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Exploring medical ethics' implementation challenges: A qualitative study

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Abstract:

BACKGROUND: Adherence to medical ethics principles by medical professionals is required to improve health-care system's quality. Recognizing medical ethics' challenges and attempting to resolve them are important in the implementation of medical ethics in practice. This study aimed to explore such challenges at Iran's medical sciences universities in 2018.

MATERIALS AND METHODS: This descriptive, qualitative study utilized a conventional content analysis approach for data analysis. This study was conducted using purposeful sampling from participants with experience in teaching or practicing of medical ethics field, and by considering maximum variety of disciplines (e.g., gynecology, internal medicine, surgery, and medical ethics). The data were gathered using semi-structured interviews. The interview guide was designed based on previous research findings by two members of the research team and contained the main interview questions and participants had the opportunity to express their perspectives in detail. Participants were chosen from clinical and ethical faculty members as well as managers. The data collection process continued until the data saturation stage, beyond which no new information or concept achieved by continuing interviews.

RESULTS: After interviewing 14 faculty members and managers, findings were classified into 4 themes, 9 categories, and 42 sub-categories; four main categories of medical ethics challenges are affected by cognitive, educational, practical, and structural factors, respectively.

CONCLUSION: This study suggested that medical ethics' cognitive and educational challenges can alleviate using educational programs intended for improving qualitative and quantitative aspects of medical ethics teaching for medical professionals ranging from students to faculty members. Medical ethics' structural and practical challenges are within policymaking and scheduling activities dealt with through future researches by health-care system's managers and planners.

Keywords:

Health-care system, medical ethics, qualitative research, teaching

Introduction

Patients and their families face many problems in health-care system as follows: medical errors, long waiting time to receive diagnostic or therapeutic services, end-of-life complications and fatal diseases for terminal patients, and ethical decision-making challenges laying in many situations.^[1]

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Improving health-care services' quality, in response to the patients' growing health needs, depends on how observant the medical professionals are of the ethical principles;^[2] Lack of such observation undermines patients' trust and reliance in the medical professional community.^[3]

Learning ethics principles is a major challenge in practicing and observing medical ethics. Evidences emphasize

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that ethical competency, like any other one, can be thought and acquired,^[4] and can significantly improve communications at various levels among medical staff and patients, finally leading to professional commitment enhancement.^[5,6] The present study show that teaching programs for such competency have not seriously been taken into account yet.^[7]

Many clinical specialists with adequate medical knowledge lack medical ethics' awareness.^[8] Additionally, in many cases, medical team with adequate knowledge of medical ethics overlook ethics principles in practice leading to moral misconduct,^[9,10] and hence mitigating people's and community's trust in medical professionals and health-care team. Insufficient medical ethics knowledge of physicians and health-care team; weakness of the educational system for effective training of medical students in adhering to ethical principles; and lack of clear management policies to promote and develop medical ethics in the educational and medical body. To resolve, such challenges of medical ethics must be constantly monitored to find appropriate solutions.

Various cultural context of patients as well as cultural gap among patients and healthcare team can be the reason of patients' diverse perspectives regarding the ethical subjects. Cultural context of each patient and his/her family should be considered in providing respect to patient autonomy^[11] as well as in providing patients and their families with bitter truth-telling regarding their health issues and treatment plan.^[12,13]

Even in societies with awareness of medical ethics principles, different understandings and interpretations of these principles can exist.^[14] Hence, every society depending on its cultural conditions and prevailed beliefs promote medical ethics consideration by medical professionals to effectively implement and apply medical ethics principles in health-care system.

This qualitative study aimed to recognize and explain the challenges and problems of medical ethics implementation in Iran.

Materials and Methods

This research was a descriptive, qualitative study using semi-structured interviews. The findings were analyzed using content analysis approach.^[15]

Participants

Using purposeful sampling while considering maximum variation factor, participants were selected from different clinical disciplines (e.g., clinical scientific faculty members, medical ethics faculty members, and university managers) as well as female and male genders.

