinces of the Republic of Kenya and currently has been divided into several counties. The study concentrated within the Nakuru district which consists of Molo, Naivasha, Gilgil and Nakuru Town. The district is on the base of the Great Rift Valley, covering an area of 7,190 sq km. The research was conducted, in Naivasha , Gilgil, and Molo towns. These are towns in which government hospitals under the study are located. Nakuru district serves as one of the lucrative business centres in the country, given that a transnational highway transverses through the district to other East and Central African countries.

The four hospitals that were chosen from the district were quite significant because of their location. They are located along the transnational highway which carries the highest human traffic. Due to this, the hospitals chosen attend to most healthcare problems that arise from this large population. The towns also accommodate different people who are normally on transit. These include salesmen/women, truck drivers and many others who stop overnight.

Consequently, this attracts migrant and trafficked sex workers who possibly are affected by HIV/AIDS and move from one town to another, practicing unsafe sex.

3.4 Target Population of the Study

The target population for the study included doctors, nurses, clinical officers and laboratory technologists. In total, the researcher interviewed 11 doctors, 91 nurses, 13 clinical officers, 10 laboratory technicians and 120 HIV/AIDS patients, totaling to 245 respondents. In Gilgil hospital, 29 healthcare professionals and 32 patients filled the questionnaire representing (23.2%) and (22%) respectively. In Naivasha hospital, 35 healthcare professionals and 43 patients filled the questionnaire, representing (28.0%) and (36.0%) respectively. In Nakuru hospital, only 2 healthcare professionals representing (1.6%) filled the questionnaire and lastly in Molo hospital, 59 healthcare professionals and 55 patients filled the questionnaire, representing (47.2%) and (46.0%) respectively.

3.5 Sampling Procedure and Sample Size

There are two types of methods of sampling, namely probability and non-probability and for the purpose of collecting data for this research, non probability sampling method was used which comprised of purposive sampling and snow ball sampling. The sample size consisted of 11 doctors, 91 nurses, 13 clinical officers, 10 laboratory technicians and 120 HIV/AIDS patients, totaling to 245 participants. The sampling unit was the hospitals.

3.5.1 Purposive Sampling

This method was used to select doctors, nurses, clinical officers and laboratory technicians, given that the research was dealing with a sensitive issue, which was quite personal. The purpose of applying this method on doctors and other personnel was for the sake of identifying the healthcare professionals and the HIV/AIDS patients, who in turn were selected to fill in the questionnaire. In purposive sampling, all the available subjects were selected.

3.5.2 Snowball Sampling

Snowball sampling was specifically used for selection of patients. This meant that once a patient was identified and was willing to fill the questionnaire, the same patient was asked to identify some of his/her friends who could also be willing to fill a similar questionnaire.

3.5.3 Instrumentation

The study involved government hospitals in Nakuru County, namely Naivasha, Gilgil, Nakuru and Molo, thus targeting a population of 50% of HIV/AIDS patients and healthcare

professionals. While conducting this research, the following were used in collecting data, namely library, questionnaire and internet. The library source was used to identify other professional relevant researches that were done in the same field. It aimed at reviewing more relevant and current literature on the subject of study. This included manuscripts, articles, magazines, periodicals, reviews and publications among other documents in reference to ethical issues in medical practice. The questionnaire was used in this research to seek information regarding ethics, conduct and professionalism in healthcare practice. It was also used to collect views from HIV/AIDS patients. Internet was also used as one source that had information on the subject matter, including all other scientific studies. It offered the latest publications on this research.

3.6 Validity and Reliability of Instruments

An instrument in research study is a device used to measure the concept of interest in research project. Instruments can be observable scales, questionnaires or interview schedules. Validity and reliability therefore are two statistical properties used to evaluate the quality of research instruments. Validity refers to whether the researcher actually measured what he intended to achieve and in this case it was fulfilled. This study used questionnaires which were self-report data collection instrument, which were filled by the respondents. The questionnaires were used to measure individuals' experiences, attitudes, opinions, beliefs, values and knowledge in connection to how HIV/AIDS patients were treated by the healthcare professionals.

The questionnaires were phrased appropriately, giving proper options for responding and had proper content validity as confirmed by the supervisors. The researcher established criterion validity within two sets of questions, covering the healthcare professionals and the HIV/AIDS patients. The respondents were given questionnaires on a similar construct, which meant that the results focused on the study objectives. No intimidation of whatever sort was exercised.

Reliability of instruments was reflected by responses to the questionnaire which were consistent, meaning that if the same questionnaires were to be repeated to the same respondents, the results would still be similar. The repeatability (test-retest) of questions was high, meaning that the questions were consistent, and their accuracy confirmed the validity and reliability of the research instruments.

3.7 Data Collection Procedure

Having defended the proposal both at the departmental and faculty levels, and having made all corrections suggested, the School of Postgraduate Studies at Egerton University allowed the

study to proceed to the field. The research sought authority from the Rift Valley Medical Director and from the Rift Valley Ethical Committee. The letters of authority to do research were obtained and the Medical Supretendants of Naivasha, Gilgil, Nakuru and Molo were informed accordingly by the Rift Valley Provincial Medical Director. The researcher later travelled to all the hospitals mentioned to meet the hospital Supretendants to make arrangements as to how to administer the questionnaires. It was agreed that since the topic under research was sensitive and personal, more so to patients, all questionnaires for all respondents were to be left with the nurses in charge of VCT centres as the custodians. It was also agreed that two nurses were to handle questionnaires for HIV/AIDS patients and nurses. Two clinical officers were to be in charge of themselves and doctors while two laboratory technicians were to in charge of their colleagues. This arrangement was to be done in all respective hospitals. Those administering the questionnaires were reminded of strict confidentiality and those healthcare professionals who wished to carry away the questionnaire were allowed to do so, who later returned when completed. The respondents were at liberty to withdraw from the exercise at their own volition without any external coercion.

3.8 Data Analysis

Data collected was coded and analysed using both descriptive and inferential statistics involving ANOVA, Pearson, Correlation Coefficient and Chi-Square. Qualitative data was analysed thematically. Data analysis was done with the aid of the computer based Statistical Package for Social Sciences (SPSS). Tables, means, averages, and percentages were also used.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

The chapter presents the results and discussions of the study findings. The data was analysed using descriptive and inferential statistics aided by Statistical Package for Social Sciences (SPSS). The hypotheses were tested by application of a Chi-Square Test. Both hypotheses tests were performed at a significance level of a=.05. Acceptance or rejection of the null hypotheses was based on the calculated test statistics, and the value of the probability of significance (p value). The null hypothesis was accepted if p>.05 and rejected if p<.05. The results are presented in form of tables and figures. Each section of this chapter corresponds to the objectives and hypotheses of the study.

4.2 Demographic Information

Kenya as a country is the leading black African tourist destination with splendid coastal areas, highly developed wildlife-viewing opportunities and an infrastructure that has been very safe and comfortable. This has created different opportunities for employment. Nakuru is one of the districts with diversity and employment opportunities that attract many people from their rural areas, creating an urban area with extremely high incidence of AIDS. Despite efforts from various organizations including US Agency for International Development (USAID), AIDS still remains on the increase in nakuru district, causing a high demand on health institutions, healthcare professionals and community leaders, UNAIDS, (2012). The target population was 125 healthcare professionals and 120 HIV/AIDS patients, totaling 245 participants out of an overall no. of 340 people. The sample size included 11 doctors, 91 nurses, 13 clinical officers, 10 laboratory technicians and 120 HIV/AIDS patients.

Table 1: The Number of Healthcare Professionals Involved in the Study.

Profession	No.	Percent
Doctor	11	8.8
Nurse	91	72.8
Clinical Officer	13	10.4
Lab Technician	10	8.0
Total	125	100.0

The study used a sample of 125 healthcare professionals, composed of 91 nurses (73%), 13 clinical officers, (10%), 11 Doctors (9%) and 10 laboratory technicians, (8%). From the above table, nurses had the highest number of 91 from the total of 150 in all healthcare institutions in this study. The study also established that there were very few doctors whom patients rely on for consultations and specifically in Gilgil, Naivasha and Molo district hospitals

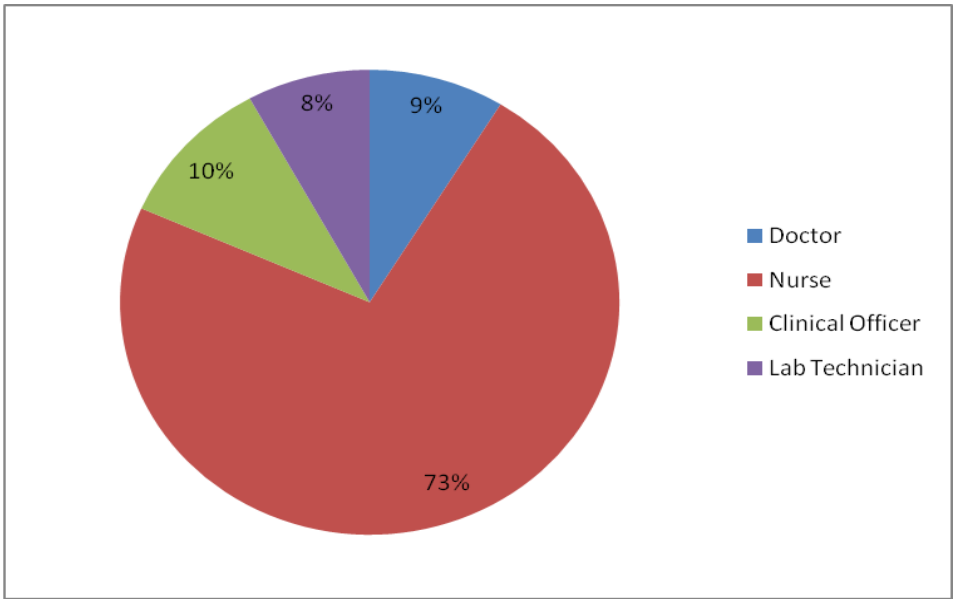

Figure 2: Percentage of Participants from Government Hospitals

Figure 2 indicates the percentage of participants from government hospitals. The nurses had the highest number of (73%), and the laboratory technicians were the least with (8%). The difference in percentage was due to the fact that the nurses were the majority in comparison to other

healthcare professionals. The ethical issues in healthcare start from the very questions which confront today's medical scientists and the whole of mankind in society. They are issues which the medical profession questions itself seriously about the care of patients. In this case, ethical issues arise in management of HIV/AIDS patients. Over the years, there has been much talk about the loss of ethos of medical staff or the eminent danger of its loss and at the same time, the healthcare professionals have engaged more than ever before in discussions on ethical issues arising from their profession, Haring (1995). The healthcare professionals should inspire the minds of their patients with gratitude, respect and confidence.

Table 2: Distribution of Healthcare Professionals in Government Hospitals

Location	No.	Percent
Naivasha	35	28
Gilgil	29	23
Molo	59	47
Nakuru	2	2
Total	125	100

Table 2 shows the distribution of district government hospitals and the number of healthcare professionals involved in the study. Molo hospital had the highest number of 59, consisting of (47%), Naivasha hospital had 35 healthcare professionals, consisting of (28%), Gilgil hospital had 29 healthcare professionals, consisting of (23%) and Nakuru hospital had the least number of staff members, consisting (2%).

