

Determinants of Patients' Perception of Healthcare Professionals' Ethics in Bangladesh

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Abstract. Employees in organizations face a myriad of moral issues in their everyday decision-making. It is of great significance when the decisions entail a professional conduct where the individuals have fiduciary relationship with one or more stakeholders – as in the case of doctors and patients. In the healthcare sector of Bangladesh, a number of malpractices and unethical behaviours have been highlighted in the media and by the insiders to the industry. Hence, the aim of this exploratory research was to see the prevalence of such practices and try to relate these practices with the existing HR scenario of the respective organizations. The study was conducted using the questionnaire survey method, where response from 128 patients were taken to carry out a one-tailed hypotheses testing. Moreover, a few semi-structured interviews were also carried out with a number of industry experts (particularly representing the management of a number of healthcare organizations). The findings indicated that majority of patients do feel that doctors wilfully prescribe specific brands of medicine in majority of the cases and they also perceive prescription of brand drugs, repeat medical tests (particularly from referred diagnostic centres) as unethical. Such behaviours are further questioned on account of the presence of similar to commission-based pay in their respective organizations etc.

Keywords: healthcare sector, unethical behaviour, doctors, HR practices, Bangladesh.

1 Introduction

1.1 Background of the Study

Healthcare service is one of those complex sectors where the function of service marketing poses numerous opportunities for ethical violations. The management and governance of healthcare organizations do face ethical challenges in the wake of competing needs or values or even in meeting various shareholders' demands etc. This is a likely happening in a competitive market, and also in markets, where consumers have limited knowledge, face uncertainty, and have to depend on marketers to provide ethical, customer-oriented guidance (Bush, Harris, & Bush, 1997; Stolt, Leino-Kilpi, Ruokonen, Repo, & Suhonen, 2018).

Even within this scenario, the healthcare industry has become a thriving business. And despite the underlying social goal of this sector, with the industry becoming 'corporationalized', the individual units are being forced to compete to remain viable; thereby, further compounding the challenge of ethical considerations as the units compete to strive for economic goals (Silva, 1998).

In healthcare sector of Bangladesh, with players both in the 'for-profit' private sector and 'not-for-profit' public sector, the resources of the professionals (specialists, such as doctors, technicians etc) are being shared. It is a booming business with intense competition.

Study by Fornaciari and Callens (2012) found that competition rules are just as applicable to the healthcare players as any other industry; considering the consequences of those rules being applied – the core ideal behind competition is it protects consumers from unfair practices. However, whilst consumers in other sectors make informed choices, healthcare sector information asymmetry creates situation where patients lack sufficient information to make informed choices (cf Fornaciari & Callens, 2012). As a result, such situations can create opportunities for certain practices to take place, which, in the absence of adequate control system, can be deemed questionable / unethical.

A typical example of ethics in healthcare can be given from a scenario in one province in China,

where in an online post in Nov 15, 2010 it was alleged that dozens of doctors at several hospitals were taking bribes. The doctors were accused of accepting gift items from a local medical device (healthcare) company and in return, were buying the company's products. The story brought out a lot of backlash from the public but the widespread belief was – it was an institutional problem, called Bribe-gate, in China's health care system (Yang & Fan, 2012).

According to the report, in China, pharmaceutical and medical equipment companies pay 'kickbacks' and bribes to healthcare professionals (namely, doctors and hospital staff) to increase company's sales. Such form of bribes included not just gift items but also a part of the cost of drugs, which in essence, was included in the drug pricing; as a result, the cost is basically passed on to the consumer.

1.2 Problem Statement

In Bangladesh, the healthcare industry may be partitioned to include hospitals, diagnostic centres, and pharmaceutical companies as different sub-groups. As in the case of any other nation, healthcare sector here too operates on information asymmetry that prejudices against the service receivers. There are unethical practices that surface from time to time, which might be the direct consequence of different 'individual units' within these sub-groups being financially reliant on one another (Westra, Angeli, Carree, & Ruwaard, 2017).

