Original Research Article

Journal of College of Medical Sciences-Nepal, Vol-21, No.4, Oct-Dec 2025

ISSN: 2091-0657 (Print); 2091-0673 (Online) Open Access
DOI: 10.3126/jcmsn.v21i4.87450

Knowledge and Practice of Medical Ethics, Negligence, and Patient Safety among Healthcare Professionals in a Tertiary Care Center in Central Nepal

Kaschev Shrestha[1], **Hari Prasad Upadhyay**[2], **Arish Upreti**[3], **Yoveen Kumar Yadav**[4], **Devendra Man Palikhe**[5], **Natasha Shrestha**[6]

[1]Department of Forensic Medicine, College of Medical Sciences, Bharatpur, Chitwan Nepal, [2]Department of Statistics, Birendra Multiple Campus, Bharatpur, Chitwan, [3]Department of Community Medicine, Nepalgunj Medical College, Kohalpur, Banke, [4]Department of Public Health, Hope International College, Mahalaxmistan, Lalitpur, [5]Department of Forensic Medicine, Manipal College of Medical Sciences, Pokhara, [6]Department of Orthodontics and Dentofacial Orthopaedics, College of Medical Sciences, Bharatpur, Chitwan, Nepal.

ABSTRACT

Background

Medical ethics, patient safety, and awareness of medical negligence are fundamental components of quality healthcare. Healthcare professionals' knowledge and practices in these areas are critical to ensuring patient well-being and ethical clinical conduct. Previous studies in Nepal and South Asia have highlighted gaps in ethical knowledge and inconsistent practices among doctors, nurses, and medical students. The objective of this study is to assess the knowledge and practices related to medical ethics, medical negligence, and patient safety among healthcare professionals in a tertiary care center in Central Nepal.

Methods

A cross-sectional study was conducted among 207 healthcare professionals. Data on sociodemographic characteristics and knowledge levels were collected using a structured questionnaire. Knowledge was categorized as low (<50%), average (50-70%), and excellent (>70%). Descriptive statistics and chi-square tests were applied to explore associations between knowledge and sociodemographic variables.

Results

The majority of participants (72.9%) demonstrated excellent knowledge, 19.3% had average knowledge, and 7.7% showed low knowledge. None of the variables were found to be statistically significant (p-value>0.05).

Conclusions

The study shows that healthcare professionals in Central Nepal have strong knowledge of medical ethics, patient safety, and medical negligence. Most participants understood key ethical principles and demonstrated confidence in managing ethical dilemmas. Despite gaps in formal training and access to ethics committees, adherence to safety protocols was high across all professional groups. These findings emphasize the need for structured ethics education and regular training to further strengthen ethical practices in clinical settings.

Keywords: medical ethics; medical negligence; patient safety; healthcare professionals; Nepal.

Correspondence: Dr. Kaschev Shrestha, Department of Forensic Medicine, College of Medical Sciences, Bharatpur, Chitwan Nepal. Email: shresthakaschev@gmail.com, Phone: +977-9845237333. **Article received**: 2025-10-16. **Article accepted**: 2025-11-12. **Article published**: 2025-12-28.

INTRODUCTION

Ethics is the study of right and wrong, offering guidance on how individuals should act to ensure fairness, uphold responsibilities, and contribute to societal welfare.[1] Medical ethics, a branch of professional ethics within bioethics, emphasizes patient rights, dignity, and autonomy, guiding healthcare professionals in addressing dilemmas and ensuring coordinated, cost-effective, and high-quality care.[2-4] Historically, unethical practices in mental health care, such as Bedlam tours in 17th-century London and non-consensual experiments during Nazi and Soviet regimes, highlighted the urgent need for ethical frameworks. This led to milestones like the Nuremberg Code (1947), Declaration of Helsinki (1964), Belmont Report (1979), and Beauchamp and Childress's Four Principles (1985), which focus on autonomy, beneficence, non-maleficence, and justice.[2,3,5,6] Negligence in healthcare refers to failure to meet accepted standards of care, requiring proof of duty, breach, causation, and damages.[7–9] Patient safety, based on the principle of "First, do no harm," seeks to minimize preventable harm, yet global evidence shows persistent risks with serious human and financial consequences.[10,11] This study aims to assess healthcare professionals' knowledge and practices regarding medical ethics, negligence, and patient safety in a tertiary center in central Nepal.