4.3 Objective 1: To establish whether healthcare professionals in Nakuru government district hospitals understood their ethical codes of conduct.

This section analysed the understanding and application of Hippocratic Oath and other codes of conduct by the healthcare professionals. The study used a questionnaire to find out the extent of how well healthcare professionals were conversant with medical codes of conduct. This was expressed through various tables and figures. The total numbers of respondents for this category were 125healthcare professionals as shown in table 1.

Table 3: Healthcare Professionals who took the Ethical Code of Conduct

Response	No.	Percent
Yes	121	97
No	4	3
Total	125	100

Table 3 shows the frequency and percentage of healthcare professionals who took an oath of their profession. The Majority of the respondents, 121 representing (97%) indicated that they had taken an oath of their profession, while 4 respondents, representing (3%) said they had not taken any professional oath.

The healthcare ethical codes of conduct basically set out two sets of duties. It spells out duties to the patient and duties to other members of the profession, Percival, (1803). Code of ethics make explicit the primary goals and values of the profession. When individuals become healthcare professionals, they make moral commitment to uphold the values and special moral obligations expressed in their code. The code for nurses for instance is based on belief about the nature of individuals, nursing, health and society, The Code of Ethics for Registered Nurses, (1980). It in compasses the protection, promotion and restoration of health, the prevention of illness and the alleviation of suffering in the case of clients, including individuals, families, groups and communities.

Ethical codes are necessary in making clinical judgments whose decisions are based on considering the consequences and of universal moral principles, both of which prescribe and justify healthcare actions. The statements of the ethical codes of conduct and their interpretation provide guidance for conduct and relationships in carrying out healthcare responsibilities consistent with ethical obligations of the profession with high quality nursing care.

4.3.1 Healthcare Professionals who took the Oath and those who did not

The healthcare personnel need to offer professional services and their professionalism ought to be guided by the ethical principles at all times as stated in the Hippocratic Oath of doctors and in other codes of conduct for other health workers. This therefore is the necessary reason why healthcare professionals must undergo certain training and must also undertake some oath to safeguard healthcare profession.

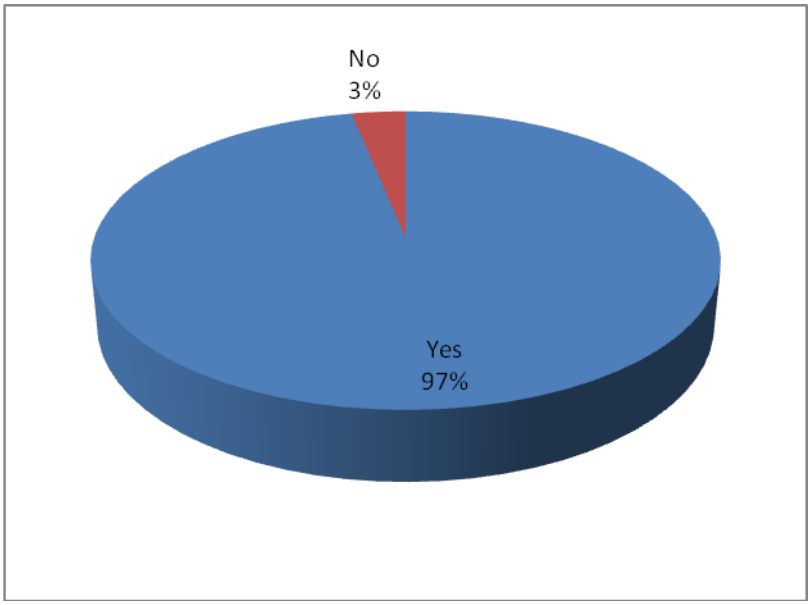

Figure 3: Percentage of those who took the Oath and those who did not

Figure 3 indicates in percentage the healthcare professionals who took the Oath and those who did not. (3%) of healthcare professionals did not undertake any Oath of their profession and yet the underlying assumption is that any person offering any medical treatment or advise ought to have taken an Oath. According to Edge and Grove (1994), a code of conduct means that as a healthcare professional, one must have the responsibility to work to standard which is stipulated within the Oath. The (3%) who did not undertake the Oath raise the question of whether they underwent proper medical training or not. However, (97%) of the healthcare professionals undertook ethical codes of conduct of their profession, to provide services with respect for human dignity and uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes or the nature of health problems.

Table 4: Distribution of Healthcare Professionals Who Took the Oath of their Profession

Name of profession	Yes	%	No	%
Doctors	11	9	0	0
Nurses	90	72	1	1
Clinical officers	11	9	2	2
Laboratory Technician	9	7	1	1

Table 4, shows distribution of the individual healthcare professionals who took their codes of conduct respectively. It indicates that the largest number of healthcare professionals who took their oath were nurses, followed by doctors. The codes of conduct are different for different professions but they all have one theme in common, namely, to maintain the highest standards of professional conduct. All doctors took oath of their profession, and 90 nurses out of 91 had also taken the ethical code of conduct that governs their profession. There were 11 clinical officers who took their oath and 9 laboratory technicians out of 10 had taken their professional oath.

The Ethical Code of doctors (2004), The International Ethical Code for Nurses, (1994), International Nursing Council (1973) and The Code of Professional Conduct for Medical Laboratory Technologists (2004), all stipulate duties for each profession. The Ethical Code for doctors, (2004), demand that the doctor must always bear in mind the obligation of preserving human life from conception. The patient is owed complete loyalty and the doctor must always preserve absolute secrecy concerning all he/she knows about a patient because of the confidence trusted in him. The doctor must observe the principles of the Declaration of Geneva, (1948), which is understood as part of the Hippocratic Oath.

The clinical officers and the nurses are bound to their duties by the International Ethical Code for Nurses, (1973). The codes of conduct stipulate the area of responsibility for the nurse as to carry out nursing care, to communicate, manage and develop nursing which is directed toward people in need of nursing. The clinical officer and the nurse amongst other duties ought to safeguard the clients' right to privacy by judiciously protecting information of a confidential nature. They must act to safeguard the client and the public when health care and safety are affected by the incompetent, unethical or illegal practice of any person, and assume

responsibility and accountability for individual nursing judgments and actions. The clinical officer and the nurse should have integrity. The code for laboratory technologists demand that they must be dedicated, must work with other healthcare professionals, must promote the image and status of the profession, protect confidentiality of patient information and be able to take responsibility for their professional acts among other duties.

Table 5: Views of Healthcare Professionals on What Ethical Codes of Conduct state concerning HIV/AIDS Patients

All health care professionals	No.	Percent
Handle them as per the instructions received	32	26
No preference for any patient	7	6
No mention in the oath	18	14
Not aware	5	4
Treat them with confidentiality	7	6
Handle them as any other patient	56	44
Total	125	100

Table 5, shows that there were different responses regarding what the Hippocratic Oath and other codes of conduct in healthcare profession state about the management of HIV/AIDS patients. The majority of the respondents (45%) indicated that the HIV/AIDS patients were handled like any other patient. (26%) indicated they handled HIV/AIDS patients as per the instructions received from their superiors. (14%) admitted that there was no mention in their oath about the management of HIV/AIDS patients, while (5.6%) showed no preference to any patient and (6%) agreed that there must be confidentiality when dealing with HIV/AIDS patients. However (4%) had no opinion whatsoever of what their codes of conduct stated about the management of those with HIV/AIDS. From the above information, it shows that the different ethical codes of conduct in healthcare profession did not mention anything to do with how to deal with HIV/AIDS patients. It was all left to individual workers to interpret the ethical code of conduct to the best of their knowledge when dealing with those infected.

4.3.2 HIV/AIDS Patients Admitted in Nakuru District Government Hospitals

Despite considerate success in HIV/AIDS prevention and treatment, an estimated 1 million Kenyans are HIV-infected or about (7.4%) of the population. HIV/AIDS accounts for more than half of all hospital admissions, NASCOP, (2011).

Table 6: The Number of HIV/AIDS Patients Admitted in Nakuru District Government Hospitals

All District Hospitals Naivasha, Gilgil, Nakuru & Molo	Approximate population Admitted	No.	Percent
	1 - 50	111	89
	51 - 100	7	6
	101 - 200	3	2
	Above 200	4	3
	Total	125	100

Table 6 indicates the number of HIV/AIDS patients admitted in Nakuru district hospitals. Most hospitals (89%) admitted between 1 to 50 patients and occasionally, the population would rise beyond 50 HIV/AIDS patients. Kenya's healthcare system consists of public and private services, staffed by more than 4500 physicians and 37000 nurses according to UNAIDS, (2012). The system is based on a referral system, extending from Kenyatta National Hospital, through provincial and district hospitals to rural health centers and dispensaries. Rapidly growing population and the HIV epidemic have put increasing strain on the country's ability to provide basic services.

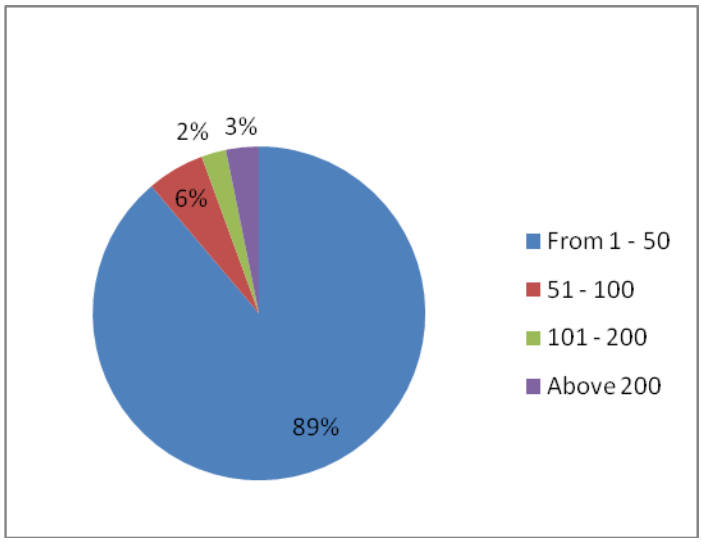

Figure 4: Population Percentage of HIV/AIDS Patients in Nakuru Government Hospitals

Figure 4 confirms that HIV/AIDS patients were admitted in all government district hospitals. All the respondents confirmed and indicated the approximate population of patients admitted in these hospitals. Most hospitals had at least 50 HIV/AIDS patients admitted, representing (89%).

Kenya's HIV epidemic has affected all sectors of the population. Various studies have revealed a high prevalence amongst a number of key affected groups including sex workers, injecting drug users, (IDUs), men who have sex with men, (MSM), truck drivers and cross-border mobile population, UNGASS,(2012). Some of these groups are marginalized within society. For instance, homosexuality is illegal in Kenya and punishable by up to 14 years in prison and therefore these groups are difficult in terms of seeking medication. While many people in Kenya are still not being reached with HIV prevention and treatment services, access to treatment is increasing as indicated in figure 4. The study revealed that the minimum population of HIV/AIDS patients were 50 and above, affirming that medication was regular.

