The Impact of Code of Medical Ethics on Health Service Quality among Physicians at Saudi Hospitals of Jeddah

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Abstract. This research aims to determine the scope of applying medical ethics among physicians at Saudi hospitals. This research consists of the independent variables represented by code of medical ethics principles (namely autonomy, beneficence, non-maleficence, and, justice) and dependent variable which represented by health service quality. In order to explore the relationship between independent and dependent variables the quantitative method was applied to collect primary data through a questionnaire, which was administered in the government, and private sector hospitals in Jeddah city. The research population consists of 2871 physicians. The research sample consists of the 287 physicians (10%). The researcher retrieves 176 valid research questionnaires accounted (61%). A purposive sampling strategy was used to choose the participants in this research. The results confirm significant relationship between the codes of medical ethics and health service quality. The result shows that four independent variables are significant (autonomy, beneficence, non-maleficence, and justice) on health service quality. This research contributes to recognizing the vital roles of medical ethics in improving the patient service quality. Regarding the beneficence the physician if consider patient well being and contribute to develop their medical profession by update knowledge and continuous medical education through clinical practice research (randomized control trials) applying evidence based medicine providing that physician deliver health care in a quality standard regarding (attitude ,skills , knowledge, and experience). In turn will lead to increase cure rate, and improve patient well-being. Therefore the medical ethics need to be flexible and open to change and adjust regularly. The medical ethics depends on the future of medicine (e.g. new procedures and techniques).

Keywords: medical ethics code, health service quality, Saudi Arabia.

1. INTRODUCTION

The term "medical ethical" is used in opinions of the Council on Ethical and Judicial Affairs to refer to matters involving moral principles or practices and matters of social policy involving issues of morality in the practice of medicine (Furrow and Johnson, 1991). Medical ethics is a code of conduct of practicing doctors/ surgeons evolved over centuries nationally and internationally that is based on the most admirable human values and principles implications for certain biological and medical procedures, technologies, and treatments, as organ transplants, genetic engineering, and care of terminally ill (Furrow and Johnson, 1991). Historically; Greek healers in the 4th century B.C., drafted the Hippocratic Oath and pledged to "prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone". The prophet MOHAMMAD,(PBUH) Said: " On the day of judgment, nothing more weighty than good conduct is placed in the balance of every man".

A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights. He/ she shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or

deception, to appropriate entities. Physicians respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient. He/ she shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
He/ she shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated. He/ she shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care. Physicians shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health. They while caring for a patient, regard responsibility to the patient as paramount. He/she shall support access to medical care for all people (AMA, 1997).

The purpose of the current research is to explore the impact of code of medical ethics on health service quality among physicians at Saudi hospitals of Jeddah.

2. LITERATURE REVIEW

2.1 Code of Medical Ethics

MEDICAL ethics, as a branch of general ethics, must rest on the basis of religion and morality. They comprise not only the duties, but, also, the rights of a physician: and, in this sense, they are identical with Medical Deontology - a term introduced by a late writer, who has taken the most comprehensive view of the subject. In framing a code on this basis, we have the inestimable advantage of deducing its rules from the conduct of the many eminent physicians who have adorned the profession by their learning and their piety (Bell, 1995). From the age of Hippocrates to the present time, the annals of every civilized people contain abundant evidences of the devotedness of medical men to the relief of their fellow-creatures from pain and disease, regardless of the privation and danger, and not seldom obloquy, encountered in return; a sense of ethical obligations rising superior, in their minds, to considerations of personal advancement. Well and truly was it said by one of the most learned men of the last century: that the duties of a physician were never more beautifully exemplified than in the conduct of Hippocrates, nor more eloquently described than in his writings (Bell, 1995).

A few considerations on the legitimate range of medical ethics will serve as an appropriate introduction to the requisite rules for our guidance in the complex relations of professional life. Every duty or obligation implies, both in equity and for its successful discharge, a corresponding right. As it is the duty of a physician to advice, so has he a right to be attentively and respectfully listened to. Being required to expose his health and life for the benefit of the community, he has a just claim, in return, on all its members, collectively and individually, for aid to carry out his measures, and for all possible tenderness and regard to prevent needlessly harassing calls on his services and unnecessary exhaustion of his benevolent sympathies. His zeal, talents, attainments and skill are qualities which he holds in trust for the general good, and which cannot be prodigally spent, either through his own negligence or the inconsiderateness of others, without wrong and detriment both to himself and to them. The greater the importance of the subject and the more deeply interested all are in the issue, the more necessary is it that the physician -he who performs the chief part, and in whose judgment and discretion under Providence, life is secured and death turned aside- should be allowed the free use of his faculties, undisturbed by a querulous manner, and desponding, angry, or passionate interjections, under the plea of fear, or grief, or disappointment of cherished hopes, by the sick and their friends (1995).