METHODS

An analytical cross-sectional study was conducted among healthcare professionals in the Department of Forensic Medicine of College of Medical Sciences Teaching Hospital, Bharatpur, Chitwan, Nepal. Ethical approval was obtained from the Institutional Review Committee of the College of Medical Sciences Teaching Hospital (COMSTH-IRC/2025-039). The study was carried out over a period of six months (February to July 2025) among healthcare professionals working in tertiary care hospitals in Bharatpur, Chitwan. The study population included doctors, nurses, and health officers, with a calculated sample size of 196, determined using the formula for an infinite population at a 95% confidence level, 50% prevalence, and a 7% margin of error. A non-probability convenience sampling method was employed for participant selection. The inclusion criteria comprised registered medical professionals currently working in tertiary care institutions, while non-registered healthcare workers, medical students, administrative or non-clinical staff, professionals on long-term leave, and those unwilling to provide consent were excluded. Data were collected using a structured, self-administered online questionnaire developed in Google Forms. The questionnaire consisted of two sections: Section I included socio-demographic characteristics (age, gender, designation, years of experience, workplace), and Section II contained knowledge-based multiple-choice questions related to medical ethics, medical negligence, and patient safety. The survey link was distributed electronically via official emails and professional groups, and informed consent was obtained electronically before participation. Each correct response was scored as one and each incorrect response as zero, with overall knowledge categorized as low (<50%), average (50–70%), or excellent (>70%). The collected data were exported to Excel, checked for completeness and accuracy, and then analyzed using SPSS version 20. Both descriptive and inferential statistical tools were applied. For descriptive statistics, frequencies and percentages were calculated for categorical variables, while means and standard deviations were computed for continuous variables. For inferential statistics, the chi-square test was used to assess associations between categorical variables, and a p-value of <0.05 was considered statistically significant.

RESULTS

The majority of participants were below 30 years of age (75.8%), followed by 23.2% aged 30–40 years and only 1% above 40 years. Females comprised 57% of the respondents, while males accounted for 43%. Most were unmarried (69.6%), and 30.4% were married. In terms of education, 55.6% held a bachelor's degree, 23.7% a diploma, and 20.8% a master's degree or higher. Regarding religion, Hindu participants dominated (86%), followed by Buddhists

(11.1%), while Christians, Muslims, and others each accounted for 1%. Professionally, 55.6% were doctors, 18.4% nurses, 11.1% from other categories, 10.1% technicians, and 4.8% pharmacists (Table 1).

Table 1. Sociodemographic information of respondents. (n=207)

Variables	Frequency (%)
Age (years)	
<30	157(75.8)
30-40	48(23.2)
>40	2(1)
Sex	
Female	118(57)
Male	89(43)
Marital	
Married	63(30.4)
Unmarried	144(69.6)
Education	
Bachelors	115(55.6)
Diploma	49(23.7)
Master's degree or above	43(20.8)
Religion	
Hindu	178(86)
Buddhist	23(11.1)
Christian	2(1)
Muslim	2(1)
Other	2(1)
Profession	
Doctor	115(55.6)
Nurse	38(18.4)
Other	23(11.1)
Pharmacist	10(4.8)
Technician	21(10.1)

Among the participants, 37.7% had received training in medical ethics, while 62.3% had not. About one-third (33.3%) were very familiar with ethical guidelines, 57% were somewhat familiar, and 9.7% were not familiar. Access to an ethics committee was reported by 37.2%, while 33.8% had no access, and 29% were unsure. Ethical dilemmas were encountered rarely (32.4%), weekly (28%), daily (21.7%), and monthly