There are frequent accounts of preventable deaths and mistreatment of patients due to negligence or incompetence that surface over the informal communication landscape within the country. Of those numerous accounts, some get reported to the respective healthcare organizations or to the medical council; notable cases are taken up by Ain-o-Shalish Kendra and few find their way to be reported in the national dailies.

In a piece of news published in the Dhaka Tribune in January 2018, it was reported by Ain-o-Shalish Kendra (a rights group) that more than 500 people died across the country on account of medical mishaps between October 2008 to February 2016 that could have been prevented. (Dhaka_Tribune, 2018). In another case that was taken to court, the reported incident was about 20 people who lost their eyesight after surgery at a certain healthcare centre (UNB, 2018).

The government has drafted the Medical Care Protection Act, 2016; the Act would protect healthcare professionals with impunity for negligence in treatment (Dhaka_Tribune, 2018) given the clause that any act "performed with good faith" will not be considered a criminal act. While the sentiment behind the legal step is understandable, it gives little protection to the consumer (patients) group to hold healthcare professional accountable for their actions – some of which may although be 'performed in good faith' but are lacking in knowledge, skill, competence or simply 'care'.

Such cases of malpractice or negligence are not restricted to Bangladesh. In 2018, a news report printed in Business Day based in South Africa highlighted the findings of a study of 122 nursing malpractice cases in South Africa. It was reported that out of the 122 cases, a fifth resulted in death while 70% of the rest suffered on quality of life as they either required further surgery or were left disabled. The common causes leading to such 'malpractice' were found to be lack of knowledge, insufficient training, poor monitoring of patients or not administering prescribed medicine timely etc (Gous, 2018).

The Bangladesh Medical and Dental Council (BMDC) is the only body where victims of medical malpractice (patients) can lodge formal complaints. In the past 6 years, a total count of 337 written allegations were made to the council, of which action was taken against a doctor in one case alone (Mamun, 2017). According to a senior council member, BMDC has no legal power to act on complaints; if the government were to empower the council, it could serve show-cause notice to the health care service providers to build more accountability in future.

In another case of wrong treatment reported by Dhaka Tribune, a popular national daily in Bangladesh, a 3-year old girl died; two physicians were dismissed after two probe committees found them guilty of negligence. The news reports were abuzz not just at the untimely sad demise of the little girl but how the healthcare professional community reacted to the dismissal case: doctors at private hospitals and clinics went on an indefinite strike (UNB, 2018).

The case was taken to court and the court defined this as unethical behaviour: "To err is human. Doctors are not gods. Committing mistakes is not unethical, but calling a strike to justify mistakes is unethical," (UNB, 2018).

Such is the healthcare landscape in Bangladesh. This research focuses on the privatized healthcare sector of Bangladesh, which has become far ‘corporationalized’ with very little government intervention resulting in ‘customers (patients)’ harbouring mistrust for the local units and going for treatment abroad even though there are internationally affiliated healthcare units within the country (Nurunnabi & Islam, 2012; UNB, 2018). There is an accountability gap in the sector, and there is a need for government initiatives and also more customer protection through law.

The aim of this research is to study whether healthcare professionals show (or, have a chance to show) unethical behaviour (behaviours deviant from the societal norms and expectations) toward the patients.

1.3 Research Question and Research Objectives

Research Question

What is the general perception of people regarding the behavioural ethics of the healthcare professionals in the country?

Research Objectives

The objectives of the study are:

- To identify plausible unethical practices that may be manifested by the healthcare professionals (doctors);
- To test the widespread perception of the patients regarding the prevalent unethical behaviour in the industry.

2 Literature Review

“Ethics” is a set of moral principles governing an individual or a group. It helps in dealing with what is good and bad, and with moral duty and obligation. The concept of ethics is historically viewed from the perspective of three schools of thought: teleological theories, deontological theories and virtue-based theory (Baumane-Vitolina, Cals, & Sumilo, 2016). These frameworks help define the concept of ethics and what is the scope of evaluation (of person, motive, action or event) that define the goodness or wrongness of the action or practice in light of some accepted principles.