Table 7: Healthcare Professionals willing to treat HIV/AIDS Patients

Statement	No.	Percentage
Those willing to take of HIV/AIDS patients	124	99
Those not willing to take care of HIV/AIDS patient	1	1
Total	125	100

Table 7 established that the majority of the healthcare professionals, (99%) were quite willing to take care of HIV/AIDS patients, while (1%) stated the contrary. Ethical codes were promulgated for physicians since ancient times, but ethical problems in medical practice have never been more concern or so widely discussed as they are today. Pellegrino (1988) argues that there are two conceptions of medicine today and each has different implications regarding the healthcare duties to treat HIV/AIDS patients. The first conception sees medicine as an occupation like any other and therefore the healthcare also has 'rights' including the right to refuse services as any other individual. He argues that medication can also depend on the nature of illness and the physician's knowledge. Pellegrino states that in taking an oath on graduation, it is a collective covenant which demands the use of acquired competence in the interests of the sick. Based on these grounds therefore, they give rise to an obligation on the part of the physicians to make their knowledge available to all who need it even if that involves sacrificing the physicians' self interest.

Table 8: Reasons for Willingness to Treat HIV/AIDS Patients

Reasons for taking care	No.	Percentage
Their profession demands so	63	51
On humanitarian ground	54	42
As a career	6	5
Those with No reason	2	2
Total	125	100

Table 8 indicate (51%) of healthcare professionals do treat HIV/AIDS patients because their profession dictates the same, while (42%) offer their services to HIV/AIDS patients out of humanitarian grounds. The remaining (5%) offer their services as a career and (2%) did not have any reason as to why they should or should not treat HIV/AIDS patients.

Immanuel Kant (1981) argues that one should always treat rational beings as having intrinsic value or worth and not as mere objects or instruments that only possess extrinsic value. This has been reflected in different ethical codes for physicians and other healthcare practitioners. The Geneva Declaration (1948), which was approved by The World Medical Association (1949), which dictates to physicians to consecrate their lives to the service of humanity. To practice their profession with conscience, dignity, and not to permit considerations of religion, nationality, race, party politics or social standing to interfere with their profession.

As much as ethical codes of conduct spell out duties of the healthcare to patients, there were some other obstacles that hindered proper management of HIV/AIDS patients, such as prejudice, culture, tribe, society, environment and many other factors. Despite all these, healthcare professionals enumerated other reasons as why they treated HIV/AIDS patients. Some indicated it was because of their profession, while others did so as a career.

Table 9: Reasons for not willing to treat HIV/AIDS Patients

Reasons for not taking care of HIV patients	No.	Percentage
No motivation	1	1
No opinion	109	87
Not applicable	15	12
Total	125	100

Table 9 indicates what was perceived as reasons for not willing to treat AIDS patients. Out of 125 healthcare professionals, (1%) stated there was no motivation whatsoever; while (87%) had no opinion and (12%) found it not applicable. According to Callham,(1990), the goals of medicine include the promotion of health and the prevention of disease, the relief of pain and suffering, the cure of those who are ill and the care of those who cannot be cured. Despite (87%) of healthcare workers did not have any opinion of whether they should treat HIV/AIDS patients or not, they are bound by specific medical goals which should act as reasons as to why they should treat patients. These goals include and not limited to;

- The relief of pain and suffering caused by maladies
- The care and cure with those with a malady and the care of those who cannot be cured
- The avoidance of premature death and the pursuit of a peaceful death

All the above goals should be taken into account by medical fraternity as enough reasons to be more than willing to take care of HIV/AIDS patients in general.

4.3.3 Training of Healthcare Professionals

For one to become a doctor or a healthcare expert, it is mandatory to complete a course study prescribed by a medical board. In Kenya, a doctor must complete a minimum of 5 years training which comprises of the first two years in classroom work, learning basics of anatomy, diseases and body functions. The remaining of medical training is comprised of clinical, hands-on-patient work, usually in a teaching hospital or an academic medical centre which comprises of Internship. Other professions like clinical officers and nurses also undergo training in their areas which take a minimum of 4 years, under the supervision of clinical practice and Internship at an accredited medical training institution and hospitals, who should again register with the relevant medical board of their country, Haring,(1991).

Table 10: Training of Healthcare Professionals on HIV/AIDS

Statement	No.	Percentage
Healthcare professionals trained in management of HIV/AIDS	121	97
Those not trained in management HIV/AIDS	4	3
TOTAL	125	100

Table 10, indicates that majority of the respondents (97%) had some form of training in the management of HIV / AIDS patients, while (3%) indicated that they did not have any training on the same. This raised questions as to whether the training of the healthcare professionals on handling patients with special cases like HIV/AIDS is part of their syllabus or these skills are simply acquired through workshops.

According to Dunn (1999), when medical students graduate, they recite the following;

> I solemnly pledge myself to consecrate my life to the service of humanity. I will practice my profession with conscience and dignity. I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient, (Pg 68).

Dunn states that the above quote should also include non discrimination of patients because of their HIV status. This is recited in various ethical codes like those of doctors, clinical officers

and nurses as expressed in The Declaration of Helsinki, (1964), The Declaration of Sydney, (1968), The Declaration of Oslo, (1970), The Declaration of Tokyo,(1975), The Islamic Code,(1980) and many more others.

Table 11: Clinical Experience in Managing HIV / AIDS Patients

Statement	No.	Percentage
Healthcare professional with sufficient knowledge on how to advice HIV/AIDS patients and their families	104	83
Healthcare professionals with insufficient knowledge	21	17
Total	125	100

Table 11 shows that majority of the respondents (83%) indicated they had sufficient knowledge and experience of advising HIV /AIDS patients, their families and friends, while (17%) had insufficient knowledge.

The experience level of healthcare personnel in managing HIV/AIDS patients can adequately be evaluated by their competence. Buchanan, (1975), argues that competence evaluations must strike a balance between the values of a patient, self determination and the patient's well being, by protecting the patient from harm that might result from inexperienced staff. Buchanan states that no single standard of experience is appropriate for decision making. Consultation therefore become a necessary tool within the medical fraternity, despite the number of experienced years in the profession and this is more emphasized when dealing with HIV/AIDS patients.

Table 12: Period of Training Healthcare Professionals

Training period of healthcare professionals	No.	Percentage
1-3 years	66	53
3-10 years	52	42
Above 10 years	7	6
Total	125	100.0

Table 12 indicates that (53%) of healthcare professionals had been trained for not more than 3 years, (42%) were trained between 3 to 10 years and (6%) indicated above 10 years. In Kenya, Medical training for a doctor takes a minimum of 5 years to be awarded a bachelors degree in medicine and surgery (MB chB). This is followed by one year period of Internship. In other African countries like Ghana and Egypt the basic medical education lasts for 6 years.

After training, the healthcare professionals require permission from their respective countries to practice. Such permission is intended to promote public safety and protect the public from any unprofessional service, (WHO, 2010). In Kenya for instance, The Medical Practitioners and Dentist Board is a statutory authority established by the Kenya government under cap 253 Laws of Kenya. It is meant to regulate the practice of medicine and dentistry in the country. The aims towards offering Kenyans the most effective and efficient medical services available by ensuring the medical practitioners and dentists are highly qualified and ensure that they continuously develop their career through short courses and retraining.

Table 13: Understanding of the Hippocratic Oath and other Ethical Codes by Medical Practitioners

Statement	No.	Percentage
Healthcare professionals who have read and understood Hippocratic Oath and other ethical codes	89	71
Those who did not read and understand their ethical codes.	36	29
Total	125	100

Table 13 shows the level of understanding of the Hippocratic Oath and other ethical codes for the healthcare professionals. When asked whether they had read the Hippocratic Oath or any other code of conduct for their profession, the majority of the respondents (71%) said yes, while

(29%) said they had not. The majority who had read the codes of conduct of their profession indicated that most of them emphasized the high degree of professional conduct as regards the doctor-patient relationship. The minority either had no opinion or could not remember anything from the oath of their profession.

Every trained healthcare professional ought to comprehend or be aware of the ethics of that profession and the eminent danger of its loss. Medical profession has engaged more than ever before in discussions on ethical questions arising from its field. There is a relationship between ethos and different ethical codes which guide professional groups. It fosters adherence to certain values. Haring,(1995). Ethical code consists of a studied effort to foster and guarantee the ethos and for the healthcare professionals, it is meant to go beyond by assuring patients and the public a professional standard of human relationships. No other professional community has elaborated an ethical code so early in its history and as universally as has the medical profession. This therefore makes it mandatory for the healthcare professionals to read and understand their different ethical codes that guide their profession.

Table 14: The Influence of Ethical Codes on Healthcare Practice

Statement	No.	Percentage
Healthcare professionals who adhere to the oath of their profession	68	54
Healthcare professionals who do not adhere to what their code of conduct demands	42	34
Healthcare professional who seem not to know what their codes of conduct state	15	12
Total	125	100

Table 14 shows the influence of ethical codes of conduct to the healthcare professionals. The total of (54%) stated they were influenced by their professional ethical codes, (34%) were not and (12%) were not aware of what their ethical codes of conduct stated. This reflected negatively on the level of professionalism on the side of some healthcare professionals.

The codes of conduct of healthcare profession arise from their ethical convictions and humanitarian vocation. Historically, it is an outstanding testimony which is developed through the mutual support of the members of the profession. The medical profession ranked among the first in expressing its ethos worthily and pledging members to it by vows, oaths and medical

codes. The Oath of Hippocrates has survived for more than two thousand years. Generations of doctors have made it their programme and their pledge. In many universities today, graduates of medical schools still take the Oath of Hippocrates in its historical form, only changing the words 'Apollo' and 'Aesculapius' for the word 'God'. This shows indeed that medical ethical codes have in one way or the other had influence on medical practice as indicated in the following quote, 'I will practice my profession with conscience and dignity; the health of my patient will be my first consideration'. WHO,(1948).

Table 15: Confidentiality of the HIV/AIDS records in Government Hospitals

Confidentiality of HIV/AIDS records	No.	Percentage
Very good	17	14
Good	90	72
Poor	12	10
Very poor	2	2
No opinion	4	3
Total	125	100

Table 15 indicates how medical records for HIV/AIDS patients were kept in government hospitals. The majority of the respondents (72%) described the record keeping system as good, (13%) described it as very good, (10%) described it as poor and (2%) described it as very poor. The remaining (3%) had no opinion on how the medical records were safeguarded and according to Ross, (1980), physicians have a particular duty to the patients, to promote their health and respect their confidence to avoid stigma and discrimination. The exposure of the patients' medical records creates mistrust and erodes physician-patient relationship.

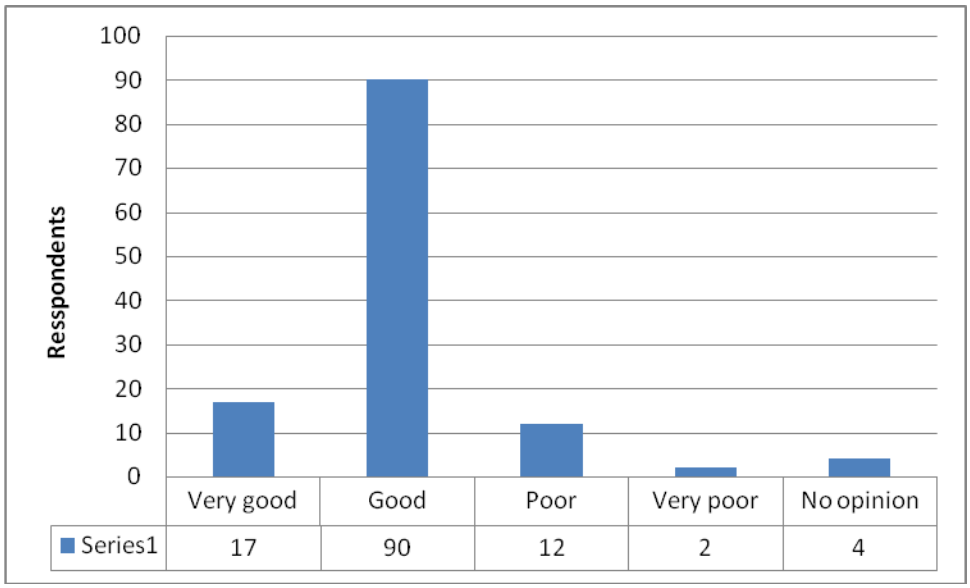

Figure 5: Confidentiality of HIV/AIDS records in government hospitals.