The dimensions of ethics code in this research will be four dimensions: autonomy, beneficence, non-maleficence, and Justice.

2.1.1 Autonomy—It is patient's autonomy of thoughts , intention, agreement to respect another's right to self-determine a course of action; support of independent decision making regarding health care ,and understand all risks and benefits of the procedure then the patient has the right to refuse or choose their treatment (Beauchamp and Childress, 2009).

Values of Autonomy:

a). informed consent : it is a legal procedure to ensure that a patient or client willing acceptance and knows the nature of the treatment , possible alternative treatments, the potential risks and benefits of the treatment and costs involved in a treatment.

Constitutes of informed consent:

- Disclosure: information to allow reasonable person to make a decision.
- Understanding: comprehension of the information given.
- Voluntary: no coercion or incentive to accept or deny.
- Agreement: verbal or written (preferred) to discuss intervention (Beauchamp and Childress, 2009).

b). confidentiality, privacy, respect, dignity, honesty, and truth fullness:

- Respect and dignity maintained so each person encountered in our working day deserves our respect – patients, visitors, co- workers.
- Confidentiality based on loyalty and trust.
- Maintain the confidentiality of all personal, medical , and treatment information that legal protection prevent physicians from revealing their discussions with patients , even under oath in court (Beauchamp and Childress, 2009).

c). breaking bad news: Physician prepares the ground, keeping in mind the patient knowledge and the extent patient wants to know by involving patients' family. Provide appropriate care for patient, even when cure is no longer possible (holistic approach). Consider terminally ill patients.

2.1.2 Beneficence: It is doing good for patient, in a way that physician develop and maintain skills, knowledge, and training continually up to date. Considering individual circumstances of all patients and strive for net benefit (Beauchamp and Childress, 2009).

- Patient welfare as first and care consideration competence.
- Better knowledge for safe care.
- A practitioner should act in the best interest of the patient.
- Maximize the benefit and minimize the harm for the patient (Beauchamp and Childress, 2009).

2.1.3 Non-maleficence: Ensure that treatment will not produce harm, negligence, misconduct, and avoidance of harm or hurt; core of medical oath and physician ethics (Beauchamp and Childress, 2009).

- Patient safety is first.
- Avoid the causation of harm.
- Avoid participation in or support practices that violate basic human rights.

2.1.4 Justice: It is fair distribution of scarce, resources, competing needs, rights obligations and potential conflict with established legislation (Butts and Rich, 2008).

- based on analysis of benefits and burdens of decision.
- Justice implies that all citizens have an equal right distributed, regardless of what they have contributed or who they are.
- Actions are consistent, accountable, and transparent.
- Respect of the law.
- Equity and distribution of burden and benefits.

Saeed (1999) compares the perceptions of physician executives and clinicians regarding ethical issues in Saudi Arabian hospitals and the attributes that might lead to the existence of these ethical issues. Self-completion questionnaire administered from February to July 1997. Different health regions in the Kingdom of Saudi Arabia. Random sample of 457 physicians (317 clinicians and 140 physician executives) from several hospitals in various regions across the kingdom. There were statistically significant differences in the

perceptions of physician executives and clinicians regarding the existence of various ethical issues in their hospitals. The vast majority of physician executives did not perceive that seven of the eight issues addressed by the study were ethical concerns in their hospitals. However, the majority of the clinicians perceived that six of the same eight issues were ethical considerations in their hospitals. Statistically significant differences in the perceptions of physician executives and clinicians were observed in only three out of eight attributes that might possibly lead to the existence of ethical issues. The most significant attribute that was perceived to result in ethical issues was that of hospitals having a multinational staff. The study calls for the formulation of a code of ethics that will address specifically the physicians who work in the kingdom of Saudi Arabia. As a more immediate initiative, it is recommended that seminars and workshops be conducted to provide physicians with an opportunity to discuss the ethical dilemmas they face in their medical practice.