The overall concept of ethics in our day-to-day life has evolved over the last few decades. It was after the 1960s when, with the rise of social responsibility debate, ethical concerns became of major importance to the business organizations. That decade brought social changes in the business front when businesses were feeling the societal pressure to uphold rights of minority, different interest groups, workplace safety etc.

In later decades, widespread failure of large corporations and its impact on the unsuspecting stakeholders resulted in government and legal interventions forcing businesses to incorporate ethics into their operational decisions.

Ethics in healthcare sector

Ethics has made its place in business with the trend of internationalization and technological advancement; and changes in the work environment are resulting in more and more ethical dilemmas to surface. Critical ethical considerations are now needed in debating decisions like outsourcing as lower cost alternative in the face of foreign competition, disproportionate disparity of income between CEO and lower tier, electronic surveillance and snooping behaviour of employer, etc. The need for ethics in business environment may very well be the result of escalation of materialistic values and the commodification of everything (Rose, 2008).

It can easily be seen that this is not an absolute case of one-sided (from employees’ end only) ethical challenge. Research in healthcare sector has highlighted that in facing an ethical dilemma when healthcare professionals perceive that their ethical standards are not shared or met by their respective organizations, these professionals go through an increased rate of burnout (Stolt et al., 2018).

It is true that given the unfavourable circumstances through organizational contextual factors, individual ethics get adversely impacted and those who cannot / do not acclimatise to such culture, fail to perform or leave the job.

The organizational contextual factors mentioned before have a lot to do with the ‘entanglement’ between the medical profession and the pharmaceutical industry and other health care service providers

(Moynihan, 2009). The entanglements refer to the custom of gift giving, payment for promoting products (commission or fee) etc. Such entanglements do go beyond personal interaction and small gifts and form a widespread network of corruption or unethical practices that mar the healthcare industry.

According to the findings of Moynihan (2009), pharmaceutical marketeers use respected physicians as opinion leaders who are often likened to the job of the salespeople. Within the scope of their study, it came out from an ex-insider of the industry that such organizations actually measure the return on investment on the opinion leader by following up on their “performance (i.e. presentations of updated research findings)” to measure the impact they had on sales of the company before the company would decide to invite the physician back in future. At some level, it would appear that such opinion leaders remain within the payroll (loosely defined) of the company without having an employment contract.

Studies related to the structure / design of compensation plan have shown that ‘Commission-based pay system’ can create a conflict of interest for the salesperson, especially when the focus is on the short-term achievement of company goals (as has been seen in CEO compensation). Such a system fails to motivate salespeople to act in customer’s best interests (Román & Munuera, 2005).

Healthcare professionals are no different from employees of other professions. Research conducted on medical students in Germany in postulating their choice of healthcare organization (for-profit vs. non-profit) based on self-motivation factors found that (medical) students’ career aspiration and need for work-life balance were also closely related to employee benefits and financial security (Buelens & Van Den Broeck, 2007; De Cooman et al., 2011 cf. Winter & Thaler, 2016).

Both from studies above – salesperson commission pay and employees’ need for benefit and financial security – it can be exclaimed that it is no wonder that one of the most prominent ethical considerations in HR is the design of compensation with inclusion of incentive pay, particularly for special groups. ‘Special groups’ in the field of reward management are salespersons, supervisors, technical specialists or even professionals like doctors etc (Milkovich & Newman, 2004), for they present a need to counter the conflict of interest present in their job or profession.

It is not just the entanglement of the medical professionals with the pharmaceutical and medical service providing sector that drive up unethical behaviour in healthcare professionals, nor is it solely the result of challenging design of employee compensation, many research do show there are unintended and unwanted effects of competition as well in healthcare sector (Westra et al., 2017).