Figure 5 portrays similar information graphically how respondents gave their views regarding the confidentiality of medical records. From the population of 125 healthcare professionals, 90 of them indicated that the record keeping system is good, 17 respondents stated very well, 12 indicated poor, while 2 and 4 stated very poor and no opinion respectively.

Lack of confidentiality by the healthcare causes significance of HIV related stigma and discrimination issues and as a result, efforts were made to articulate the consequences of addressing or not addressing factors that bring about stigmatisation. The effects of HIV related stigma and discrimination can be felt at different levels in society, which boils down to individuals, family and even the community, Delor and Hubert, (2000). When this happens, it prevents an individual from being tested and therefore it also inhibits HIV positive members of society from seeking care, support and even treatment.

Table 16: Healthcare Professionals who are Happy with their Profession

Statement	No.	Percentage
Healthcare professionals who are happy with their profession	96	77
Those unhappy with their profession	29	23
Total	125	100

Table 16 shows that the majority of the healthcare professionals, (77%) were happy with their profession while (23%) were unhappy. Various factors were cited as some of the causes to these responses. Smart,(1995),argues that utilitarianism as a theory can be described as a doctrine which states that rightness or wrongness of an action is determined by the goodness or badness of its consequences and therefore, utilitarians believe that morality of an action is dependent upon producing the greatest happiness for the greatest number of people. This is self evident that happiness is good and suffering is bad, hence modern utilitarians advanced the theory which stated that the best way to maximize overall happiness is to maximize the satisfaction of individuals by favouring their personal preferences. In this case, medicine is a special calling and not just like any other profession. One must be ready to serve the sick without any reservations that may have been contributed by the patient. The medical profession is to serve and this is stipulated in different ethical codes of healthcare professionals.

Table 17: Reasons for being Happy with the Profession

Reasons for those who are happy with their profession	No.	Percentage
Enthusiasm	4	3
Commitment to patients	11	9
Desire to learn more	10	8
Those with no comments	100	75
Total	125	100

Table 17 gives various reasons cited by healthcare professionals for being happy with their profession. It was indicated as (9%) were committed to their patients, (8%) were simply eager to learn and (3%) were just enthusiastic over their profession. Surprisingly, (75%) did not have any comment. As per the ethical codes of conduct for the healthcare professionals, it states that patients are of priority to every medical practitioner and therefore the healthcare professional must treat them with dignity and respect, irrespective of other factors not withstanding.

Table 18: Reasons for not being Happy

Reasons for those not being happy	No.	Percentage
No morale	43	34
Low salaries	46	37
Routine job	18	14
No opinion	18	14
Total	125	100

Table 18 gives the main reason considered as the cause of unhappiness of healthcare professionals, which was cited as low salaries, (37%). This contradicts the main objectives of The International Code of Medical Ethics, (1964) that states a doctor should practice uninfluenced by motives of profit. Other reasons cited as some of the causes were low morale booster, (34%), routine work, (14%) and the remaining (14%) did not have any opinion.

4.3.4 Hypothesis 1:

The healthcare professionals in Nakuru district government hospitals do not understand their professional ethical codes of conduct while handling HIV/AIDS patients

A Chi-Square test was done to establish the relationship between healthcare professionals' understanding of ethical codes and their handling of patients. This test established the relationship between the Independent Variables (IVs) and the Dependent Variables (DVs). The x^2 Chi-Square tests were used to calculate this correlation. The objective of the study was to establish whether or not lack of understanding of independent variable by healthcare professionals has an effect on dependent variables which can have either positive or negative effect on HIV/AIDS patients.

Table 19: The Chi-Square Test Results on Healthcare Attitude

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.655(a)	12	.474
Likelihood Ratio	13.715	12	.319
Linear-by-Linear Association	.439	1	.507
N of Valid Cases	120		

The results in table 19 indicate that the t value of X^2 for 12 degrees of freedom at 5% level of significance is 21.026. The calculated value of X^2 (11.655) is less than 21.026 which means that the calculated value cannot be said to have been less just because of chance. It is not significant. Hence, the hypothesis is rejected. This means that majority of healthcare professionals have a positive and good attitude while handling HIV / AIDS patients. This therefore justifies what different ethical codes of conduct for the healthcare demand, that they must maintain at all levels the highest standards of care and professional conduct while dealing with patients.

Table 20: The Attitude of Healthcare Professionals towards HIV/AIDS Patients

Personnel	Very good no & %		Good no & %		Very bad no & %		They do not care no & %		Total
Doctors	29	24	27	22	3	2	1	1	60
Nurses	9	7	6	5	0	0	0	0	15
Clinical Officers	14	11	18	15	0	0	2	1	34
Those with No opinion	2		0		0		0		2
All healthcare professionals	2		7		0		0		9
Total	56		58		3		3		120

Table 20 indicates the attitude of different healthcare professionals towards their patients. This is because the quality of the patient-physician association is important to both parties. The better the interaction, the better will be the amount and quality of information about the patients, Pandya,(2010). The table shows how patients assessed the healthcare professionals. (24%) of doctors were assessed to have very good attitude towards patients, while (22%) were assessed to be good. (11%) of clinical officers were assessed to be very good and (15%) to be good. Nurses were assessed not to have a very good attitude towards HIV/AIDS patients compared to other healthcare professionals.

Table 21: Chi-Square Test Results on the Healthcare Relationship with HIV/ADS Patients

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.551(a)	12	.971
Likelihood Ratio	5.316	12	.947
Linear-by-Linear Association	.003	1	.957
N of Valid Cases	120		

The results in table 21 indicate that t value of X^2 for 12 degrees of freedom at 5% level of significance is 21.026. The calculated value of X^2 (4.551) is much less than 21.026 which means that the calculated value cannot be said to have been less just because of chance. It is not significant. Hence, the hypothesis is accepted. This means that majority of doctors relate well while handling HIV / AIDS patients.

Table 22: The Relationship between Healthcare Professionals and HIV/AIDS Patients

Personnel	Very Good No& %		Poor No & %		They don't care No & %		No Opinion No & %		Total
Doctors	58	50	1	1	1	1	0	0	60
Nurses	15	13	0	0	0	0	0	0	15
Clinical Officers	33	28	0	0	0	0	1	1	34
No Option	2	1	0	0	0	0	0	0	2
All healthcare professionals	9	8	0	0	0	0	0	0	9
Total	117		1		1	1			120

Table 22 shows how healthcare professionals related to their patients. The doctors were rated highest with (58%), followed by clinical officers (32%) and lastly the nurses with (15%). This connotes negatively on nurses' care because it is supposed to be administered without any form of intimidation as stated in the UN Universal Declaration on Human Rights,(1948). The nurse should ensure that patients receive and understand the information needed to make choices, and if the relationship between the two is poor, then it hinders proper treatment.

Table 23: Chi-Square Test Results on Mistreatment of Patients by Healthcare Professionals

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.539(a)	12	.569
Likelihood Ratio	11.907	12	.453
Linear-by-Linear Association	.357	1	.550
N of Valid Cases	120		

The results in table 23 show that the t value of X^2 for 12 degrees of freedom at 5% level of significance is 21.026 The calculated value of X^2 (10.539) is much less than 21.026 which means that the calculated value cannot be said to have been less just because of chance. It is not significant. Hence, the hypothesis is rejected. This means that majority of patients indicated that they were not mistreated by doctors, nurses, clinical officers. This demonstrates that the professionals consider ethical principles and do understand Hippocratic Oath with other codes of

conduct while handling HIV / AIDS patients. This therefore justifies what different ethical codes of conduct demand of healthcare professionals. That they ought to maintain the highest professional standards at all times when handling patients.

Table 24: HIV/AIDS Patients who felt Mistreated by Healthcare Professionals

Healthcare professionals	YES		NO		No opinion	Total
	Frequency	Percentage	Frequency	Percentage		
Doctors	13	11	45	37	2	60
Nurses	3	2	11	9	1	15
Clinical officers	3	2	31	26	0	34
All healthcare professionals	0	0	9	8	0	9
No option	1	1	1	1	0	2
Total	20		97		3	120

Table 24 indicates that some patients felt mistreated by all healthcare professionals which included doctors,(10%), nurses (2%), and clinical officers (2%). These percentages are however quite insignificant. This does not uphold what the International Code of Medical Ethics demand, that the healthcare professionals should maintain the highest standards of professional conduct.

As indicated in table 24, the Chi-square test shows that majority of healthcare professionals understand ethical principles while handling HIV / AIDS patients. The hypothesis which stated "**that the healthcare professionals in Nakuru district government hospitals do not understand the professional ethical codes of conduct and principles while handling HIV / AIDS patients"** is therefore rejected.

4.4 Objective 2: To establish whether healthcare professionals in Nakuru County government hospitals adhere to and are guided by professional ethical codes of conduct and principles in discharging their duties concerning HIV/AIDS patients.

This section considered views of HIV/AIDS patients regarding how they were handled by healthcare professionals from different government healthcare institutions within nakuru district. The total numbers of respondents for this category were 120 distributed as indicated in table 25 below

Table 25: Total Numbers of Respondents in the Hospitals

Hospital	No.	Percentage
Naivasha	43	36
Gilgil	22	18
Molo	55	46
Total	120	100

Table 25 shows the total numbers of HIV/AIDS patients within Nakuru district government hospitals that were involved in the study. The study findings revealed that (46%) of the HIV/AIDS patients were from Molo district hospital, (36%) were from Naivasha district hospital and (18%) were from Gilgil district hospital. Since HIV/ADS was recognized in Kenya in 1984, the scourge has had a devastating effect to both Kenyan economy and to society at large. There have been different efforts from Non-Governmental Organisations and Kenya government to try and fight the scourge and indeed this campaign brought about some changes which reduced the prevalence rate from (14%) in 2000 to (6%) in 2011. NACC,(2011).

The National AIDS Control Council (2011) and UNAIDS (2009) reported that 40 million people live with AIDS in the world, whereby 35.3 million live in Africa. Between 1983 and 1985, 26 cases of AIDS were reported in Kenya, UNAIDS, (2004). Sex workers were the first group to be affected according to UNGASS, (2008). The same report indicated that most of the HIV/AIDS victims admitted in hospitals were mostly sex workers who in most cases engaged in unprotective sex. Apart from sex workers, the study also revealed a high HIV prevalence

amongst other key groups including injecting drug users (IDUs), men who have sex with men (MSM), truck drivers and cross- border mobile populations.