Table 2. Information of the respondent on different statements of ethics. (n=207)

Statement	Frequency (%)
Received training in medical ethics	
No	129(62.3)
Yes	78(37.7)
Familiar ethical guidelines	
Not familiar	20(9.7)
Somewhat familiar	118(57)
Yes very familiar	69(33.3)
Access to an ethics committee	
No	70(33.8)
Not sure	60(29)
Yes	77(37.2)
Encounter ethical dilemmas	
Daily	45(21.7)
Monthly	37(17.9)
Rarely	67(32.4)
Weekly	58(28)
Resolving ethical dilemmas in healthcare	
Not confident	18(8.7)
Less confident	58(28)
Confident	110(53.1)
High confident	16(7.7)
Very confident	5(2.4)
Received training	
No	167(80.7)
Yes	40(19.3)
Have you ever encountered	
No	172(83.1)
Yes	35(16.9)
The institution conducts training on ethics	
No	161(77.8)
Yes	46(22.2)
Rate your awareness	
Not aware	15(7.2)
little aware	43(20.8)
Aware	116(56)
More aware	17(8.2)
Very aware	16(7.7)
Familiar with the WHO's ethical norms	
No	99(47.8)
Yes	108(52.2)
Hand hygiene protocols	
Always	145(70)
Often	54(26.1)
Rarely	2(1)
Sometimes	6(2.9)

(17.9%). More than half (53.1%) felt confident in resolving ethical dilemmas, while smaller proportions reported being less confident (28%), not confident (8.7%), highly confident (7.7%), or very confident (2.4%). Only 19.3% had received training in related areas, and 16.9% had previously encountered such issues. Institutional conduct regarding ethics was reported by 22.2%, while 77.8% denied it. In terms of awareness, 56% were aware, 20.8% a little aware, 8.2% more aware, 7.7% very aware, and 7.2% not aware. Familiarity with WHO guidelines was noted among 52.2% of participants. Regarding hand hygiene, 70% always followed protocols, 26.1% often, while only a small proportion followed them sometimes (2.9%) or rarely (1%) (Table 2).

In this study, the majority of participants (80.2%) correctly identified non-maleficence as the rule in medical ethics meaning "do no harm," while 90.8% recognized justice as providing healthcare fairly to everyone. Honesty in patient care, or veracity,

Table 3. Knowledge of respondents on each question. (n=207)

Questions	Correct answer	Frequency (%)
The rule in medical ethics that means "Do no harm" is	Not causing harm (Non-maleficence)	166(80.2)
The principle of justice in healthcare refers to	Giving healthcare fairly to everyone	188(90.8)
Being honest and giving correct information to patients is known as	Telling the truth (Veracity)	159(76.8)
Doing good for the patient (beneficence) is shown by	Giving pain relief to a dying patient	117(56.5)
When a patient refuses life-saving treatment, the principle involved is	Patient's right to choose (Autonomy)	176(85.0)
An important requirement to prove medical negligence is	Breaking the duty to care	84(40.6)
An example of negligence is	Missing a diagnosis that a good doctor should catch	186(89.9)
If a healthcare worker is found guilty of negligence, the consequence can be	Legal or official punishment	168(81.2)
Healthcare workers can avoid being blamed for negligence by	Giving good care and writing everything clearly	192(92.8)
When a possible mistake in patient care is seen, the first step should be	Ask your senior	120(58.0)
If the wrong medicine is given by mistake, the immediate action should be	Tell your supervisor and check the patient	196(94.7)
If a colleague is doing something unsafe, the first step should be	Talk to them directly	147(71.0)
Informed consent before performing a procedure or treatment should be obtained	Always	146(70.5)
When there is a language barrier, patient understanding before treatment should be ensured by	Using a translator or interpreter	82(39.6)
The potential risks and benefits of treatment should be explained to patients	Yes, always	169(81.6)
Patient confidentiality during discussions and documentation should be maintained	Always	130(62.8)
When a safety hazard is identified in the hospital, the correct practice is	Report it immediately to the responsible authority	191(92.3)
A key step to protect oneself from accusations of medical negligence is	Following institutional protocols and documenting care properly	194(93.7)
If a patient demands a harmful and non-evidence-based treatment, the ethical and safe response is	Refuse the treatment and explain the risks and lack of benefit	162(78.3)
If overworked and fatigued but assigned a critical patient, the most ethical and safe response is	Immediately inform your supervisor and request support or replacement	181(87.4)