Most participants had 1 to 5 years of medical ethics teaching; or, they worked in medical ethics field; or, they had management positions in various healthcare system divisions. Totally, 14 people were interviewed, including eight males and six females. The demographic profile of the participants is depicted in Table 1.

Process

This study was conducted using purposeful sampling from participants with experiences in teaching or practicing of medical ethics field, management experience, and by taking maximum variety of disciplines and genders into account. Our data-gathering method was the semi-structured interviews conducted through face-to-face communication of the interviewer and interviewees; the interviewees did not know the interviewers.

The interview duration was between 30 and 90 min based on the dynamic interaction between the researcher and the participant. Initially, the interview purpose was explained to the participant. The core interview questions were asked one at a time using an interview guide sheet and the participants had sufficient time to answer.

The researcher used probing questions to explore interviewees' opinions profoundly. The time and location of the interviews were set considering the participants' preferences. The interviews were audio recorded after receiving participant's consent, and then transcribed. Data collection was continued until data saturation stage, beyond which no new information or concept achieved by continuing interviews.

Table 1: Demographic profile of the participants

Specifications	Number
Faculty members	14
Gender	
Males	8
Females	6
Disciplines	
Medical ethicist	5
Internist	2
Surgeon	2
Pediatrician	2
Gynecologist	1
Internist and gastroenterologist	1
Internist and endocrinologist	1
History of teaching or practicing medical ethics (years)	
More than 10	5
5- 10	4
1- 5	2
Management experience (years)	
More than 10	4
5- 10	4
1- 5	3

To verify data trustworthiness in this study, several methods were used. To improve data creditability, participants were chosen using purposeful sampling from various disciplines (e.g., gynecology, internal medicine, surgery, and medical ethics). Other approaches to enhance data creditability are as follows: continuous data analysis while gathering data, data analysis following interviews, using interviews' findings to modify and adjust subsequent interviews' questions.

Furthermore, in this study, to enhance data dependability, during data collection, interviews' audio recordings were transcribed. For the confirmability of the gathered data, a qualitative research expert was asked to check the compatibility of his previous knowledge with the study's findings; all notes and reports prepared by the researchers were delivered to the expert.

Data analysis

Conventional content analysis method^[16] was employed for data coding. First, each interview's transcript was carefully read several times and then divided into several semantic units. Then, related semantic units were further summarized and the codes were prepared. Considering the similarities and differences among the extracted codes, they were organized into categories and subcategories. The research codes, categories, and subcategories were reviewed by a qualitative research expert. Finally, the research's main categories or themes were defined and documented.

Ethical considerations

This research had approval from the Research Ethics Committee of Tehran University of Medical Sciences with IR.TUMS.MEDICINE.REC.1398.736 code of ethics.

The interviews were conducted at interviewees' preferred time and location with their informed consent and withdrawal right at any time. In these interviews, information confidentiality was conserved.

Results

In this study, 14 faculty members and managers were interviewed; the findings were classified into 4 theme, 9 categories, and 42 subcategories; the details are presented in Table 2. Four main categories of medical ethics field are cognitive, educational, practical, and structural factors.

Cognitive factors

The participants classified medical ethics field's cognitive defects into two groups of knowledge and reasoning defects.

Knowledge defects

According to faculty-member interviewees, medical professionals misbelieve that they have adequate

medical ethics' knowledge and awareness, or they have superficial and non-scientific viewpoints regarding medical ethics field.

"People are not familiar with professional behavior, professional ethics, and scientific principles. People are not acquainted with ethics field's scientific knowledge; and they merely rely on personal experiences in resolving ethics-related situations" (Gynecology faculty member, female).

According to participants, another medical ethics' cognitive challenge is that an approvable, well-mannered person has potentials to teach ethics without ethics field formal education.