Table 26: Patients' Length of Stay in Hospitals

Month	No.	Percentage
1-6	24	20
6-1 year	15	12
More than 1 year	81	68
Total	120	100

Table 26 indicates the period of stay in hospitals by HIV/AIDS patients. The majority of the respondents (68%) indicated they had been admitted in these hospitals for more than a year while (32%) had been admitted for a period less than one year. The principle aim of 2009/10 and 2013/14, Kenya National HIV and AIDS Strategic Plan (KNASPIII), was to reduce the number of new HIV infections. It was hoped that once this was done, it would reduce the number of HIV/AIDS admissions in public healthcare institutions which are currently overcrowded and have overstretched the capacities.

In 2003, only (5%) of people needing ART were receiving antiretroviral therapy, UNAIDS (2012). In 2006, Kenya's president announced that antiretroviral drugs would be provided for free in public hospitals and health centres, UNGASS (2012). By 2009, the number of people receiving antiretroviral therapy had significantly increased to 336,980 people. By 2010, access to treatment increased to432, 621 of those receiving treatment UNAIDS (2012). From that year, the number of those seeking for treatment has risen by (59%), UNAIDS, (2012). The above figures imply that there could be many of those infected with HIV/AIDS but they do not turn out to be admitted in health institutions, which mean that they could be visiting hospitals to be reviewed and acquiring of antiretroviral to be used at their homes. This has led to decrease in AIDS related death and reduced the admission numbers in already overstretched facilities in government hospitals, UNAIDS (2012).

Table 27: Response on Treatment by Healthcare Professionals

Health care professionals	No.	percentage
Doctors	60	50
Nurses	15	13
Clinical officers	34	27
All healthcare professionals	9	8
Other	2	2
Total	120	100

Table 27 revealed that (50%) of HIV/AIDS patients were being treated by doctors and the remaining were attended to by other healthcare professionals who were the clinical officers, (27%), nurses, (13%) and (8%) were attended to by all the healthcare workers. However, (2%) did not know who attended to them medically. Medicine is a life of service to the patients, to their families and to society. The ideal motto for the physician is "cavitas et justitia" (love and justice). Expressed in another way, the purpose of medicine is "sometimes to cure, often to relieve and always to console" Dunn (1994). Similarly, the role of a healthcare professional to a patient is clearly stipulated in different ethical codes of conduct which are taken as oaths to all professionals. Codes of conduct demand that there ought to be a high level of standards in terms of professionalism. To practice uninfluenced by motives of profit and to ensure that any act or advice that could weaken physical or mental resistance of an individual must be used only in the interest of that particular individual.

Table 28: The Response of Patients on Patient Management by Healthcare Professionals

Statement	Doctors, nurses and clinical officers			
	YES		NO	
	No.	Percentage	No.	Percentage
They are kind to patients	99	83	1	1
They are professional in their duties	14	12	4	3
They listen to patient problems	23	19	7	6
They encourage patients	31	26	1	1

Table 28 indicates how the HIV/AIDS patients viewed the attitude of medical professionals towards them. The majority of the respondents (83%) stated that doctors, nurses and clinical officers were kind to them while (1%) did not approve and (16%) had no opinion. Different reasons were cited as evidence to indicate how medical staff manifested their kindness to HIV/AIDS patients. The patients indicated the medical staffs were professional in their duties because they listened to their problems and also they encouraged them regarding their sicknesses.

The code of ethics for doctors, nurses, and clinical officers serve as a foundation for ethical practices. It provides guidance for ethical professionalism which is standards of conduct that apply to people who occupy a professional occupation or role, Bayles (1988). A person who enters a profession acquires ethical obligations because society trusts them to provide valuable services that cannot be provided unless their ethical obligations betray their trusts. This implies that healthcare professionals should be positive in managing not only HIV/AIDS patients but to all those who seek their medical assistance, since medicine is a noble profession and society has given them that trust as medical professionals.

Table 29: Responses of mistreatment of Patients by Healthcare Professionals

Statement	Doctors, nurses and clinical officers			
	YES		NO	
	No.	Percentage	No.	Percentage
Patients who felt mistreated		17	97	81
Patients who felt ridiculed	21	18	22	18
HCP who laughed at patients	4	3	7	6
HCP who denied medication to patients	11	9	81	68
HCP who did not care	73	61	5	4

Table 29 shows the views of HIV/AIDS patients, indicating how they were handled by healthcare professionals. However, majority of the respondents (81%) indicated they were not mistreated by healthcare professionals. (17%) said there were such times they felt mistreated while (3%) had no opinion. Reasons given as indicators to show possible mistreatment were stated as follows. (61%) stated the medical staff sometimes did not care about HIV/AIDS patients. Those who felt ridiculed by medical workers were (18%), and those who felt were denied necessary attention were (9%). In the interest of justice, efficiency and a harmonious relationship, it is important for both the healthcare fraternity and the patient to appreciate their individual roles. The healthcare professionals are the servants of the patient, but not the patient's slave. If the patient is unhappy with any healthcare worker, one is free to seek a second opinion. This is a great protection which is only rarely offered in other professions.

4.4.1 Confidentiality of Patients' Records and Information

A person enjoys privacy when other individuals do not without permission invade what can be called his or her " sphere of privacy", a realm of intimate or sensitive information about the person that he or she generally does not wish to share with others or wishes to share with only a small circle of persons. Thus sensitive medical information about Mr. X lies within his sphere of privacy. While privacy involves others' not entering a persons's sphere of privacy without permission, confidentiality involves those who have legimate access to private information not bringing it out of that sphere and sharing it with others without permission. A doctor may legitimately access large segments of a patients' sphere of privacy, such as the patients, medical history, the appearance of his or her naked body during examination, or other aspects of the patients' social history that bear directly on the patients' medical situation, but the doctor should not disclose any information about the patient to individuals other than healthcare professionals who are closely involved with the patients' care. Such disclosure constitutes a breach of confidentiality. Appel, (2006).

Table 30: Confidentiality of HIV/AIDS Patients' Information

Statement	YES		NO	
	No.	Percentage	No.	Percentage
Doctors	91	81	20	17
Nurses	81	68	11	9
Clinical Officers	73	63	5	4

Table 30 indicates that HIV/AIDS patients' information was kept confidentially by the healthcare professionals. Majority of the respondents (81%) agreed that their medical information was kept confidential by doctors while handling them, (68%) stated nurses kept their records confidentially and (63%) agreed that clinical officers kept their medical records confidential. The study sort to establish how healthcare professionals maintain HIV/AIDS patients' records. Today, a great deal of medical care is provided in hospitals, nursing homes, clinics and other healthcare institutions. The medical professionals therefore have the obligation to take into account the emerging problems of confidentiality. A clear understanding of

confidentiality is best achieved in view of the distinction between privacy and confidetiality. Annas, (1975).

4.4.2 Hypothesis 2:

The healthcare professionals in Nakuru district government hospitals do not adhere to and are not guided by professional ethical codes of conduct and principles in the discharge of their duties concerning HIV/AIDS patients.

This test established the relationship between the Dependent Variables (DVs) and the Independent Variables (IVs). The x^2 Chi-Square tests were used to calculate this correlation. The objective of the study was to establish whether or not the healthcare professionals in Nakuru government hospitals adhered to and were guided by professional ethical codes of conduct and principles in the discharge of their duties concerning HIV/AIDS patients.

Lack of professional adherence of healthcare professionals to different codes of conduct cause stigmatization, discrimination, fear and despair to HIV/AIDS patients. Table 31 indicates the Chi-Square Test Results on the medical staff duties.

Table 31: Chi-Square Test Results on the Medical Staff Duties

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.743(a)	4	.005
Likelihood Ratio	5.620	4	.229
Linear-by-Linear Association	1.527	1	.217
N of Valid Cases	125		

The results in Table 31 show that t value of X^2 for 4 degrees of freedom at 5% level of significance is 9.488. The calculated value of X^2 (14.743) is much higher than 9.488 which means that the calculated value cannot be said to have been more just because of chance. It is insignificant; hence, the hypothesis is rejected. That majority of staff indicated that they were willing to take care of HIV/AIDS patients. This demonstrated that the healthcare professionals in government hospitals in Nakuru District did adhere to Hippocratic Oath and other Codes of conduct prescribed in their Oath while handling HIV/AIDS patients and other patients within their health institutions.

Table 32: Medical Staff Duties to the HIV/AIDS Patients

Duties	Yes	No	Total
Treatment only	16	0	16
Nursing only	23	0	23
Management care only	69	0	69
Taking blood sample only	7	1	8
All duties	9	0	9
Total	124	1	125

Table 32 shows the main duties of healthcare professionals to HIV/AIDS patients. The majority of the medical staff indicated their main duty was management care only. However others indicated that they offer treatment, nursing and taking blood samples. According to Jonsen (1990), the duties of the healthcare professionals were traditionally thought of not harming the patient. By virtue of their profession, they had more stringent obligations of beneficence than most of other professions. Edge and Grove (1974) state that the healthcare professionals ought to do what their job description demanded for the safety of their clients.

The Hippocratic Oath and other ethical codes of conduct which most medical graduates are asked to repeat after their training, contains three elements. First is the code duties to the patients, second is the covenant on obligations to their teachers and thirdly, the swearing of agreement to the first two parts by an oath to God. The duties of the healthcare toward their patients are that they must always act for their benefit according to their best judgment and ability and more generally to keep patients from harm and injustice. This is considered to be the moral rule of Hippocratic Oath and other professional ethical codes, though these rules have undergone considerable development and modification by the successive declarations of the World Medical Association (1948), through where we are today.

Table 33: Chi-Square Test Results on the Influence of Codes of Conduct on the Healthcare Profession

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.447(a)	3	.015
Likelihood Ratio	15.266	3	.002
Linear-by-Linear Association	1.464	1	.226
N of Valid Cases	125		

The results in Table 33 show that the t value of X^2 for 3 degrees of freedom at 5% level of significance is 9.488. The calculated value of X^2 (10.447) is higher than 9.488 which means that the calculated value is significant. Hence, the hypothesis is rejected. This means that majority of staff indicated that the Hippocratic Oath and other codes of conduct in medical practice influenced their professionalism. This demonstrates that the Healthcare professionals in Government hospitals in Nakuru District adhered to Hippocratic Oath and other Codes of conduct prescribed while handling HIV / AIDS patients.

Hospitals have many functions to perform including the enhancement of health status, health promotion and the prevention and treatment of injury and disease. All these activities must be conducted within an overriding concern for the values and dignity of patients. The health care professionals ought to provide services to the patient with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes or the nature of the health problems. Ryan,(2010).

Table 34: The Influence of Different Ethical Codes of Conduct in Healthcare Profession

Health care professionals	Does Different Codes of Conduct Promote Professionalism? YES		NO	
	No.	Percentage	No.	Percentage
Doctors	11	9	0	0
Nurses	64	51	27	21
Clinical officers	12	9	1	1
Laboratory technician	10	8	0	0
Total	97		28	

Table 34 shows how different ethical codes of conduct influence the performance of healthcare professionals. Generally, all medical workers agreed that ethical codes of their profession had helped them to be professional in their duties. The nature of ethical codes of conduct is to enhance values and standards of any profession. Unethical behavior of healthcare professionals contributed to the suffering and pain of HIV/AIDS patients and therefore proper training and acquiring of necessary skills is core to any profession. Ethical code of ethics makes explicit the primary goals and values of the profession. When individuals are trained in health care, they make a moral commitment to uphold values and special moral obligations expressed in their code. The ethical codes are based on a belief about the nature of individuals, nursing, health and society. Rebello, (2003). Health care encompasses the protection, promotion and restoration of health. The prevention of illness and the alleviation of suffering in the care of clients, including individuals, families, groups and communities, is a requirement for a trained health care professional. Godkin and Markwell,(2003).