was acknowledged by 76.8%, and 56.5% linked beneficence to giving pain relief to dying patients. Autonomy, reflected in a patient's right to refuse life-saving treatment, was identified by 85.0%. Regarding medical negligence, 40.6% pointed to a breach of duty of care, and 89.9% cited missing a diagnosis as an example. A total of 81.2% understood negligence could lead to legal punishment, while 92.8% emphasized proper care and documentation as preventive measures. In handling mistakes, 58.0% would consult a senior, and 94.7% stated that reporting to a supervisor and checking the patient was essential if wrong medication was given. Unsafe practices by colleagues were addressed directly by 71.0%. On informed consent, 70.5% stressed it must always be obtained, and 39.6% recommended using translators when language barriers existed. Explaining risks and benefits was endorsed by 81.6%, and maintaining confidentiality was supported by 62.8%. Most respondents (92.3%) would report hospital safety hazards immediately, while 93.7% highlighted following protocols and documentation to avoid negligence accusations. Ethically, 78.3% would refuse harmful non-evidence-based treatment, and 87.4% emphasized informing supervisors when fatigued but assigned a critical patient (Table 3).

The majority of participants demonstrated excellent knowledge, with 151 (72.9%) scoring above 70%. A smaller proportion, 40 (19.3%), had an average level of knowledge (50–70%), while only 16 (7.7%) exhibited a low level of knowledge, scoring below 50% (Table 4).

Table 4. Level of knowledge. (n=207)

Level of knowledge	Frequency (%)
Low (<50%) level	16(7.7)
Average (50%–70%) level	40(19.3)
Excellent (>70%) level	151(72.9)

Most participants across all sociodemographic groups had excellent knowledge, with slightly higher proportions among those aged 30–40 years (77.1%), males (74.2%), married respondents (76.2%), and doctors (78.3%). Education and religion type also showed consistently high knowledge levels, though variations existed. However, none of the sociodemographic variable was found to be statistically significantly associated with the level of knowledge (p-value >0.05) (Table 5).

DISCUSSION

This research was conducted to assess the healthcare professionals' knowledge and practices regarding medical ethics, medical negligence, and patient safety in a tertiary care center in Central Nepal. The sociodemographic profile showed that a majority of participants (75.8%) were below 30 years of age, followed by 23.2% in the 30-40 years group, while only 1% were above 40 years, highlighting a predominance of young professionals. Females accounted for 57% of respondents compared to 43% males. Most participants were unmarried (69.6%), whereas 30.4% were married. In terms of education, more than half (55.6%) held a bachelor's degree, while 23.7% had a diploma and 20.8% a master's degree or higher. Religion-wise, Hindu participants constituted the majority (86%), followed by Buddhists (11.1%), while Christians, Muslims, and others each represented 1%. Professionally, 55.6% were doctors, 18.4% nurses, 11.1% from other professions, 10.1% technicians, and 4.8% pharmacists. The present study revealed that a majority of healthcare professionals (72.9%) possessed excellent knowledge of medical ethics, while 19.3% demonstrated average knowledge and 7.7% low knowledge. These findings suggest comparatively higher than that reported in much of the existing literature, both nationally and internationally. Research conducted by Hirachan and Shrestha found striking disparities in Pokhara Valley, where only 56.5% of doctors and 1% of nurses were aware of the Hippocratic Oath, and awareness of the Nuremberg Code and Helsinki Declaration was negligible.[12] Similarly, Nepal et al., reported limited awareness among undergraduate medical students, particularly regarding patients' rights and treatment, despite better knowledge in clinical students compared to