Healthcare is a sector of mass public concern. Many nations have demonstrated the non-profit environment where healthcare has flourished with cooperative inter-organizational relations; however, competition has also been seen to have positively altered the context of healthcare in many western nations. There is an interplay of various healthcare organizations offering a myriad of products or services – such inter-organizational relations have been seen to provide a mechanism for efficient and effective utilisation of healthcare services.

However, according to Westra et al. (2017), there is a need for ‘managed competition’ within defined rules to obtain maximum value for money. It is the role of the policymakers to bring a balance in the design of the rules of competition to ensure a control over (or ceiling for) public healthcare expense while still promoting efficiency through competition in the industry.

The notion of competition in such fragmented industry (with highly inter-linked sub-sectors) promotes the challenge of managing ethicality when the control is not under one single domain.

So, what is indeed considered an unethical behaviour by the healthcare professionals?

To define the fine line between ethical vs. unethical behaviour, it is important to understand the context of ethical behaviour.

An ethical decision is one that affects human welfare or human fulfilment in some significant manner; an ethical decision is one where someone’s welfare is at stake. At the very basic level, every decision one makes has an ethical dimension; such view, however, loses practical significance when the multitude of decisions that one makes is considered. Hence, ethical decisions are further elucidated as those decisions where questions of justice and rights are serious and relevant moral considerations: there are three questions that one should ask (Buchholz, 1989):

- Can the decision be defended on grounds of justice?
- Is it fair and equitable in some sense to all the parties affected?
- Does the decision violate some basic human rights, such that it may be labelled an immoral decision?

Unethical behaviour can be commonly defined as behaviours that violate widely accepted (societal) moral norms (Cojuharenco, Shteynberg, Gelfand, & Schminke, 2012).

According to Cojuharenco et al (2012), unethical behaviour is dependent on the 'self-construal' of individual, which is based on the notion of self and part of the concept of individual's self definition depended on his/her relationship and notions of others. This relationship for concern for others has been seen to be consistently associated with a lower likelihood of engaging in unethical behaviour.

Similar findings related to the 'concern for others', show that people judge behaviour as more unethical when they can identify (or relate to) the victim and also when the behaviour leads to a negative rather than a positive outcome (Gino, Shu, & Bazerman, 2010).

From Gino et al.'s (2010) work, it can be seen that it can be hard to empathise with the consequence of an unethical behaviour when the victim is distanced or unidentifiable.

In the healthcare profession, ethics is codified on grounds of professional ethics. According to Heath (2006), professional ethics stems from the professional role imposing its own set of obligations upon the person which are not necessarily part of general morality.

The ethicality of professionals is more difficult to codify. It is one thing to have a job and quite another, to practise a profession. In some situations, it is possible for parties in an employment relation to specify all the terms of contract, to monitor performance completely, and to institute a system of incentives that guarantee perfect compliance. However, when it is impossible to specify the terms of an employment contract completely (as in the case of professionals like doctors, lawyers etc), imperfect observability of effort makes monitoring difficult. In such cases, a lot depends on self-monitoring. When it is impossible to eliminate moral hazards, the 'purchaser' of labour services must rely on the voluntary cooperation of 'seller'. A certain amount of trust, or moral constraint, is required in these relationships.

The nature of unethical behaviour seen in this sector emerge in the guise of Bribe-gate, a term used in China's healthcare system (Yang & Fan, 2012) where doctors were accused of accepting gifts in exchange of authorising the purchase of that company's medical products, for accepting gift or monetary benefit for prescribing expensive drugs to the patients – the cost of all of which are included in the drug pricing and passed on to the consumer.

It was in 1989, when for the first time, major medical journals took up the issue of gift-giving as a practice of dubious ethical concern. They highlighted such behaviour as falling under "self-serving bias" in conflict-of-interest situations and they cited that psychological data suggest that individuals cannot make impartial judgments when their own self-interest is at stake, even if the stakes are small (Moskop, Iserson, Aswegan, Larkin, & Schears, 2012).