"Another problem is the illusion of knowing all, meaning that doctors with several years of work experience consider themselves fount of knowledge, polymath, and express opinions about ethics-related cases" (Endocrinology and metabolism department's faculty member, male)

Interviewees also pointed out to a lack of effective communication skills when doctors deal with patients and their families.; and when they manage patients in certain situations (e.g., delivering bad news to the patients or their family, and relating to angry or depressed patient).

"Most students have strong scientific background; however, most medical malpractice complaints are due to unethical and ineffective communication with the patients. We have not been educated about medical ethics principals as well as effective communication skills. We do not know proper ways of delivering uncomfortable news" (Medical ethics faculty member, female).

Reasoning defects

According to the participants, other problems in medical ethics are due to a lack of several skills such as critical thinking or moral reasoning. Such lack of skills can lead medical professionals to use ethical fallacies and commit cognitive mistakes in ethical challenges.

"I have a set of beliefs...These beliefs justify the righteousness of my actions. Based on these beliefs; I make decisions in different situations and regarding different people, including patients, family or others. In most cases, the reasoning behind each belief is unknown to its beholder. When people are questioned about such background reasoning, they come up with justifications that are mostly fallacies." (Endocrinology faculty member, male).

"A person interprets and justifies an unethical or unreasonable act as otherwise. In case of misconduct, we may justify that the taken actions are right while the reasoning for this rightness are weak. If the weakness

Table 2: Categories and the resulted themes

Themes	Categories	Subcategories
Cognitive factors	Knowledge defects	Limited or no knowledge of ethical decision-making A false sense of medical ethics principles' awareness Unscientific and superficial viewpoints to medical ethics Lack of effective communication skills with patients Unfamiliarity with medical ethics' resources and reference Lack of medical ethics learning through study
	Reasoning defects	Defects in critical thinking and ethical thinking competency Lack of moral reasoning approaches in a physician in dealing with patients Incidents of moral fallacies Cognitive errors in dealing with ethical decisions
Educational factors	Formal curriculum defects	Lack of structured educational programs in clinical ethics Insufficient hours and units of ethical education in the curriculum Teaching by professors with unrelated specialties Arbitrary confrontation to the medical ethics Improper teaching methods for learners of ethics Unattractiveness of ethical content for medical students Limited or no integration of related disciplines (jurisprudence, law, philosophy) into the medical ethics
	Hidden curriculum defects	Limited number of ethical role models Underrepresentation of role models in clinical sections Unawareness of the role models of their impressions Impressionability of students from the unethical role models Lack of teachers' reflection skill regarding experiences in ethics-related challenges
Practical factors	Decline in moral practices	Unethical behavior incidents in facing with patients or colleagues Reduced ethical principles' adherence in medicine Decreased empathy among medical students during their medical school years Decreased aspirations of ideals and ethical values in medical students Lack of moral sensitivity in health-care professionals
	Improper attitude to human dignity in the treatment process	Disregarding patients' autonomy Lack of patients' participation in treatment decisions Lack of attention to patients' human rights
Structural factors	Health-care system's structural problems	Financial problems of health professionals Large number of patients and high demands for treatment
	Medical ethics' structural problems	A nascent science and primitive stages of medical ethics-based practice Lack of ethics' dissemination in health care and educational systems' structure Inadequate promotion and introduction of ethics in the healthcare system Lack of roadmap and plan for medical ethics Lack of ethical protocols and codes Lack of proper definition of medical ethics position
	Evaluation process' structural problems	Lack of definition of specific criteria to evaluate ethical practice Lack of formal ethical evaluation in universities Defects in encouragement and punishment system for unprofessional behavior

is obvious, it is a fallacy. Otherwise, such weakness stems from a fragile or erroneous reasoning. Hence, in many cases, for our unethical actions, we have wrong reasoning or fallacies, which both fall into the justification category” (Endocrinology faculty member, male).