Nishimura (2005) discusses a code of professional ethics for the physician in Japan is being prepared caused by the progress of the medical conditions. The Japan Medical Association (JMA) enacted "the guideline on professional ethics for the physician" in 2004. However, as for the substantial effect of this guideline, it may not be able to be expected. The present state of the professional group of the physician in Japan can be shown as that reason. (1) First, there is not any physician's group of the compulsory admission, but only professional ability profit group of the voluntary admission in Japan. (2) There are not ethical regulations of the profession which has legal effect to face in the physician's misconduct in Japan. (3) In addition, there is not any autonomous organization inside the professional group which examines and imposes disciplinary punishment to the physician who went through misconduct in Japan. After all, the ethics in the physician would be left to each physician's conscience. Then, how should we do to solve such various fundamental problems? In this paper, the situation in various foreign countries is surveyed as an indication of the Japanese medical profession's future conduct. Moreover, I present some solutions to the various problems in fulfilling the professional ethics for the physician in Japan.

Bostick et al (2006) argue that patients belonging to racial and ethnic minority populations continue to receive lesser-quality healthcare relative to other patients, even when controlling for relevant demographic variables. Such disparities represent a significant challenge for physicians who are ethically committed to serving all patients equally, irrespective of personal characteristics. Accordingly, this report explores the ethical obligations of individual physicians and the medical profession as they pertain to racial and ethnic disparities in healthcare. To address these disparities, the AMA Council on Ethical and Judicial Affairs recommends that physicians customize the provision of medical care to meet the needs and preferences of individual patients. Moreover, physicians must learn to recognize racial and ethnic healthcare disparities and critically examine their own practices to ensure that inappropriate considerations do not affect clinical judgment. Physicians can also work to eliminate racial and ethnic healthcare disparities by encouraging diversity within the profession, continuing to investigate healthcare disparities, and supporting the development of appropriate quality measures.

Anderson (2009) discussed a code of ethics for sports physicians needs to be clear, appropriate and practically useful to clinicians in everyday clinical circumstances and for situations that may be difficult or contentious. For a code of ethics to be so opposite requires that it have some basis in the ethical concerns of clinicians. This article reflects on the recent experience of rewriting the code of ethics for the Australasian College of Sports Physicians, describing the findings from the research, the processes and challenges that arose, and providing suggestions for other code writers in this field.

O'Connor (2010) discussed that the scandal of health professionals' involvement in recent human rights abuses in United States military detention centers has prompted concern that Australian military physicians should be well protected against similar pressures to participate in harsh interrogations. A framework of military health ethics has been proposed. Would a code of professional conduct be a partial solution? This article examines the utility of professional codes: can they transform unethical behavior or are they only of value to those who already behave ethically? How should such codes be designed, what support mechanisms should be in place and how should complaints be managed? A key recommendation is that codes of professional conduct should be accompanied by publicly transparent procedures for the investigation of serious infractions and appropriate disciplinary action when proven. The training of military physicians should also aim to develop a sound understanding of both humanitarian and human rights law. At present, both civil and military education of physicians generally lacks any component of human rights law. The

Australian Defence Force (ADF) seems well placed to add codes of professional conduct to its existing ethical framework because of strong support at the highest executive levels.

Popović (2011) study the historical relationship of early medical professional codex and contemporary demands and challenges, which are currently being placed before physicians, the first such text, known as Hippocratic Oath has been re-translated. According to the source, it is clear that this is a Code of professional conduct, primarily for the welfare of patients, and in order to maintain and preserve medical authority. All parts of the Oath have been discussed and presented, as well as the historical data from which one can see how the system in ancient Greece and Rome worked. The study includes historical data from that time on two controversial issues: the liability of medical awards, and addressing medical services. These are mistakenly considered to belong to the text of the Oath. Examples of the amount of medical awards are stated, as well as the examples of selflessness and dedication of the physicians in that time. A physician was obliged to help by law, only in the case of accidents and injuries. It is obvious that "medical doctrine" existed also in this time. Requirements set to a doctor were realistic, modest and appropriate to the call, with the main purpose of protecting the reputation and dignity of the profession. Despite the historical distance, classical text of the Oath is still up to date. In this context, ambiguities and errors result from not being familiar with the both, the basic text, and the circumstances prevailing at the time and society, in which the Oath was made.