Such studies were challenged in the industry of healthcare professionals and heavy-weight pharmaceutical companies. According to the accused professionals, they do not do not perceive themselves as biased and it can be attributed to the concept that as self-serving bias works at a subconscious level, it remains unconscious and unintentional to the perceiver.

Studies in US market have demonstrated the nature of manipulation that goes behind the 'unacknowledged unethical behaviour'. Based on a study of doctors' prescriptions in US, it was found that in markets with pharmaceutical product marketing regulations in place, the uptake of new costly medicine was lower; and in states where gifts to doctors were banned, there was a reduction in market share between 39% to 83%. In the absence of gift offerings, peer influence took over as the source of influence (a less biased channel for physicians) when a relatively beneficial drug was introduced in the market (King & Bearman, 2017). As a result of such significant consequences, it can be inferred why pharmaceutical companies do get heavy-handed in the marketing of their products.

King and Bearman (2017), on the other hand, found that the curtailing of such practices indeed benefitted consumers as the physicians are less likely to prescribe costly new medications that have few advantages over existing alternatives. The benefit could perhaps be further extended in the form of lower medicine cost as the promotions to physicians usually get included in the drug pricing (Yang & Fan, 2012).

Tiessen and Kato's (2017) study of Japanese healthcare market present a model of healthcare providers operating both in private and public sectors, but on a not-for-profit basis. Their model is a success case. Competition exists amongst the healthcare organizations in Japan; however, as prices of service are fixed centrally (with all party representation), competition soars on quality and not on price. It is the organizations that compete for patients with an offering of diverse type of products. There has

been considerable research in Europe and US, where it was found that competition in this sector under such modality can be associated with quality improvement and lower mortality rates.

As prices of services are adjusted centrally, incentives can be adjusted to influence appropriate behaviour (Tiessen & Kato, 2017). At the end of the day, it is the patients who benefit.

The healthcare industry needs an overhauling, mostly all over the world, with more control with code of ethics, managed competition and ethics education or ethicality awareness for individual professionals. In Bangladesh, the whole sector needs a massive upheaval as it too is suffering from service provision problems like: "... over servicing, over prescribing, unnecessary tests, over-using technology, fee splitting, profit motivation, negligence, poor standards and poor business ethics" (cf Nurunnabi & Islam, 2012, pg. 627).

3 Research Framework and Hypotheses

The study has been designed to empirically study from the perspective of the consumers (patients) whether there is a prevalence of 'service provision problems (Nurunnabi & Islam, 2012) and whether these are perceived as unethical behaviours.

Unethical behaviour has been identified from various literature presented in the last chapter as that behaviour that cannot be defended on legal grounds, is not fair or equitable, or violates another's rights (Buchholz, 1989). In the case of healthcare sector, many researches have shown that accepting gift or any pecuniary benefit that could present a conflict of interest situation with a self-serving bias that could likely result in any stakeholder getting adversely affected fall under the domain of unethical behaviour (King & Bearman, 2017; Moskop et al., 2012; Moynihan, 2009).

The null hypotheses based on prior research are:

- Hypothesis 1: Patients experience that doctors prescribe medicine in majority of cases after consultation.
- Hypothesis 2: Patients experience that doctors prescribe specific brands of medicine.
- Hypothesis 3: Patients experience that doctors prescribe medical tests in majority of cases after consultation.
- Hypothesis 4: Patients experience that doctors disregard existing test results and ask for repeat tests to be done.
- Hypothesis 5: Patients experience that doctors either specify or imply specific diagnostic centres to do tests from.
- Hypothesis 6: Patients do not feel that doctors give them enough time to listen patiently to their ailment and answer their queries.
- Hypothesis 7: Patients perceive that doctors' behaviour to prescribe brand medicine over generic brands to be unethical.
- Hypothesis 8: Patients perceive that doctors' behaviour to prescribe a lot of tests to be unethical.
- Hypothesis 9: Patients perceive that doctors' behaviour to prescribe medical tests to be repeated from specific diagnostic centres to be unethical.