Educational factors

According to the participants, major challenges of the medical ethics in Iran were due to the educational and teaching shortcomings.

Formal curriculum

According to the faculty-member interviewees, one of the major ethics field's challenges is a lack of proper

teaching in the clinical ethics field as well as a lack of inadequate teaching hours.

“In ethics-related university courses, theoretical material are taught, and such theories are put into practice limitedly through problem-solving exercises. However, once the student passes this two-unit medical ethics course, the teaching and maintenance exercise are stopped; the student may work under the supervision of the clinical professors or teachers with no medical ethics knowledge; hence, the student may never put the taught theories into practice. With no practical experience, continuous teaching and exercise, all taught theories would vanish over time and the student would never

acquire problem-solving skills or opportunities” (Medical ethics faculty member, female).

Another important challenge of the medical ethics teaching in curriculum is the limited units of courses taught in a specific period in a snapshot style; semester-based, long-term, and integrated teaching programs in medical ethics teaching are missing in the curriculum.

“For various disciplines, the number of units per medical ethics courses are inadequate. In the 6-year process of training a medical student to become a professional, a requirement is merely a two-unit medical ethics course covering limited topics in limited hours.” (Medical ethics faculty member, female).

Lack of specialized and experienced teaching professors as well as proper teaching methods, lead to medical students' enthusiasm loss.

“In every discipline and major, different educational groups are in charge of teaching medical ethics with their own taste of principles and framework” (Medical ethics faculty member, female).

Absence of effective teaching methods is a weakness in medical ethics teaching.

“Over the years, different methods have been employed in medical ethics teaching in diverse disciplines. The importance of the methods make them a research topic in medical ethics field (e.g., small group discussions, large group discussions, lecture-based teaching, workshop-based teaching, or any combination thereof). However, none of these methods could make medical ethics a subject of interest for students” (Medical ethics faculty member, female).

Another shortcoming in medical ethics teaching is that related disciplines such as philosophy, law, or jurisprudence have not yet been effectively integrated and fed into the medical ethics teaching.

“Medical ethics field has not yet been efficiently interacted with law, philosophy and jurisprudence in medical ethics teaching. With medicine major background, we could more easily communicate with therapeutic and clinical disciplines; however, philosophy, jurisprudence, and law potentials have not yet been employed in medical ethics teaching” (Medical ethics faculty member, male).

Hidden curriculum

Another challenge is a lack of appropriate role models in medical ethics teaching from various aspects including the presence hours in clinical practices. Awareness of such role models is also an important subject to explore.

“Underrepresentation of ethics role models causes residents and students expose less to them and consequently ethics education and teachings” (Internal medicine and gastroenterology faculty member, male).

“How many role models do we have? How aware are these role models of their impression and educational role? We have not provided appropriate role models; however, we magically expect student to see ethic-adhering professor or teachers in their environment or working atmosphere” (Medical ethics faculty member, female).

From the participant's perspective, another issue regarding the hidden curriculum is the impression of unethical role models on students. The negative role models are serious potential impediments in creating professional and ethical behaviors in the learners.

“Both ethical and unethical role models are around, and a student does not know who to follow. Unethical models are easier to follow as role models” (Medical ethics faculty member, female).

“One of the problems leading us to become unethical is the role modeling subject; we do not have role models and the so-called role model are not attentive to ethical issues” (Endocrinology faculty member, male).

A reason for a lack of a positive ethical role model is that not only is the ethical reasoning experience limited at the patient's bedside, but also sensitivity to these issues is low.

“Doctors act unethically because of the following reasons: having unethical role model, not having morally-sensitive role models, or not having role models making ethical reasoning at patient bedside” (Endocrinology faculty member, female).

According to the participants, another problem is a lack of reflection skill in teachers and professors. They do not reflect on their behavior and have not developed such skills.

“Faculty members have never had any reflective practice, meaning that they never review their daily or weekly actions and events in order to check if the ethical principles are taken into account” (Internal medicine faculty member, male).