As a conclusion, the Chi-Square test results in Table 33 indicate that majority of Healthcare professionals in government hospitals in Nakuru district adhered to Hippocratic Oath and other Ethical Codes of conduct prescribed in their profession while handling HIV/AIDS patients and therefore, the hypothesis which stated that ' **The healthcare professionals in Nakuru County government hospitals do not adhere to and are not guided by professional ethical codes of conduct and principle in the discharge of their duties concerning HIV/AIDS patients'** is rejected.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The purpose of this study was to examine whether healthcare professionals in Nakuru district government hospitals understood the professional ethical codes of conduct while handling HIV/AIDS patients and if they did adhere to and are guided by the same professional ethical codes and principles in the discharge of their duties in handling HIV/AIDS patients. In this chapter, the major findings of the study are summerised, conclusions and recommendations made. Also suggestions for further research in related areas were outlined.

The study was conducted in the Rift Valley Province, Nakuru County, where Naivasha, Gilgil, Nakuru and Molo District Hospitals are located. From the total number of 177 health workers, 125 filled the questionnaires and from the total number of 153 HIV/AIDS patients, 120 filled the questionnaires. The total respondents were 245 from a population of 330.

5.2 Summary of Findings

The study was undertaken to investigate how lack of considering ethical issues by healthcare professions in Nakuru district government hospitals affected HIV/AIDS patients. The study examined Independent variables which were codes of conduct, confidentiality, professionalism, privacy and doctor- patient relationship, and these had effect on the dependable variables. This study therefore established that as per the objectives and hypotheses of the research, there was a relation between the Independent Variables (IVs) and the Dependent Variables (DVs) These findings are summarized in relation to the stated objectives as follows;

i. The majority of the healthcare professionals (97%) indicated they took Oath of their profession, however (3%) did not take any Oath.
ii. The different Oaths that were taken by healthcare professionals did not mention or give preference to any person suffering from HIV/AIDS. This meant that HIV/AIDS patients were handled similarly with other patients, notwithstanding the stigma and discrimination that is caused by this pandemic.
iii. All the Nakuru district government hospitals admitted HIV/AIDS patients, Molo hospital leading with (46%), Naivasha hospital (36%) and Gilgil

hospital (22%). Nakuru district government hospital was not accessed as stated in limitations of the study.

iv. The majority of healthcare professionals, (97%) indicated they had been trained on HIV/AIDS management and had professional knowledge on how to manage and advise infected patients, families and their friends.

v. The study revealed that the majority of the healthcare professionals, (71%) understood and have read different codes of ethics and conduct which emphasize professional conduct as regards doctor-patient relationship.

vi. The study established that confidentiality of HIV/AIDS patients' records were fairly kept confidential. (73%) describing it as good, while (13%) described it as very good.

vii. The study established the majority of healthcare professionals, (97%) adhered to and were guided by professional ethical codes of conduct and principles in the discharge of their duties on HIV/AIDS patients.

5.3 Conclusions

The following was concluded based the study objectives;

Objective 1. To establish whether healthcare professionals in Nakuru district government hospitals understand ethical codes of conduct.

i) The correlation between Independent Variables (IVs) and the Dependent Variables were positive and significant. It implied therefore that the Dependent Variables could change either positively or negatively depending on other factors.

ii) The highest percentage of healthcare professionals was well trained and their level of professionalism was quite high.

Objective 2. To establish whether healthcare professionals in Nakuru district government hospitals adhered to and were guided by professional ethical codes of conduct and principles in the discharge of their duties on HIV/AIDS patients.

i) The study established that (97%) of the medical staff was well trained and that they adhered to their ethical codes of conduct while treating

HIV/AIDS patients. It was also indicated that the healthcare professionals were being guided by their different ethical codes of their profession.

5.4 Recommendations

Based on the findings of each research objective and specific conclusions, the following recommendations were made;

1. The study is valuable to Government healthcare institutions and to Non-governmental Organizations (NGOs) who are concerned with health of HIV/AIDS patients in different parts the Republic of Kenya. Despite its findings being positive, there is need to make sure that the management of HIV/AIDS patients in public healthcare institutions is foolproof, implying that the services to HIV/AIDS patients can be improved.
2) In some cases, some healthcare professionals had either forgotten about the Oath they took or they simply did not care. This become dangerous more so when one was dealing with the health of a person. The study suggests that different Oaths of Conduct in different healthcare professions should be improved to capture different emerging diseases.
3) The patients need to be encouraged to seek medication since the government provides free Antiretroviral. The study revealed that most patients preferred to be treated and left to return to their homes with fear that being admitted, the society would know the nature of one's disease leading to being discriminated and stigmatized.
4) Other areas of great concern were about confidentiality of HIV/AIDS records. The study showed that secrecy was not observed fully as required by different codes of conduct and that explained why only (54%) of healthcare professionals abide with their codes of conduct, (34%) do not abide by it and (12%) argue that it was not quite applicable when managing HIV/AIDS patients.
5) Since HIV/AIDS creates stigma and discrimination, it is recommendable that professional ethical codes for the healthcare professionals ought to be revised to capture in their oath the special attention to deal with those infected professionally.
6) Finally the study recommends that all healthcare professionals should be trained properly and must be made to understand the important role they play in society and that their profession is a special calling and not any other business oriented training and therefore they must all the time be guided by the code of their profession. There is need for

frequent in service courses for healthcare professionals for the sake of improving their quality of service.

5.5 Suggestions for Further Research

It is suggested that further research can be done in the following areas;

1) That during data collection, questionnaires for patients were administered by nurses, which could have had psychological effect to the patients such as fear and anxiety and could have had effect on the relationship between (DVs) and the (IVs). A study with proper control of these instruments is therefore suggested.
2) The study did not deal with reasons as to why some healthcare professionals did not take any Oath. It is suggested that further research should be done to establish the reasons to this phenomenon.
3) The relationship between laboratory technicians and the HIV/AIDS patients was indicated as very poor. Further investigation is suggested to establish factors that contribute to this poor relationship and its effect on patients.
4) The study concentrated on the government public health institutions. Further research in this area with a larger population, including private health institutions is necessary.
5) Lastly, given the emerging quest for degrees by the nurses. The study suggests further research should be done to establish whether this will cause a conflict between doctors and nurses in terms of service delivery.

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APPENDICES

APPENDIX A:

Questionnaire for Doctors, Nurses, Clinical Officers and Laboratory Technicians

Instructions

Dear friends,

I am a Post-graduate candidate in Philosophy at Egerton University undertaking a brief survey for the purposes of obtaining data to enable me contribute to the existing knowledge on the management of HIV/AIDS patients in government district hospitals specifically Nakuru county. My target groups are the doctors, nurses, clinical officers, lab technicians and the HIV/AIDS patients.

Please note the following;

That the questions **are only for academic purposes** and the answers you give will be strictly confidential.

Do not indicate your name anywhere on paper. It is not required.

Please answer all the questions as honestly as possible.

Please cycle one or more answers.

1. Name of the profession
    a) Doctor
    b) Nurse
    c) Clinical officer
    d) Lab Technician
2. My duties to the HIV/AIDS patients include the following
    a) Treatment only
    b) Nursing only
    c) Management and care only
    d) Taking blood samples only
    e) No opinion
3. In which government hospital do you work?
    a) Naivasha
    b) Gilgil
    c) Molo

d) Nakuru

4. Did you undertake any Oath of your Profession?
   a) Yes
   b) No
5. As a doctor, what does the Oath of your profession state about HIV/AIDS patients?
   a) Treat them with confidentiality
   b) Handle them as any other patient
   c) Condemn them
   d) No mention in the Oath
   e) No opinion
6. As a nurse, what does the Oath of your profession state about HIV/AIDS patients?
   a) Handle them as advised by the doctor
   b) Handle them as any other patient
   c) Condemn them
   d) No mention in the Oath
   e) No opinion
7. As a clinical officer, what does the Oath of your profession state about HIV/AIDS patients?
   a) Handle them as per the instructions from the doctor
   b) No special preference to any patient
   c) No mention in the Oath
   d) No Oath is taken
   e) No opinion
8. As a laboratory technician, what does the Oath of your profession state about HIV/AIDS patients?
   a) Handle them as per the instructions received
   b) No preference for any patient
   c) No mention in the Oath
   d) No Oath taken
   e) No opinion

9. Are HIV/AIDS patients admitted to your hospital?
    a) Yes
    b) No
10. If yes, what is the approximate population?
    a) 1 – 50
    b) 51 – 100
    c) 101 – 200
    d) > 200
11. If NO, why do you think they have not come to your hospital?
    a) They fear medical staff
    b) Lack of proper medication
    c) No doctors
    d) Medical fraternity is insensitive
    e) No opinion
12. Are you willing to take care of HIV/AIDS patients?
    a) Yes
    b) No
13. If willing, state your reason
    a) You are being paid risky allowance
    b) Your profession requires you to do so
    c) Because of humanitarian reasons
    d) As a career
    e) No opinion
14. If No, state your reason
    a) No motivation
    b) Fear of getting infected with HIV/AIDS
    c) Your profession prohibits you
    d) No opinion
15. Will you ask for transfer to another department if you had to care for HIV/AIDS patients daily?
    a) Yes

b) No

16 If yes, what are your reasons?

a) Fear of getting infected with HIV/AIDS
b) You have never cared for HIV/AIDS patients
c) The Oath of your profession does not state anything about management of HIV/AIDS patients
d) No opinion

17. If no, what are your reasons?

a) You do not fear contracting HIV/AIDS
b) Humanitarian reasons
c) The Oath of your profession does not allow
d) No opinion

18. How do you think HIV/AIDS is transmitted?

a) Hand shaking and body contact
b) Eating together
c) Coughing
d) Mosquito bites
e) Sexual intercourse
f) No opinion

19. Do you have any knowledge or training about management of HIV/AIDS patients?

a) Yes
b) No

20. What is your perceived knowledge about HIV/AIDS?

a) Very Good
b) Good
c) Fair

21. Do the healthcare workers have professional duty to care for HIV/AIDS patients?

a) Yes
b) No

22. Do you have sufficient knowledge of HIV/AIDS to advice on the infection to patients' families and friends?
    a) Yes
    b) No
23. How many years were you trained in your profession?
    a) <3 years
    b) 3-10 years
    c) >10 years
24. How long have you been in medical care?
    a) >1 year
    b) 1 to3 years
    c) to 5 years
    d) 5 years and above
25. How long have you been managing HIV/AIDS patients?
    a) < 1 year
    b) 2years
    c) years
    d) >4 years
26. Have you ever read the Hippocratic Oath or any other Code of Conduct in medical practice?
    a) Yes
    b) No
27. If yes, what does it state about doctor/patient relationship?
    a) Maintain high level of professional conduct
    b) To be influenced by motives of profit
    c) No mention from the Oath
    d) No opinion
28. How does this Oath or any other Code of Conduct in medical practice influence you in handling HIV/AIDS patients?
    a) To be professional
    b) To seek riches

c) To be unkind

d) No opinion

29. Is the Hippocratic Oath and other Codes of conduct being followed by all healthcare professionals?

a) Yes

b) No

30. If yes, what shows that they follow?

a) They care for patients partially

b) Patients are not mistreated

c) They frequently read the Oath

d) Overcharge their fees

e) No comment

31. If no, what has happened to it?

a) Unimportant

b) Irrelevant

c) Forgotten

d) No opinion

32. How confidential is HIV/AIDS patients' record in this hospital?

a) Very good

b) Good

c) Poor

d) Very poor

e) No opinion

33. Are there some medical staff that are not happy with their profession?

a) Yes

b) No

34. If yes, what has contributed to this?

a) No morale booster

b) Low salaries

c) Tired and Old staff

d) Routine job

e) No opinion

35. If no, what indicates?

a) Enthusiasm

b) Commitment to the patients

c) Desire to learn more

d) No opinion

APPENDIX B:

Questionnaire for Patients

Instructions

Dear friends,

I am a postgraduate candidate in Philosophy at Egerton University undertaking a brief survey for the purposes of obtaining data to enable me contribute to the existing knowledge on the management of HIV/AIDS patients in government district hospitals specifically Nakuru district. My target groups are the doctors, nurses, clinical officers, laboratory officers and the HIV/AIDS patients.