The hypotheses (H1 to H5) were created to first check the prevalence of unethical behaviour in the market (to be inferred whether majority or more than 50% of the population have experienced the stated behaviours). Hypothesis 6 to H9 were created to check the widespread perception of the population regarding the stated beliefs.

4 Methodology

4.1 Research Design

This is a quantitative research in which patients' perception of unethical behavioural manifestation of healthcare professionals is studied empirically.

The study can be considered an exploratory research addressing a social need in the healthcare sector, where there is a general perception of the presence of rampant unethical practices by the healthcare professionals. A survey method was used to collect primary data directly from patients using

questionnaires. A few semi-structured interviews were also conducted to explore the context of HR practices existing in healthcare organizations (namely, hospitals) within the country.

The data from the survey was used in testing hypotheses for the population using a one-tailed z distribution, where the z (critical) value is +1.65 at 95% confidence level.

4.2 Sampling Plan

A cluster sampling method was chosen to represent various socio-economic zones of Dhaka city to cover hospitals of varying sizes (in terms of range of service, volume of business, local vs. foreign ownership etc.) that cater to patients from all background.

A sample of 128 patients was used in the study. Respondents are patients of different hospitals that were visited by field survey team on different days and time of day over a period of two weeks.

4.3 Data Collection Tools

Semi-structured Interview

In the initial phase, a few semi-structured interviews were conducted with experts in this area (renowned doctors, HR representatives of a few healthcare organizations etc.). The purpose of these interviews was to understand the challenges marring the healthcare professionals in the industry and also to generate holistic perspective of the organizational context regarding HR practices and policies within the healthcare organizations.

Questionnaire

A structured questionnaire was used in the next part of the research: to gather opinion and perception of patients regarding the chosen manifested behaviour by doctors.

The questionnaire was designed with the purpose of identifying the following:

- What is the general feeling of the population about the practices of the healthcare professionals in Bangladesh?
- What behaviours by doctors are perceived as unethical by the patients?

With this purpose in mind, the questionnaire was developed with three parts: the first dealt with basic demographic data, the second dealt with behavioural questions on patients' experience with doctors' services, and the last dealt with questions on perception covering specific behaviours by doctors that they consider unethical.

The questions relating to patients' experience with doctors' services covered issues on prescription of generic vs. branded medicine, prescription of medical tests and doctors' personal interaction with the patients.

All questions were closed-ended. The attitudinal questions were either multiple choice questions to elicit opinion on behavioural frequency, or choices on agreement scale in eliciting information on attitudinal preference / perception.

5 Findings

Data Analysis

One-tailed hypothesis tests were conducted to test the hypotheses at 5% level of significance. The data consisted of 128 responses from patients spread across 36 locations across Dhaka city; had 45% of female respondents and were roughly evenly balanced across different age groups.

The hypothesis testing was carried out as follows:

H1: Patients feel that doctors prescribe medicine in majority of cases after consultation.

Null Hypothesis 1 (Ho1):

50% or less than 50% of the population (patients) experienced that doctors prescribe medicine in majority of the cases.

Alternate Hypothesis (Ha1):

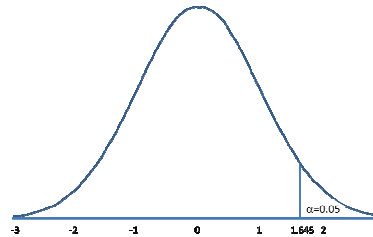
More than 50% (majority) of the population experienced that doctors prescribe medicine in majority of the cases.

$$z \text{ (critical at 5\% level of significance)} = 1.65$$

$$z \text{ (statistic)} = (p - \Pi) / \sqrt{\{p \times (1-p) / n\}}$$

In case of Ho1,

$$z \text{ stat} = (0.59 - 0.50) / \sqrt{\{0.59 \times (1 - 0.59) / 128\}} = 2.16$$



In a one-tailed test, as z-statistic is greater than z-critical, the Null hypothesis is rejected. Hence, it can be inferred from the population that “Majority (or more than 50%) of the population experienced that doctors prescribe medicine in majority of the cases.”