Table 5. Association between level of knowledge and selected sociodemographic variables. (n=207)					
Variables	**Level of knowledge**			**Chi-square**	**p-value**
	Low n(%)	**Average n(%)**	**Excellent n(%)**		
Age (years)					
<30	12(7.6)	33(21)	112(71.3)	1.726	0.786
30-40	4(8.3)	7(14.6)	37(77.1)		
>40			2(100)		
Sex					
Female	7(5.9)	26(22)	85(72)	2.22	0.329
Male	9(10.1)	14(15.7)	66(74.2)		
Marital					
Married	6(9.5)	9(14.3)	48(76.2)	1.697	0.428
Unmarried	10(6.9)	31(21.3)	103(71.5)		
Education					
Bachelors	7(6.1)	21(18.3)	87(75.7)	2.539	0.638
Diploma	4(8.2)	12(24.5)	33(67.3)		
Master's degree or above	5(11.6)	7(16.3)	31(72.1)		
Religion					
Buddhist		5(21.7)	18(78.3)	4.6	0.799
Christian			2(100)		
Hindu	16(9)	35(19.7)	127(71.3)		
Muslim			2(100)		
Other			2(100)		
Profession					
Doctor	6(5.2)	19(16.5)	90(78.3)	8.03	0.431
Nurse	4(10.5)	6(15.8)	28(73.7)		
Other	3(13)	8(34.8)	12(52.2)		
Pharmacist	1(10)	2(20)	7(70)		
Technician	2(9.5)	5(23.8)	14(66.7)		

pre-clinical ones.[13] Adhikari et al., also demonstrated moderate knowledge but poor application of ethical principles in practice, citing barriers such as lack of training, cultural influences, and systemic constraints in resource-poor settings.[14] Raut et al., emphasized that without addressing cultural barriers, poor infrastructure, and inadequate guidelines, the principles of autonomy, justice, beneficence, and non-maleficence remain difficult to operationalize.[15] In contrast, Shrestha et al., showed that formal medical ethics education significantly improved doctors' knowledge, attitudes, and practices at a tertiary hospital, reinforcing the importance of integrating ethics into the medical curriculum. More recently, legal perspectives have also gained attention.[16] An analysis of judicial precedents highlighted inconsistencies in handling medical negligence cases in Nepal, underlining the urgent need for clear legal definitions and procedural safeguards. Together, these studies suggest that while awareness is improving, especially with formal education, large gaps remain in uniform knowledge and application across cadres and institutions.[17]

Evidence from South Asia mirrors these concerns.

Ateeb et al., in Pakistan reported limited formal training and frequent ethical dilemmas in practice, influenced by designation, gender, and experience.[18] In India, Thangavelu et al., found that although 65.2% of healthcare professionals demonstrated adequate knowledge, only 34.4% adhered to good or fair practices, with common lapses such as failing to obtain proper consent.[19] Similarly, Reddy and Abhinandana reported poor awareness of medicolegal requirements among interns and residents in Karnataka, highlighting the need for curriculum reform and CME programs.[20] In Sri Lanka, Ranasinghe et al.[21] documented that 81.2% of doctors had poor knowledge, though most expressed positive attitudes toward training, and Jayalath et al., noted gaps between knowledge and practice among specialists. These findings align with the present study in demonstrating variability in knowledge but also show that knowledge alone may not guarantee ethical practice.[22]