Please note the following;

That the questions are **only** for academic purposes.

The answers you give will be strictly confidential.

Do not indicate your name anywhere on this paper. It is not required.

Please answer all the questions as honestly as possible.

You may circle one or more answers

1. Which hospital are you admitted in?
    a) Naivasha
    b) Gilgil
    c) Nakuru
    d) Molo
2. How long have you been here?
    a) 1– 6 months
    b) 6months – 1 year
    c) > 1 year
3. Who treats you?
    a) Doctor
    b) Nurse
    c) Clinical Officer
    d) No opinion
4. If (a), (b) or (c), how do you assess their attitude towards you as a patient?
    a) Very good

b) Good
c) Very bad
d) They do not care

5. How do doctors relate to you as a patient?
    a) Very well
    b) Badly
    c) They don't care
    d) No opinion
6. How do nurses relate to you as a patient?
    a) Very well
    b) Badly
    c) They don't care
    d) No opinion
7. How do clinical officers relate to you as an HIV/AIDS patient?
    a) Very well
    b) Badly
    c) They don't care
    d) No opinion
8. How do laboratory technicians relate to you as a patient?
    a) Very well
    b) Badly
    c) They don't care
    d) No opinion
9. Do you think doctors, nurses, clinical officers are kind to you?
    a) Yes
    b) No
    c) No opinion
10. If yes, what do they do to you to show it?
    a) They are professional in their duties
    b) They are kind to their patients
    c) They listen to your problems

d) They encourage you to be stronger

11. If No, what do they do to you that annoy you?
    a) They discriminate and stigmatize you
    b) They deny you medication
    c) They do not attend to your problems
    d) They are interested only in those who pay them
    e) No opinion
12. Are there times, when you feel mistreated by doctors, nurses, clinical officers and lab technicians?
    a) Yes
    b) No
13. If yes, state how
    a) They ridicule you
    b) They laugh at you
    c) They deny you what you need
    d) They do not feed you
    e) They don't care about you
14. If no, state how
    a) They attend to you promptly
    b) They move close and care about you
    c) They give you proper medication
    d) They avoid you
15. What can you say about the attitude of doctors, nurses, clinical officers and lab technicians about HIV/AIDS patients?
    a) Very good
    b) Bad
    c) They don't care
    d) No opinion
16. Have you ever felt disappointed by doctors, nurses, lab technicians and clinical officers?
    a) Yes
    b) No

c) No opinion

17. If yes, state how

a) They do not attend to you while in pain

b) They show open bias towards you

c) They handle you rudely

d) They do not talk to you while asking for assist

18. If No, explain

a) They attend to you promptly

b) They encourage you to be strong

c) They are mindful of your needs

d) They give you proper medication

e) No opinion

19. Do you think doctors, nurses, clinical officers and lab technicians are confidential when treating you?

a) Yes

b) No

c) No opinion

20. If yes, what shows?

a) They do not disclose information of your illness to other people

b) You have not heard other patients complain about them

c) They handle you individually

d) No opinion

21. If no, what do they do that is not confidential?

a) They discuss your illness in public

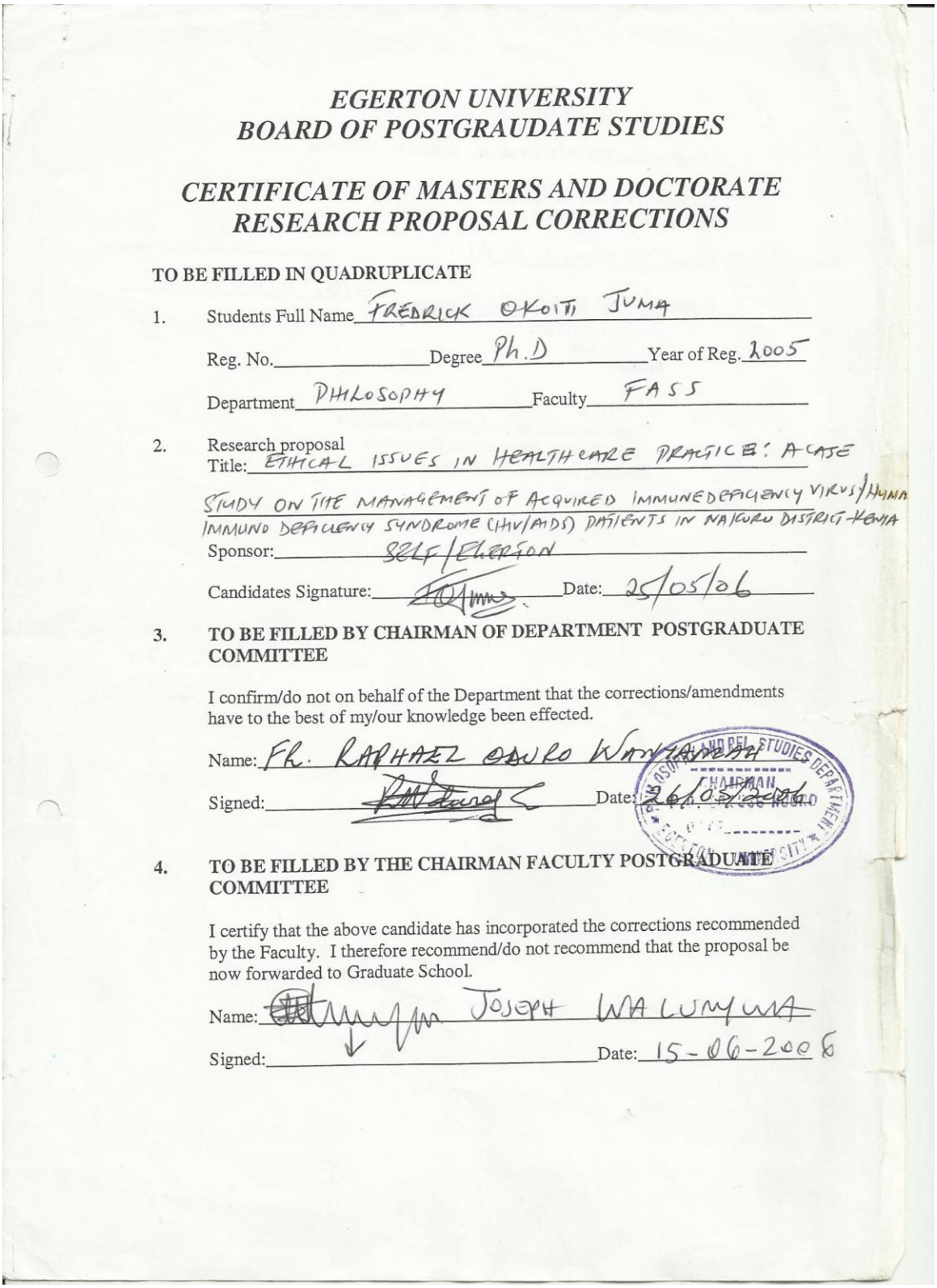
b) They discriminate you from other patients

c) Your treatment records are left for public consumption

d) Tests are done on you without any privacy

APPENDIX C

RESEARCH AUTHORITY LETTERS



EGERTON UNIVERSITY
BOARD OF POSTGRAUDATE STUDIES

CERTIFICATE OF MASTERS AND DOCTORATE RESEARCH PROPOSAL CORRECTIONS

TO BE FILLED IN QUADRUPLICATE

1. Students Full Name FREDRICK OKOITI JUMA

   Reg. No._____ Degree Ph.D Year of Reg. 2005

   Department PHILOSOPHY Faculty FASS

2. Research proposal Title: ETHICAL ISSUES IN HEALTHCARE PRACTICE: A CASE STUDY ON THE MANAGEMENT OF ACQUIRED IMMUNEDEFICIENCY VIRUS/HUMAN IMMUNO DEFICIENCY SYNDROME (HIV/AIDS) PATIENTS IN NAIVASHA DISTRICT-KENYA

   Sponsor: SELF/EGERTON

   Candidates Signature:_____ Date: 25/05/06

3. **TO BE FILLED BY CHAIRMAN OF DEPARTMENT POSTGRADUATE COMMITTEE**

   I confirm/do not on behalf of the Department that the corrections/amendments have to the best of my/our knowledge been effected.

   Name: FR. RAPHAEL OSURO WANYAMBA

   Signed:_____ Date: 26/05/2006

   CHAIRMAN

4. **TO BE FILLED BY THE CHAIRMAN FACULTY POSTGRADUATE COMMITTEE**

   I certify that the above candidate has incorporated the corrections recommended by the Faculty. I therefore recommend/do not recommend that the proposal be now forwarded to Graduate School.

   Name: JOSEPH WALUMUNA

   Signed:_____ Date: 15-06-2006

5. **TO BE FILLED BY GRADUATE SCHOOL**

I confirm that I have received/not received the following:

Minutes of Faculty Postgraduate Committee/Board ☐ Certificate of Correction ☑ Proposal forwarding form ☑

Name: DR. THEURI M. M

Signed _____ Date 16/06/06

DEAN, FACULTY OF ARTS & SOCIAL SCIENCES
EGERTON UNIVERSITY
P.O. BOX 536
NJORO.

cc. Candidate
Chair, Department Postgraduate Committee
Chair, Faculty Postgraduate Committee
Director, Board of Postgraduate Studies

Fredrick O. Juma
Philosophy Department
Egerton University

2nd April, 2009

The Dean
Faculty of Arts & Social Sciences
Egerton University

Thro'

The Chairman
PRS Department
Egerton University

Dear Sir,

RE: INTRODUCTORY LETTER FOR MY RESEARCH REG. NO. AD15/0204/07

The above matter refers.