The data from the survey findings are presented in the following table where ‘x’ represents the total number of people aligned with the null hypothesis statement; ‘p’ represents the sample proportion (calculated as x / n); ‘n’ is the total number of respondents; and lastly, ‘z-stat’ represents the calculated z value against each hypothesis. The last column presents the decision against each hypothesis.

Table 1. Hypotheses test results

Null Hypotheses	Data value	Z statistic	Results
Ho1: 50% or less than 50% of the population (patients) experienced that doctors prescribe medicine in majority of the cases.	x = 76 p = 0.59 se = 0.043	2.16	Rejected.
Ho2: 50% or less than 50% of the population (patients) experience that doctors prescribe specific brands of medicine.	x = 84 p = 0.66 se = 0.042	3.72	Rejected.
Ho3: 50% or less than 50% of the population (patients) experience that doctors prescribe medical tests in majority of cases after consultation.	x = 68 p = 0.53 se = 0.044	0.71	Cannot be rejected.
Ho4: 50% or less than 50% of the population (patients) experience that doctors disregard existing test results and ask for repeat tests to be done.	x = 18 p = 0.14 se = 0.031	-11.70	Cannot be rejected.
Ho5: 50% or less than 50% of the population (patients) experience that doctors either specify or imply specific diagnostic centres to do tests from.	x = 53 p = 0.41 se = 0.044	-1.97	Cannot be rejected.
Ho6: 50% or less than 50% of the population (patients) do not feel that doctors give them time to listen patiently to their ailment and answer their queries.	x = 45 p = 0.35 se = 0.042	-3.52	Cannot be rejected.
Ho7: 50% or less than 50% of the population (patients) perceive that doctors’ behaviour to prescribe brand medicine over generic brands to be unethical.	x = 92 p = 0.72 se = 0.040	5.50	Rejected.
Ho8: 50% or less than 50% of the population (patients) perceive that doctors’ behaviour to prescribe a lot of tests to be unethical.	x = 68 p = 0.53 se = 0.044	0.71	Cannot be rejected.
Ho9: 50% or less than 50% of the population (patients) perceive that doctors’ behaviour to prescribe medical tests to be repeated from specific diagnostic centres to be unethical.	x = 80 p = 0.63 se = 0.043	2.92	Rejected.

Discussion

From the hypothesis testing it can be seen that only 4 hypotheses yielded expected results from the study at 95% confidence level.

The stated hypotheses tested patients' experience on doctors' actual behaviour related to various patient services – covering allocation of time; interpersonal skill; prescription of medicine, medical tests; and suggestion as to the choice of diagnostic centre. In all these cases, the hypotheses related to prescription of medicine – firstly, 'over-prescription' and secondly, 'of specific brands' could be rejected, which means majority of the population experienced that doctors prescribe brand medicine in majority of the cases, and secondly, majority of the population also experienced 'over-prescription'.

In a study conducted in 2010 by a WHO (World Health Organization) consultant, it was found that there is a widespread prevalence of prescription of medicine of specific brands in Bangladesh (Holloway, 2010, pg 7)

Moreover, although the WHO report mentions that doctors in public healthcare tend to give only 1 to 2 minutes to each patient, the times given by the same physician consultants in own / private clinics are much higher (Holloway, 2010, pg 21). Hence, as the survey data were pertaining to patients availing private sector healthcare facilities, the hypothesis (H6) on patients' opinion as to the time doctors give them to understand their ailment and to clarify their queries could not be rejected; and it tallies with previous finding.