Practical factors

From the participants' viewpoint, a major challenge in medical ethics is the gap between theory and practice regarding ethical issues. The professionals, despite having ethics knowledge, do not present ethical practice.

Decline in moral practices

From interviewees' perspective, some professionals are not ethic adhering in practicing medicine and in their relationship with patients or colleagues.

“Several criticisms are raised against the ethical principles observance at patient bedside and in practice. Principles of professional and ethical commitment are disregarded in many cases” (Pediatrician faculty member, female).

“Medicine faculty members’ observance level of medical ethics hardly reaches 50-60 percent of the expected level at both clinical and bedside situations” (Internal medicine faculty member, male).

A participant quoted a patient visited by a famous doctor as follows:

“When visited by my doctor, in case I want to explain my problems, he aggressively says that he does not have time and he writes a prescription without any communication” (Internal medicine, gastroenterology faculty member, male).

In participants’ opinion, decline of empathy among medical students during the school years and weakening of human ideals and values degraded ethical behavior and practice when facing patients.

“According to the world statistics, empathy is a significant aspect of professionalism. As medical students proceed in their educational path through school years, less empathy is observed among them; its root causes should be explored” (Internal medicine faculty member, male).

“Universally, medical students have high moral aspirations upon entering the medical schools. Even as seniors, they want to be successful doctors who make a difference. As time passes, they observe bitter things, take negative feedback, and change their way and mindset to think of their own benefit exclusively” (Gastroenterology faculty member, male).

According to the interviewees, ethical practice degradation is due to the ethical sensitivity decline in health-care professionals.

“A large difference exists between what is said and what is done. We are not sensitive enough to ethics-related issues. Such sensitivity must be stimulated. Unless this sensitivity is provoked and the need to adhere to ethics and learn academic ethics is awakened in individuals, that sensitivity will not be accomplished despite our efforts” (Medical ethics faculty member, female).

Improper attitude to human dignity in the treatment process

Regarding the theory and practice gap, participants also believed that some professionals do not have the right attitude to human dignity, do not involve patients in their related decisions, and do not respect patients’ autonomy.

“Human dignity is not explained and its importance is not even emphasized on” (Endocrinology faculty member, male).

“In many cases, a patient has no participation in decision-makings, whereas the disease belongs to the patient and it is his or her choice to decide on the appropriateness of a treatment plan or decision” (Internal medicine faculty member, male).

Structural factors

According to the participants, a main problem of today’s medical ethics community is the structural flaws.

Health-care system’s structural defects

From the participants’ viewpoint, some problems in the health-care system automatically lead to medical ethics’ challenges in medical professionals’ practice (e.g., financial problems of physicians).

“Why doctors are sometimes unethical in practice and even in research is very important. Financial problems is important. One of the obvious examples in practice is to write unnecessary prescriptions. If we do not resolve economic issues, we do not get anywhere in scientific, ethical, or critical thinking. In other words, if a doctor is not financially secure, it will probably affect his or her adherence to ethical principles” (Medical ethics faculty member, male).

In participants’ view, a large number of patients in high demand of medical services is another challenge.

“The demand for medical and therapeutic care is high both at university and outside. Then, they can be disrespectful and act as they wish. The miserable patient has no choice and is in need of that service under any humiliation and insult” (Gastroenterology faculty member, male).

Medical ethics’ structural problems

According to participants, medical ethics science and professionalism are at their early stages worldwide, and therefore not yet fully structured.

“We are in a primitive stage and may not even feel the gap; however, many people mistakenly think they know all about it. As a case in point, when assessment questionnaires are given to the faculty members, almost all of them react by saying we do not have any problem and we do not need it” (Neurosurgery faculty member, Male).

The participants also believed that medical ethics have not yet disseminated into the healthcare system, it has not yet been fully introduced to the community, and not enough publicity has been given to it.