3. THE RESEARCH PROBLEM

The research problem evolves around investigating to what extent the physicians at Saudi hospitals practice the code of ethics during health care delivery. Discussions, informal interviews with physicians in Saudi government and private sector hospitals have indicated that medical ethics is one of the most critical problems that influence the performance in terms of health service quality of the Saudi government and private sector hospital.

4. RATIONALE OF THE RESEARCH

The research importance focus on that determination and studying of factors affecting physician practice are very important issue that help the physicians to improve quality, satisfy customer and leads to perfection in as a guide for health services in government and private sector hospitals in Saudi Arabia.

5. AIM AND OBJECTIVES OF THE RESEARCH

Based on the above section highlighting the medical ethics research problem and research rationale in the Saudi government and private sector hospitals, the broad aim of this research is to:

Determine the scope of applying medical ethics among physicians at Saudi hospitals.

To achieve this aim, three objectives have been identified, which guided the investigation of the research problem:

1. To reveal and define the components of the code of medical ethics among physicians of the government and private sector hospitals at Saudi hospitals of Jeddah.
2. To determine the extent of applying medical ethics in daily practice for Saudi government and private sector hospitals.
3. To investigate the impact of medical ethics on health service quality among physicians of the government and private sector hospitals at Saudi hospitals of Jeddah.

6. OPERATIONAL DEFINITIONS

Autonomy: agreement to respect another's right to self-determine a course of action; support of independent decision making.

a) Informed consent.

b) Confidentiality and privacy.
c) Breaking bad news (Beauchamp and Childress, 2009).

Beneficence: compassion; taking positive action to help others; desire to do good; core principle of our patient advocacy (Beauchamp and Childress, 2009).

Non- maleficence: avoidance of harm or hurt; core of medical oath and physician ethics (Beauchamp and Childress, 2009).

Justice: derived from the work of John Rawls, this principle refers to an equal and fair distribution of resources, based on analysis of benefits and burdens of decision. Justice implies that all citizens have an equal right to access health service, distributed, regardless of what they have contributed or who they are (Butts and Rich, 2008).

7. RESEARCH HYPOTHESES

Based on the medical ethics code factors and health service quality the researchers formulated a number of hypotheses to assist in analyzing the research problem and fulfilling its objectives. The hypotheses are based on examining the effect of medical ethics code factors on health service quality of the western region Saudi hospitals. The general hypothesis is:

H1: medical ethics code factors have a positive significant effect on health service quality among physicians in Saudi hospitals.

This general hypothesis was divided into four sub-hypotheses:

H1a- autonomy has a positive significant effect on health service quality among physicians in Saudi hospitals.

H1b- beneficence has a positive significant effect on health service quality among physicians in Saudi hospitals.

H1c- non- maleficence has a positive significant effect on health service quality among physicians in Saudi hospitals.

H1d- justice has a positive significant effect on health service quality among physicians in Saudi hospitals.

8. RESEARCH DESIGN

This type of research is a quantitative research survey in which selective government and private sector hospitals in the Jeddah are included. This research is a descriptive analytical research of the actual relationships that may exist between dependent and independent variables as stated in the research hypotheses. The research design constructed here is based on the hypotheses formulated. These hypotheses were formulated inductively from the researcher's observation and from the literature. The descriptive part is needed to describe and identify the research factors, which constitute the ethics code components in Jeddah city hospitals. In the analytical part, the research model is being tested through examining the relationship between the ethics code components and health service quality in Jeddah hospitals in order to explore how far hospital managers perceive these factors when making their decisions regarding the introduce of health services. This research is used a cross-sectional research survey in which many hospitals operating in Jeddah health market included. This research was conducted at all health service providers sectors, located in Jeddah. Data was collected through research questionnaire with physicians in different levels at these hospitals. The population in this research is defined as all the hospitals sectors. The number of hospitals included in this research as research population was (5) hospitals. The research population consisted of all the physicians in the hospitals in Jeddah. Therefore, all the physicians called and invited to participate in the research survey, the number accounted (2871). The research sample in this research also consists of 10% of the total population accounted (287) physicians. The researcher's retrieve (176) valid research questionnaires (61%).