Globally, challenges persist. Mufti et al.,[23] in Saudi Arabia and Ismail & Kulsum[24] in Indonesia revealed inadequate knowledge among medical students and residents, though attitudes toward ethics were positive. A study in Ethiopia showed that while 75.7% of doctors were knowledgeable, attitudes varied significantly depending on education level and experience. Conceptual works, such as those by Ballesteros Del Olmo and Varkey, underscore that ethical principles must be central to clinical decision-making, with negligence and malpractice often stemming from their neglect.[7]

Limitations

This study was conducted in a single tertiary care center using a convenience sample, which may limit generalizability to all healthcare professionals in Nepal. Responses were self-reported, which could introduce social desirability bias. Moreover, the study assessed knowledge rather than actual ethical behavior in clinical practice.

CONCLUSIONS

The findings of this study indicate that healthcare professionals in the tertiary center in Central Nepal possess a strong foundational knowledge of medical ethics, patient safety, and medical negligence. Participants demonstrated a clear understanding of key ethical principles, including non-maleficence, beneficence, justice, and autonomy, and were aware of strategies to prevent errors, maintain confidentiality, and uphold patient rights. Despite a substantial proportion lacking formal training or consistent access to ethics committees, most professionals expressed confidence in managing ethical dilemmas and adhered to safety and hygiene protocols. Knowledge levels were consistently high across all sociodemographic groups, reflecting widespread awareness among doctors, nurses, and allied health staff. However, the study highlights the ongoing need for structured ethics education, institutional support, and regular training to bridge gaps in practical application and ensure that ethical principles are consistently integrated into clinical practice. Strengthening these areas will contribute to safer, more accountable, and patient-centered healthcare in Nepal.

Conflict of interest: None

Funding: None

REFERENCES

1. Lalal N, Mishal S, Padhi A, Sharma A, Audhkhasi A, Arora P, et al. Eco-Anxiety: Impact on generation Z's mental health and the contemporary significance of environmental awareness and education. International Journal of Policy Sciences and Law. 2022;2(02"):3313–31. [Google Scholar]
2. Young M, Wagner A. Medical Ethics. 2022 Nov 28. StatPearls [Internet] Treasure Island (FL): StatPearls Publishing. 2023.[Google Scholar]
3. Childress JF, Beauchamp TL. Principles of biomedical ethics. Oxford University Press Oxford.–; 1994. [Google Scholar]
4. Council NN. National Guidelines on Continuing

Nursing and Midwifery Education (Continuing Professional Development) for Nurses and Midwives. [Google Scholar]

