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Letter to the Editor

The Elephant in Ethiopian Healthcare: Addressing a Culture of Silence

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I've been an ICU nurse for 25 years. For the last nine, I've been working in Ethiopia. Although I will live out the rest of my life here, I accept the fact that I will always be considered a Farengi. As such, some ICU patient-care policies and initiatives I've proposed over the years have been met with the likes of, "This is Ethiopia, not America."

But if change could result in improving the health of our patients, is it not our professional and ethical responsibility to address any barriers that might hinder this progress?

Enter our metaphorical Elephant.

Ethiopians share quick and easy fellowships. This camaraderie reflects visceral trust, strength, and common character. It is beautiful thing and something that endears me to Ethiopia and her people.

But, in healthcare settings, these quick friendships can be a liability when clinicians are disinclined to confront their fellow clinicians in the face of substandard performance. Frustratingly, I have observed this "silence," or failure to comment enumerable times over the years, despite the fact clinicians may be aware of the consequences.

The widespread failure to expose or critique poor-quality practices--in any field of endeavor--not only enables those failures but can even result in the standardization of inadequate performance. Such a scenario has the potential of dooming a system to long-term mediocrity. And in hospitals, reluctance to shed light on errant practices or behaviors can be considered not only an ethical (1) breach but can result in serious consequences.

Frequently, I've encountered floor areas around beds scattered with used gauze pads, discarded IV lines, empty bottles, suction tips, plaster, etc., yet no one asks, "Why the mess"? Surely some families must wonder whether such messiness translates into equally inattentive clinical care.

What about fresh post-op patients whose analgesia orders are inadequate. We all know the various negative effects of persistent pain. Yet, too often, I've witnessed staff remain silent, somehow reluctant to confront the physician, thus allowing the continuation of unnecessary patient suffering.

A study published in 2019 found that pain management of Ethiopian post operative patients was inadequate in well over 50% of patients (2).

Can it be that so many clinicians actually lack empathy?

Some years back I asked a senior consultant to wash his hands before examining one of our patients. He ignored my request saying," You don't understand Habeshas." I was shocked by his cavalier attitude and equally upset that no one else backed me up with this simple, yet fundamental care request. Is there any practicing clinician today who is not aware of the potential consequences of poor hand hygiene practices on vulnerable patients?

A 2019 study conducted in Gondar on practices of hospital infection prevention concluded that even when clinicians possessed good knowledge regarding issues surrounding hospital acquired infections, as well as a "sympathetic attitude" it did not translate into prudent practices (3).

We often talk about treating patients ethically and with compassion. Yet, when we do not (i.e., exposing a patient without the use of a privacy screen or curtain), far too often no one speaks up on the patients' behalf to demand basic dignity.

Finally, there are those who are so unaccustomed to any form of criticism or accountability that they react angrily when confronted. This "invincibility" should not be a total surprise when the system, itself, tacitly approves of this, "go along, to get along" approach.

What's the source of this fear, reluctance, or apathy to honestly address clinical or attitudinal shortcomings? Is being assertive simply contrary to the gentle nature of most Ethiopians?

I realize it takes courage to comment on a co-worker's quality of care. But isn't that a small risk to take for the sake of improved patient care?

Perhaps clinicians see no benefit in challenging behaviors. Or, as a colleague suggested, perhaps the penalties of substandard performance are simply inconsequential.

I do not believe there is a silver-bullet answer to this issue. But, at the very least, I believe medical and nursing schools' curriculums must include dedicated programs emphasizing the critical concept of constructive, congenial criticism. They must also examine the dangers of embracing, however indirectly, "cultures of silence."

Ethiopia is replete with superb clinicians whose brainpower and commitment can, without doubt, move mountains. But we must step out of our comfort zones and begin an honest and vigorous conversation about the status quo of behaviors that can affect the very quality of patient care.

Otherwise, I fear Ethiopian acute care will never advance beyond the bar of mediocrity and the elephant that resides in too many of our units will become a permanent resident.

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