The sample of this research was a purposive sample. The questions addressed in this research were close-ended questions where the respondents are offered a set of answers and asked to select the answer that most closely represented their views. The first section was investigated the demographic data where the second section was concerned with investigating the key components of code of ethics, and service quality as a dependent variable.

This section was divided into five subsections which are the following:

1- *Autonomy*
2- *Beneficence*
3- *Non maleficence*
4- *and, Justice*
5- *Dependent variable which represented by health service quality.*

9. DESCRIPTIVE ANALYSIS AND DISCUSSION

This part including the result of study depends on its hypotheses:
H1: There is a significant positive relationship between autonomy and quality of health service.
H2: There is a significant positive relationship between beneficence and quality of health service.
H3: There is a significant positive relationship between non-maleficence and quality of health service.
H4: There is a significant positive relationship between justice and quality of health service.

To test this hypothesis (Multiple Regression) was applied, table (1) shows that:

Table (1): Result of Regression for Relationship between Medical Ethics Components and Quality of service

Independent variables	B	Std. Error	Beta	T	Sig.
Autonomy	0.311	0.411	0.12	2.66	0.03
Beneficence	0.110	0.321	0.10	3.83	0.04
Non malfeasance	0.131	0.261	0.18	2.78	0.04
Justice	0.102	0.412	0.16	3.19	0.02
Dependent Variable: Quality of service	**R^2 =0.462**	**Adjusted R^2 =0.493**		**F=11.650**	**P<0.05**

Y = B0 + B1X1 + B2X2 + B3X3 + B4X4 + E

Where:
Y= the predicted value on the Quality of service
B0= the Y intercept, the value of Y when all Xs are zero
X1= Autonomy
X2= Beneficence
X3= Non maleficence
X4= Justice
B= the various coefficients assigned to the IVs during the regression
E = an error term

1. There is a significant positive relationship between autonomy and quality of health service. Where the values of (Beta, T) reached (0.12, 2.66), Sig. (0.03). Therefore the first hypothesis accepted.
2. There is a significant positive relationship between beneficence and quality of health service. Where the values of (Beta, T) reached (0.10, 3.83), Sig. (0.04). Therefore the second hypothesis accepted.
3. There is a significant positive relationship between non maleficence and quality of health service. Where the values of (Beta, T) reached (0.18, 2.78), Sig. (0.04). Therefore the third hypothesis accepted.
4. There is a significant positive relationship between Justice and quality of health service. Where the values of (Beta, T) reached (0.16, 3.19), Sig. (0.02). Therefore the fourth hypothesis accepted.

5. There is a significant positive relationship between medical ethics components and quality of health service, where the values of (R Square, adjusted R Square, F) reached (0.462, 0.493, 11.650), Sig. (0.00). Therefore the General hypothesis accepted.

10. RESEARCH CONCLUSION AND RECOMMENDATION

In terms of autonomy the physician duty is to treat patients in a good manner keeping their dignity preserved with great respect, reassuring the patient to comfort him/ her keeping strict confidentiality, and privacy with a holistic approach. This totally if practiced by physician will lead to strong bonding of physician-patient relationship and trust.
Regarding the consent the physician duty is to share patients understanding and in management of his/her case in which any procedure or intervention must be agreed by patient verbally and in written format with signature providing full information to patient except in (emergency situation where lifesaving is priority).

Regarding the beneficence the physician if consider patient well being and contribute to develop their medical profession by update knowledge and continuous medical education through clinical practice research (Randomized control trials) applying evidence based medicine providing that physician deliver health care in a quality standard regarding (attitude ,skills , knowledge , and experience). In turn will lead to increase cure rate, and improve patient well-being.

In terms of Non-maleficence physicians must keep patients right considered, and practice to prevent any harm to patient by following clinical guide lines, applying policy and procedure and recognizing limitations by a proper consultations of other specialties and team work ,also seek help of others when needed , this will promote health with reduction of morbidity and mortality.

Regarding of Justice physicians must treat all patients the same without discrimination regardless of(gender , age , position ,occupation marital state.etc). Fairness in appointments ….etc
so physicians must provide comprehensive ,and continuous care in a holistic approach (physical, social, psychological, and spiritual) this will lead to a good doctor- patient relationship, and good reputation of physician himself with records in his carrier.

Finally, Health service quality if physicians practice evidence based medicine, and follow clinical guide lines with a proper use of high technology and up to date then leads to increase quality of health service, patient satisfaction and overall improve the performance of health care service.