I intend to contact my field work research next month on my PhD proposal in Naivasha, Gilgil, Nakuru and Molo District Hospitals, and I therefore request for an Introductory letter to enable me visit the above mentioned hospitals. My topic is "**Ethical issues in Healthcare practice: A case Study on the Management of Acquired Immune deficiency Virus/Human Immuno Deficiency Syndrome (HIV/AIDS) patients in Nakuru District – Kenya".**

Yours faithfully,

FREDRICK O. JUMA

EGERTON
Tel: 051-2217839

Ext.:3191

UNIVERSITY

P.O. Box 536
Egerton, Kenya

FACULTY OF ARTS AND SOCIAL SCIENCES

8th April, 2009

TO WHOM IT MAY CONCERN

Dear Sir/Madam

MR. FREDRICK O. JUMA

The above named is a members of staff in the Faculty of Arts and Social Sciences, Egerton University.

He is carrying out field work research for his PhD studies. The title of the proposal is '**Ethical Issues in Health Care Practice: A case study in the Management of Acquired Immune Deficiency Virus/Human Immuno Deficiency Syndrome (HIV/AIDS) patients in Nakuru District – Kenya.**'

The University will appreciate any assistance accorded to him.

Thanking you in advance.

Yours faithfully

DEAN, FACULTY OF ARTS & SOCIAL SCIENCES
EGERTON UNIVERSITY
P.O. BOX 536
NJORO.

Dr. F Wako
Dean, Faculty of Arts & Social Sciences

MINISTRY OF MEDICAL SERVICES

Telegrams "PROVMED"Nakuru
Tele:Nakuru 2216710 Fax 2210350
When replying please quote

PROV. DIRECTOR OF MEDICAL SERVICES
RIFT VALLEY PROVINCE
P.O. BOX 2060
NAKURU

Ref No. L.27 Vol.1/4

27th May 2009

The Medical Superintendent/
Medical Officer Incharge

- PGH Nakuru
- Naivasha District Hospital
- Molo District Hospital
- Gilgil Sub District Hospital

RE:- ETHICAL ISSUES IN HEALTH PRACTICE RESEARCH

The bearer of this note Mr. Fredrick O. Juma is a lecturer at Egerton university faculty of Arts and Social Sciences.

He is currently pursuing PhD. Studies and area of interest is HIV/AIDS which has been approved by Institution Ethical Committee.

The purpose of this letter is to ask you to allow him to collect data on the same. Hope you will accord him all necessary assistance.

DR. BEN OSORE
PROVINCIAL DIRECTOR OF MEDICAL SERVICES
RIFT VALLEY

PROVINCIAL DIRECTOR OF MEDICAL SERVICES
27 MAY 2009

Fredrick O. Juma,
Egerton University,
Philosophy Department,
P.O. Box 536,
EGERTON.

June 10, 2009

The Chairman,
Research Committee,
Provincial General Hospital,
NAKURU.

Dear Sir,

RE: PERMISSION TO CARRY OUT RESEARCH AT PGH – NAKURU

I hereby write to seek permission to carryout research in your medical institution. I am a lecturer at Egerton University, undertaking my Ph.D studies, specifically in ethical issues in healthcare practice in managing HIV/AIDS patients as per the copy of my proposal. The research will be carried out using a questionnaire and will focus on doctors, nurses, clinical officer, lab technicians and patients. The purpose of the study is to help us improve our care towards those who need our services and, especially, those suffering from HIV/AIDS. This is an ethics study under which ethical issues arise.

I attach copies of the letters from my faculty and from the Director Provincial Medical Services for your attention.

Yours faithfully,

Fredrick O. Juma

Tel. 0720259276
0733836931

MINISTRY OF HEALTH

Telegrams: "PROVMED", Nakuru
Telephone: Nakuru 215580-90
When replying please quote

Ref. No. .....

PROVINCIAL GENERAL HOSPITAL
RIFT VALLEY PROVINCE
P.O. Box 71
NAKURU

RII/VOL.I/08

Date: 7/7/2009

To: Fredrick O. Juma
Egerton University Phylosophy Dept.
P.O. Box 536, Egerton.

Dear Fredrick Juma

RE: APPROVAL TO UNDERTAKE RESEARCH AT THE RIFT VALLEY PROVINCIAL GENERAL HOSPITAL

Reference is made to your letter dated 10/6/2009 seeking permission to do research at Provincial General Hospital, Nakuru on "Ethical issues in health care practice: A case study on the management of acquired immune-deficiency virus/human immunodeficiency syndrome (HIV/AIDS) patients in Nakuru district-Kenya"

Permission has been granted/~~Not granted~~ for the research. It is hoped that you will adhere to the ethics and standards that relate to research at our institution.

Thank you.

Yours sincerely

MEDICAL SUPERINTENDENT

MEDICAL SUPERINTENDENT
PROVINCIAL GENERAL HOSPITAL
P.O. BOX 71 NAKURU.

Dr. Gomesi

CHAIRPERSON
RESEARCH AND ETHICS COMMITTEE

EGERTON UNIVERSITY
Tel: Pilot: 254-51-2217620
254-51-2217877
254-51-2217631
Dir.line/Fax 254-51-2217847
Cell Phone

P.O. Box 536 - 20115
Egerton, Njoro, Kenya
Email: eugradschool@wananchi.com
www.egerton.ac.ke

OFFICE OF THE DIRECTOR GRADUATE SCHOOL

Ref: AD15/2046/07 Date: September 4, 2009

Mr. Fredrick Okoiti Juma,
Department of PHR,
Egerton University,
P. O. Box 536,
EGERTON.

Dear Mr. Juma,

RE: CORRECTED PROPOSAL

This is to acknowledge receipt of two copies of your corrected proposal, entitled: **"Ethical Issues in Health Care Practice: A Case Study on the Management of Acquired Immune-Deficiency Virus/Human Immuno-Deficiency Syndrome (HIV/AIDS) Patients in Nakuru District-Kenya"**

You are now at liberty to commence your fieldwork.

Thank you.

Yours sincerely,

Prof. Robert K. Obura, PhD
DIRECTOR, BOARD OF POSTGRADUATE STUDIES

c.c. Dr. S. Solomon – Supervisor
Dr. Wakube - Supervisor
Prof. A. Sindabi - Supervisor

RKO/cm

Fredrick O. Juma
Philosophy Dept.
P.O. Box 536
EGERTON

20th January, 2010

The Director
Board of Post-Graduate Studies

Thro'
Prof. Solomon Monyenye
University of Nairobi – 1st Supervisor Forwarded and Recommended 22-1-10

Thro'
Prof. A. Sindabi - 2nd Supervisor Recommended & forwarded 22/1/2010
Egerton University

Thro'
Dr. A.W. Wakube - 3rd Supervisor Forwarded & Supported 21-1-10
Egerton University

Thro'
The Dean, FASS Forwarded and supported. The Faculty recommends the candidate be granted the award to complete PhD thesis 20/1/10

DEAN, FACULTY OF ARTS & SOCIAL SC.
EGERTON UNIVERSITY
P.O. BOX 536
NJORO.

Thro'
The Chairman, PHR Forwarded and Supported 19/1/10

PHR DEPARTMENT
P.O. BOX 536
Egerton
Date
EGERTON UNIVERSITY

Dear Sir,

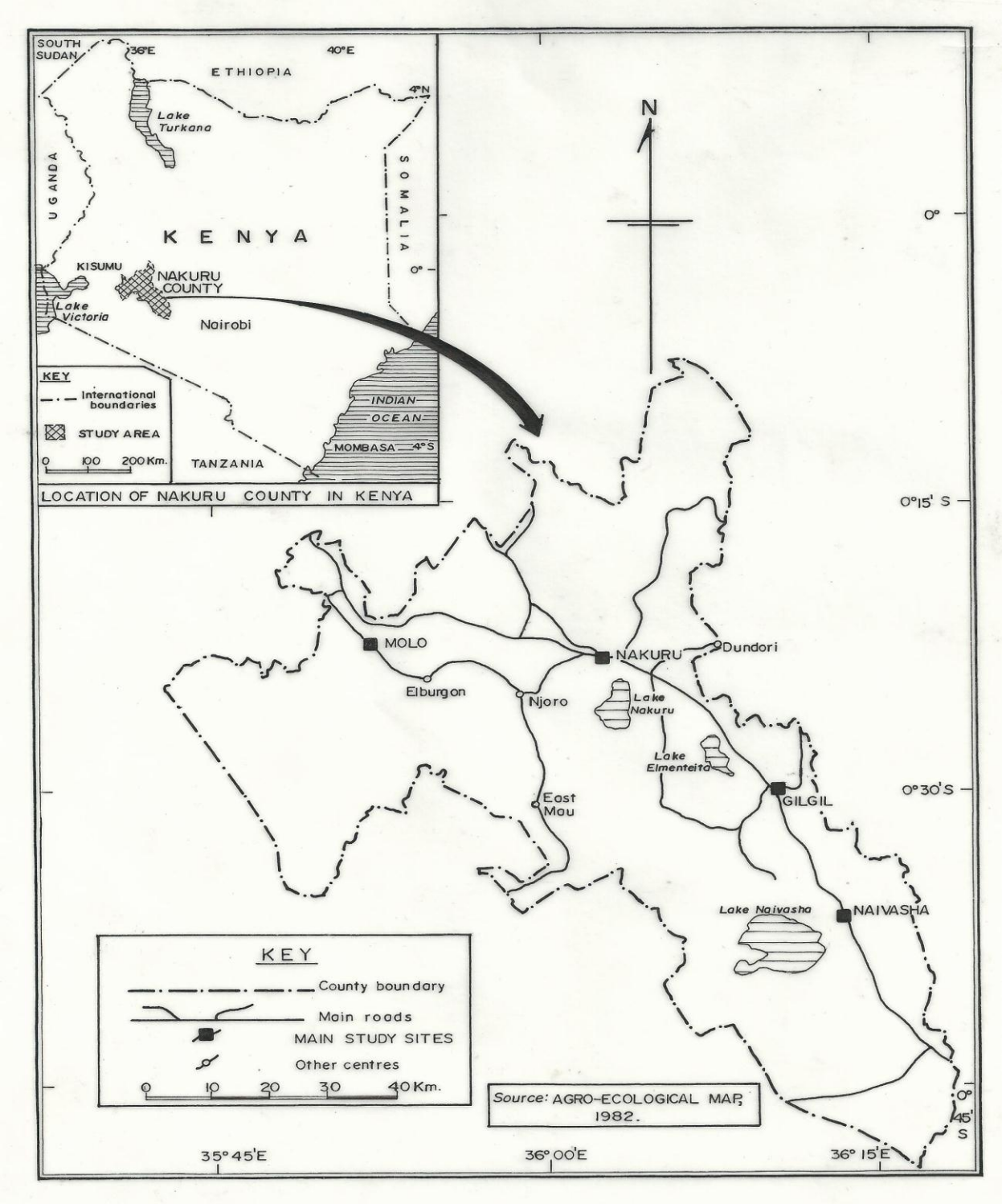
RE: APPLICANTS FOR GRADUATE RESEARCH FUNDS

I hereby apply for the above Research Funds to enable me successfully conduct my Ph.D Research.

Attach herewith 5 copies of my research proposal and a letter of approval from the Graduate School.

Yours faithfully,

Fredrick O. Juma
Reg. No. AD15/0204/07



Source ILRI

Figure 6: Map of Nakuru District showing major Towns