“Medical ethics issues are similar to the cultural issues; cultural and ethical matters should be grasped

from everywhere and in every possible way, through the environment and all five senses. This is missing in our system now. For example, festivals and short-film production competitions for conveying ethical subjects could help students feel the importance of it" (Gastroenterology faculty member, male)

Lack of a roadmap to follow medical ethics in Iran and a lack of medical ethics protocols and codes are among the medical ethics' structural problems.

"We don't have a framework for ethics right now." (Pediatrician faculty member, male).

"Naturally, we need to have a code of ethics, a protocol in the same way that you have a guideline or a clinical guide for many clinical work.(Gynecology faculty member, female).

An interviewee stated the followings about a lack of ethics codes:

"Ethics codes have not yet been developed, or if they have been drafted, they are still in context and have not yet been operatively publicized or published" (Gynecology faculty member, female).

As another challenge of medical ethics structure, the participants also believed that medical ethics have not yet found its true place in universities.

"Medical ethics knowledge is limited to several universities; Everywhere else, people do not know about the medical ethics at all" (Medical ethics faculty member, female).

Structural problems of the evaluation and monitoring process

The interviewees stated that some of the structural defects in the health-care system are related to the assessment and ethical monitoring process.

"We don't have an almost uniform and homogeneous approach. A professional's behavior may seem good to me and bad to others; we do not have any criteria to evaluate which behavior is good" (Gynecology faculty member, female).

Another ethical evaluation challenge is not having any formal ethical evaluation system in the universities.

"We need to include evaluations of professionalism and medical ethics in the curricula. Education is part of the road, and from somewhere onwards, we need to see the education's results in practice. This has not yet happened in the curricula. (Surgery faculty member, male).

The participants believed that no encouragement or punishment system exists for an ethical or unethical

behavior, respectively; hence no one is concerned about his or her behavior or its consequences.

"People commit offences. They do not face any reaction or punishment. Everything regarding such reaction is ambiguous and whatever previously stated as punishment does not happen in reality. No consequences for an ethical or unethical action are really witnessed" (Internal medicine faculty member, male).

"No encouragement and punishment system exists; and anyone who engages in unethical behavior will pass with no consequences" (Medical ethics faculty member, female).

Discussion

Major challenges in implementing medical ethics are explored in this study from the policymaking level to the bedside level. In contrast, most previous researches have only provided a list of patients' expectations, medical errors, ethical problems, or communication problems among the medical staff and patients as well as colleagues.^[17]

From the participants' perspective, the medical ethics challenges can be divided into four main areas. (i) cognitive factors, including knowledge and reasoning subdivisions; (ii) educational factors including formal and hidden curriculum defects; (iii) practical factors related to the professionals' practice and their attitudes to human dignity; and (iv) structural factors including structural defects in health-care system, in medical ethics field, and in ethical evaluation framework.

Studies show that a serious lack of medical ethics' knowledge and awareness is an important challenge considered as a prelude to unethical practices.^[18,19]

This research shows that many health-care professionals do not have necessary medical ethics' knowledge and awareness and mistake their opinions and experiences for ethical knowledge; and they have ethics-related decision-making with that insufficient knowledge.

Furthermore, for physicians and other health-care professionals, having moral reasoning capability and achieving right ethical judgments are important in challenging situations; the participants pointed out to a significant shortcoming in this regard.