The research recommendations as the following:

In order to have a proper health care service delivered should be performed with: *High cure rate, Decrease morbidity, Decrease mortality.*

All physicians must practice and apply the code of medical ethics principals in daily practice, and must follow policy and procedures precisely.

Physicians must practice evidence based medicine in management of cases regarding therapeutic intervention or diagnostic.

Physicians must follow clinical guide lines for each case they manage, be updated and participated in continuous medical education including (seminars, conferences, workshops,…etc.).

All physicians must participate in consultations skills course to apply Pendleton's tasks on their patients in day to day practice.

In brief the corner stone is that the medical ethics need to be flexible and open to change and adjust regularly. The medical ethics depends on the future of medicine (e.g. new procedures and techniques). Recertification of physicians and practice insurance to keep competent and decrease medical errors. Moreover, Patients charters and health education are essentials.

References:

American Bar Association, (1991) Health care advance directives. Retrieved from,http://www.abanet.org/publiced/practical/patient_self_determination_act.html

Anderson L. (2009). Writing a new code of ethics for sports physicians: principles and challenges. British Journal of Sports Medicine. 43(13):1079-82. doi: 10.1136/bjsm.2008.051086. Epub 2009 May 26.

Beauchamp, T. & Childress, F. (2009). Principles of biomedical ethics (6th ed., pp. 152-153). New York, NY: Oxford University Press.

Beauchamp, T. L., & Childress, J. F. (2009). Principles of biomedical ethics (6th ed., pp. 38-39). New York, NY: Oxford University Press.

Bell, John. (1995). "Introduction to the Code of Ethics," Proceedings of the National Medical Conventions Held in New York, May, 1846, and in Philadelphia, May, 1847. Philadelphia: Printed for the American Medical Association, T.K. & P.G. Collins, Printers, pp. 83-90.

Bostick N, Morin K, Benjamin R, Higginson D.(2006) Physicians' ethical responsibilities in addressing racial and ethnic healthcare disparities, Journal of National Medical Association, 98(8):1329-34.

Butts, J. B., & Rich, K. L. (2008). Nursing ethics across the curriculum and into practice (2nd ed., p. 48). Sunbury, MA: Jones and Bartlett.

Chisnall, P, (2001), "Marketing Research, Sixth Edition", The McGraw-Hill Publishing Company.

Creswell, J, (2003), "Research Design –Qualitative, Quantitative and Mixed Methods and Approaches", Second Edition, Thousand Oaks, Calif, Sage Publication.

De Vaus, D, (1993), "Surveys in Social Research", 3rd Edition (Sydney: Allen & Unwin).

Furrow, Barry R & Sandra H. (1991), Health care and Ethics. West publishing Co.St.Paul.MN.

Haim, A, (1993), "Does quality work? A review of relevant studies", Report no. 1043, The Conference Board, Inc., New York, NY,

Nathan Bostick, Karine Morin, Regina Benjamin, and Daniel Higginson (2006). Physicians' ethical responsibilities in addressing racial and ethnic healthcare disparities. Journal of the National Medical Association. August; 98(8): 1329–1334.

Nishimura T. (2005). The present state and problems of "The Code of Medical Ethics" in Japan. Journal of International Bioethique. Mar-Jun;16(1-2):41-50, 191.

O'Connor M. (2010) Codes of professional conduct for Australian Defence Force military physicians: even mating the serpent? The Journal of Law Medicine. 2010 Sep;18(1):103-23.

Ojasalo, J, (1999), "Quality Dynamics in Professional Services", Swedish School of Economics and Business Administration, Helsinki,.

Palmer, Adrian, (2001), "Principles of Services Marketing", Third Edition, McGraw-Hill Publishing Company UK.

Popović M.Klinika za digestivnu hirurgiju Prva hirurska klinika KCS Beograd. (2011) Hippocratic Oath: professional or ethic code? Acta Chir Iugosl.;58(3):9-14;

Renner, C; Palmer, E, (1999), "Outsourcing to increase service capacity in a New Zealand hospital", Journal of Management in Medicine, Volume 13 Number 5 pp. 325-338.

Saeed KS.(1999) How physician executives and clinicians perceive ethical issues in Saudi Arabian hospitals, Journal of Medical Ethics. 1999 Feb;25(1):51-6.