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The Application of Different Ethical Codes of Conduct by the Healthcare Professionals in Nakuru District Government Hospitals

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Abstract
This paper discusses the application of different ethical codes of conduct by the healthcare professionals concerning HIV/AIDS patients in Nakuru district government hospitals. The main objective was to assess the understanding of ethical codes of conduct by these practitioners to HIV/AIDS patients. Utilitarian theory by Jeremy Bentham and John Stuart Mill was used as principled criteria. The actions of any person are judged by their consequences. The informed actions are right in proportion as they tend to promote happiness and wrong as they tend to produce the opposite of happiness. The study employed descriptive research design. The target group for the study was HIV/AIDS patients in Nakuru government district hospitals. The sampling was purposive which involved 120 HIV/AIDS patients. The data was collected using a specific questionnaire for the patients who assessed the healthcare workers. The findings revealed that most of healthcare professionals (97%) understood their different ethical codes of conduct as expressed through management of HIV/AIDS patients while (3%) did not seem to understand any code of professionalism. It is hoped that this study will enlighten those dealing with patients, policy makers in healthcare institutions, ethicists, philosophers and other scholars whose main aim is to maintain professionalism in their different professions.

1. Introduction

The application of ethical codes of conduct by healthcare professionals to patients is of great importance. While philosophy and medicine began with ancient Greeks, it enjoyed a long history of mutual beneficial interactions, though the professionalization of philosophy of medicine is a recent phenomenon. The paper addresses the various aspects of ethical problems and questions, particularly the patient-physician relationship. It discusses what constitutes different ethical codes of conduct in the light of utilitarian theory of Jeremy Bentham (1749-1832) and John Stuart Mill (1806-1873).

1.1. Definition of Terms

- Ethical Code of Conduct - Refers to a set of guidelines that guarantee professionalism
- Healthcare Professionals - Refers to those professionally trained to offer medical care to patients
- Rule- Utilitarianism - A theory that a person ought to act in accordance with the rule and if followed, it would produce the greatest balance of good over over evil, everyone considered.
- HIV/AIDS Patients - Persons infected with Acquired Immune-Deficiency Virus/ Human Immuno- Deficiency Syndrome disease.

1.2. Objective.

- 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.

1.3. Hypothesis

- 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.

1.4. Significance of the Study

HIV/AIDS 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 staff while handling them. The study will contribute to the body

of knowledge in the area of medical professionalism. The findings will enlighten the upcoming scholars, researchers, policy makers and healthcare workers on issues of ethical professionalism.

2. Related Literature

2.1. Introduction

The main purpose of this paper 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. 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, stigma and discrimination can be alleviated.

2.2. 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.

2.3. 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;

- Improved understanding of stigma and discrimination, where they come from and what they do.
- Increased appreciation of links to broader existing inequalities and injustices.
- Better understanding of the complex stigma and Discrimination related issues that precipitate the epidemic.
- Clear identification of objectives for results.

2.4. 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.

2.5. 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.

3. 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.

4. Methodology

4.1. 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.

4.2. 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.

4.3. 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.

4.4. Sampling and Sampling Procedure

For the purpose of collecting data for this research, non probability sampling method was used which comprised of purposive sampling and snow ball sampling.

4.5. Data Collection Tools

Many tools were used in this research but the main one was the questionnaire, though library and Internet were also used.

4.6. 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.

5. Results and Discussions

The paper 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.

5.1. Adherence to Ethical Codes of Conduct by Healthcare Professionals

This section considered views of HIV/AIDS patients regarding how they were handled by the healthcare professionals from different government healthcare institutions within Nakuru district.

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

Table 1: Total Numbers of Respondents in District Hospitals

Table 1 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/AIDS 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.

5.2. Treatment of HIV/AIDS Patients Healthcare Workers

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 2: The Response of Patients on Patient Management by Healthcare Professionals

Table 2 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.

5.3. 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).

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

Table 3: Confidentiality of HIV/AIDS Patients' Information

Table 3 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).

5.4. Influence of Ethical Codes of Conduct to Healthcare Professionalism

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 4: The Influence of Different Ethical Codes of Conduct in Healthcare Profession

Table 4 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.

6. Summary and Conclusion

The purpose of this study was to examine whether healthcare professionals in Nakuru district government hospitals did adhere to and are guided by professional ethical codes of conduct and principles in the discharge of their duties in handling HIV/AIDS patients. The study also examined Independent variables which were codes of conduct, confidentiality, professionalism, privacy and doctor- patient relationship, and these had effect on the dependable variables. The findings were therefore summarized as follows

- 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.
- 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.
- 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.
- 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.
- In conclusion, it was established that the highest percentage of healthcare professionals was well trained and their level of professionalism was quite high.

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