5. Childress JF, Meslin EM, Shapiro HT. Belmont revisited: Ethical principles for research with human subjects. Georgetown University Press; 2005. [Link]
6. World Medical Association. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. JAMA. 2013;310(20):2191–4. [DOI]
7. Del Olmo JCB. Medical Act and Negligence: Ethical Concerns. In: Bioethics in Medicine and Society. IntechOpen; 2021. [DOI]
8. Pandit M, Pandit S. Medical negligence: Coverage of the profession, duties, ethics, case law, and enlightened defense-A legal perspective. Indian Journal of Urology. 2009;25(3):372–8. [DOI]
9. Wensley C, Botti M, McKillop A, Merry AF. Maximising comfort: how do patients describe the care that matters? A two-stage qualitative descriptive study to develop a quality improvement framework for comfort-related care in inpatient settings. BMJ Open. 2020;10(5):e033336. [DOI]
10. Bose S, Jyothula N, Kumar Andey U, Chintada GS, Roy P. Assessment of Knowledge and Awareness about Medico Legal Issues among Interns and Post GraduateStudents in Rajahmundry, Andhra Pradesh. Indian Journal of Forensic Medicine & Toxicology. 2021;15(4). [DOI]
11. Varkey B. Principles of clinical ethics and their application to practice. Medical Principles and Practice. 2021;30(1):17–28. [DOI]
12. Hirachan N, Shrestha N. Knowledge, attitude and practice of medical ethics among doctors and nurses in Pokhara Valley, Nepal. Kathmandu Univ Med J. 2022;20(4):488–92. [DOI] [PMID]
13. Nepal S, Atreya A, Kanchan T. Awareness and perceptions of medical students towards health care ethics a study from Nepal. Kathmandu Univ Med J. 2017;60(4):313–8. [Google Scholar]
14. Adhikari S, Paudel K, Aro AR, Adhikari TB, Adhikari B, Mishra SR. Knowledge, attitude and practice of healthcare ethics among resident doctors and ward nurses from a resource poor setting, Nepal. BMC Medical Ethics. 2016;17(1):68. [DOI]
15. Raut S, Kumar A. Medical ethics in clinical practice in Nepal: challenges and way forward. Journal of Universal College of Medical Sciences. 2018;6(2):69–72. [DOI]
16. Shrestha C, Shrestha A, Joshi J, Karki S, Acharya S, Joshi S. Does teaching medical ethics ensure good knowledge, attitude, and reported practice? An ethical vignette-based cross-sectional survey among doctors in a tertiary teaching hospital in Nepal. BMC Medical Ethics. 2021;22(1):109. [DOI]
17. Bhusal S. Study on Medical Negligence: A Legal Analysis Of Nepalese Laws And Judicial Precedents. Available at SSRN 5068933. 2024; (SSRN). [DOI]
18. Ateeb M, ul Haq I, Zakki SA, Altaf E, Junaid M, Ali M, et al. Assessment of the understanding and awareness of bioethics among healthcare professionals in all public and private hospitals of Haripur district, Pakistan: a multicentre cross-sectional study. BMJ Open. 2024;14(8):e083521. [DOI]
19. Thangavelu PD, Janakiraman B, Pawar R, Shingare PH, Bhosale S, Souza RD, et al. Understanding, being, and doing of bioethics; a state-level cross-sectional study of knowledge, attitude, and practice among healthcare professionals. BMC Medical Ethics. 2024;25(1):30. [DOI]
20. REDDY PS, ABHINANDANA R. Awareness of Medicolegal Issues among Interns and Resident Doctors at a Tertiary Care Hospital in Kolar, Karnataka, India: A Cross-sectional Study. Journal of Clinical & Diagnostic Research. 2023;17(8). [DOI]
21. Ranasinghe A, Fernando B, Sumathipala A,

Gunathunga W. Medical ethics: knowledge, attitude and practice among doctors in three teaching hospitals in Sri Lanka. BMC Medical Ethics. 2020;21(1):69. [DOI]

22. Jayalath M, Nanayakkara R, Jayasundara K, Abeysekara C, Abeynayake A. Knowledge, Attitudes and Practices towards Medical Ethics among Specialist Medical Officers of Selected Allopathic Healthcare Institutions in Sri Lanka: Conocimiento, actitudes y prácticas hacia la ética médica entre los funcionarios médicos especialistas de instituciones sanitarias alopáticas seleccionadas en Sri Lanka. South Florida Journal of Health. 2021;2(3):318–29. [DOI]
23. Althagafi NA, Alahmad G. Ethics education among obstetrics and gynecologists in Saudi Arabia: a cross-sectional study. BMC Medical Education. 2023;23(1):872. [DOI]
24. Dzi KT, Ndong ON, Menkem EZ, Tendongfor N. Bioethics Knowledge, Attitudes, and Practices among Healthcare Professionals in Cameroon: A survey of doctors and nurses in Cameroon's Southwest Region. 2024.[Link]

Citation: Shrestha K, Upadhyay HP, Upreti A, Yadav YK, Palikhe DM, Shrestha N. Knowledge and Practice of Medical Ethics, Negligence, and Patient Safety among Healthcare Professionals in a Tertiary Care Center in Central Nepal. JCMS Nepal. 2025; 21(4): 381-389.