Among the causes for this shortcoming is a lack of structured, long-term, and integrated teachings in medical ethics. Murrell emphasized on the importance of ethical judgment for physicians and the failure of medical schools to deliver and enrich students' moral reasoning ability, arguing that the teachings have not been effective.^[20] Sheehan *et al.* also expressed concerns

that medical students are not growing and enhancing their moral reasoning capability, and explored the causes of this issue in their study.^[21]

The first solution to a lack of medical ethics' knowledge and reasoning is to improve scientific ethics teaching to health professionals in the curricula. However, a lack of trained medical ethics specialists,^[22] a lack of enough medical ethics' teaching time in the curricula, and a lack of scientific approaches in teaching ethics to medical students lead to a lack of knowledge and skill required for ethical judgment among medical professionals.^[23]

The reason for this can be attributed to the novelty of the educational discussions in the curricula (e.g., medical ethics and communication skills); these new educational subjects compete with other subjects in the curricula. The impact of lack of programs, teaching hours and professors trained in medical ethics field can be observed in other medical schools' curricula over the world.^[9,24,25]

A lack of ethical role models in terms of the number of them and their interaction hours with the students as well as the presence of unethical role models also contribute to the ethics' educational challenges. Role models strongly affect students' professional and moral character.^[26] Hence, educational programs should consider the influence of positive role models in medical ethics' teaching methods.^[27] In addition, adequate teaching hours can enhance role models' impressionability according to Mileder *et al.*^[28]

Gap between the theory and practice can manifest itself in all ethics-related practices. Unethical behavior can be the result of a lack of ethics knowledge; however, in many cases, despite ethics knowledge, professionals engage in unethical behaviors or reasoning.^[29-32]

Many unethical practices among medical students and health-care professionals can be observed due to a lack of ethics knowledge or lack of putting this knowledge into practice. Factors that turn ethics knowledge into an ethical practice fall into two categories: internal and external factors.^[33]

To reduce the gap between theory and practice, the influential internal factors should be discovered and appropriate solutions should be adopted. In addition, effective rules, ethical motivations, and practices should be reinforced. Ethical erosion or moral sensitivity loss regarding patients are observed to happen to medical students during the school years.^[34]

Because today's doctors and professionals are yesterday's students, their unethical practices are not surprising. Their attitude to human dignity is an internal factor in

determining the nature of professional practice with patients and even colleagues. In modern medicine, patients are treated as machineries and a disease as a technical defect.^[30] With this attitude to human dignity, unethical behavior by professionals is quite expected.^[35]

The last challenge group identified by the participants were structural problems in the health-care system, in the medical ethics system, and in the ethical evaluation system. The health-care system has faced a large number of medical requests from patients. The heavy burden of responsibility placed on professionals by a large number of patients and a large number of medical requests in medical centers can also exhaust them and even cause ethical erosion.^[36]

The youth and unfamiliarity of modern medical ethics in our health-care system is another challenge. Medical ethics has not yet been introduced as a science and has not yet found its place in medical education. Policy makers of health care and medical education should pay more attention to institutionalizing medical ethics in the healthcare and educational system as well as to the importance of acquiring ethical knowledge by medical students.

Weakness in the health-care system's ethical evaluation structure was also mentioned as a medical ethics' challenge. Some medical ethics' shortcomings, playing role as external factors, can result in professionals' unethical practices: (i) failure to define specific rules and indicators for professionals' ethical evaluation, (ii) lack of formal evaluation structure in the curricula, and (iii) lack of encouragement system for ethical behaviors.

In this study, we explored the perspectives of experts in the fields of clinical sciences and medical ethics well as those with experience in the level of policymaking or executive management in the health-care system. Such a study has never been done in Iran. However, perspectives of other important stakeholders (e.g., medical students, other health-care professionals, managers, patients, or laypersons) is not explored in this study and is its limitation. In future research, the findings with regard to gaining to experiences of managers, students, healthcare practitioners, and patients regarding identified factors inhibit and motivate in adherence to medical ethics could be surveyed.

Conclusion

This study demonstrates that the medical ethics challenges are cognitive, educational, and practical; these educational and cognitive challenges can be resolved by improving the medical ethics' educational programs, both in quantity and quality, for all medical professionals ranging from medical students to faculty members. Other challenges are mostly related to health-care system's

policymaking in the medical ethics field; health-care managers and planners through extended studies and accurate research should address such challenges.

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Conflicts of interest

There are no conflicts of interest.

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