The final set of hypotheses (H7 to H9) focus on patients' perception of unethical practices and based on these tests, it can be inferred that most patients perceive that doctors manifest unethical behaviour with respect to prescription of medicine of specific brand, and also prescription of tests from specific diagnostic centres (the latter, resulting in repeat tests which turn expensive for the patients).

The empirical findings are somewhat at par with the initial findings of the semi-structured interviews which were conducted to take expert opinion as to the prevailing concerns in the industry; moreover, HR practices in different types / sizes of healthcare organizations were also looked into for a wider perspective.

Initial phase study findings revealed that in the private healthcare sector, doctors have different types of employment contracts that range from being salaried employees to being on 'fee for service', which is basically an earnings-sharing program that can be as high as at 80-20 ratio favouring the physician. Such practice resembles none other than commission-based pay.

While these are the larger hospitals luring consultants (doctors) at a competitive rate with performance parameter attached to it, smaller medical centres offer an alternative engagement plan. In these smaller centres that offer medical tests to patients, chambers within the facility are let out to the doctors at minimal cost with the unwritten obligation to help generate revenue through referrals for facility use and various prescriptions for tests. All earnings (fees from patients) are kept by these practitioners; and these doctors are not employees of the hospital and are not paid a salary.

Apart from earnings / compensation, those who join as employees are further bound to the organization through performance expectations that go well beyond patient satisfaction. Some hospitals review units and doctors with records of patient turnover (number seen), repeat patients, and also on behavioural competencies; while others have an unwritten practice of giving revenue targets to the doctors.

When asked as to what their management perceive to be the prevailing unethical practices in the industry, they highlighted commission pay for inducing increase in hospital facilities; quantitative KPIs (such as number of patients seen, no of tests given etc.); and even allowing doctors to continue in a hospital on a part-time basis while having their private practice in the afternoon could promote conflict of interest when they try to take patients away to their own / vested low cost facility.

6 Conclusion

Ethics has emerged as one of the most important organization management principles of the last 30 years, particularly in healthcare business (Moskop et al., 2012). Empirical research indicates a significant and positive relationship between organizations perceived to be ethically responsible and valuable business outcomes (such as enhanced reputation, customer loyalty and sustainable profitability) (Wickham & Donohue, 2012).

Despite its importance, however, unethical conducts are still rampant in different industries. A global survey of 1121 managers and HR experts indicate that despite the existence of company codes of ethics and conduct, the pressure to meet unrealistic business objectives and deadlines is the leading cause for unethical decision-making in Western firms (Vickers, 2005).

Healthcare sector looks particularly susceptible, not just in Bangladesh where the study was done, but all over the world. And based on the literature survey, it would appear that the unethical dimension spans from individual conflict of interest to pharmaceutical industry entanglements to interplay between various sub-sectors in a fragmented industry framework.

This research focused primarily on the opinion and perception of customers (patients) on the basis of certain prevailing behaviours of healthcare professionals. Moreover, a cursory study of the nature of HR practices within the players in the healthcare industry revealed that the prevailing unethical practices perceived by the patients could stem from pecuniary benefits the doctors are likely receiving from their respective organizations – at the cost of the primary stakeholder (patients)!

There is a lot of scope for further study in this area: nature of relationship between specific HR practices and doctors' unethical behaviour; comprehensive review of laws that balance accountability vs. rights (a balance between consumer protection and the healthcare practitioners' rights); the impact of such marketing practices by healthcare service providers on organizational turnover etc.

Further research would undoubtedly highlight the nature and extent of the problem. It may be foolhardy to expect individuals to be ethical at par with organization's level of expectation. Individual ethics is dependent on individual values and those are defined by the level of cognitive maturity the individual has reached. Without guidelines, written codes, behavioural modelling and appropriate reinforcements, the matching of individual values that drive behaviour with organizational values and norms is a lot to ask for. Organizations need formalization of ethics in performance expectations, in operational procedures etc., and likewise, individuals need training to live up to the ethical expectations.

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