

Ethical decision making by British general practitioners

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SUMMARY. *General practitioners in England and Wales were sent a questionnaire asking how they would handle the ethical problems posed by six case vignettes and their reasons for their decisions. The ethical problems included: how much information to divulge to patients, how extensively a physician should become involved in the lifestyles of patients and how to deal with a possible family problem. The varying patterns of response to the six cases suggested that ethical issues are resolved in a case-by-case, not a theoretical, basis.*

Introduction

MEDICAL ethics has attracted much attention recently, particularly in the area of life and death issues such as euthanasia, abortion and organ transplantation. Yet general practitioners in their day to day encounters with patients also confront fundamentally important, if less dramatic, ethical issues, such as what information to share with a patient and whether to intervene in a patient's lifestyle. These more prosaic ethical issues deserve attention as well, if only because they are more common.

Several theoretical investigations of ethical problems in primary care have appeared recently,^{1,2} and Canadian researchers have developed a questionnaire that has been used in an international study of the ethical decision making of family doctors in England and Wales, Canada and the United States of America. This paper reports the results from England and Wales. The results of the Canadian study have already appeared³ and the results of the American study are in the final stage of analysis. Administering the questionnaire in different countries will make it possible to explore cultural influences on ethical decision making in the future.

All three studies had two main aims. One was to determine whether the ethical decisions of general practitioners have a theoretical or pragmatic basis. In other words, would doctors adopt a consistent theoretical position for all the cases in the questionnaire, or would they respond to the contextual differences in the case? The other aim was to identify characteristics such as sex, age, religious affiliation, and type of practice that might affect ethical decision making. This paper is confined to

the first aim; the second aim will be the subject of a future publication.

Method

Data collection

Because the Canadian study had sampled the members of the College of Family Physicians of Canada, the British study used members of the Royal College of General Practitioners as a sampling frame. A one-in-seven sample with a random start was taken of the fellows, members and associates in 25 faculties in England and Wales listed in the *1984 Members reference book*. A questionnaire containing six case vignettes was sent to 1187 general practitioners in the autumn of 1985. In keeping with a modified total design method for conducting mailed surveys,⁴ the questionnaire was presented as a booklet with the six cases preceding questions about demographic and practice characteristics. A personalized, signed covering letter accompanied the questionnaire. One follow-up letter was sent to non-respondents after six weeks.

Case vignettes

The six cases in the questionnaire, precis of which follow, were based upon actual problems presented to Canadian family doctors. The descriptions of the cases were modified slightly to make them applicable to the British setting.

Case A. A single woman in her twenties who had one episode of temporary blindness is examined by the family doctor who finds no physical abnormalities. He refers her to an ophthalmologist, whose report is negative. The doctor is unsure about whether to mention the possibility of multiple sclerosis to her.

Case B. A post-menopausal patient on cyclic hormones develops vaginal bleeding. The doctor wants her to have a dilatation and curettage to rule out cancer of the endometrium but the hormones could be discontinued instead to see if the bleeding stops.

Case C. A 17-year-old man has been in hospital four times recently for asthma that is not well controlled despite the use of drugs including oral steroids. The patient continues to smoke two to three packs of cigarettes a day.

Case D. A woman in her mid-twenties comes to the family doctor because her boyfriend has venereal disease, although she has no symptoms. Cultures for gonorrhoea are taken from the urethra, cervix and anus. A positive culture is obtained from only the anal swab.

Case E. A married woman is seen in the emergency department with three vaginal lacerations requiring suturing under general anesthesia. The patient finally admits the lacerations occurred when her husband inserted a beer bottle into her vagina.

Case F. A doctor receives an operative note regarding a vasectomy performed on a patient whom he had not referred. The doctor has cared for the family for 10 years and knows that the patient's wife had a tubal ligation two years ago.

Cases A and B deal with control of information. Patients come to doctors expecting explanations of their problems, but should the doctor in case A mention as serious and unpredictable a disease as multiple sclerosis as a possible cause of the patient's blindness? To what extent can the doctor in case B withhold

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or manipulate information to try to achieve the outcome he prefers? Cases C, D and E raise the issue of how extensively a doctor may intervene in a patient's lifestyle when that lifestyle is jeopardizing the patient's health. Case F raises the question of whether general practitioners may deal with sensitive issues that patients have not directly referred to them.

Questionnaire on case vignettes

In response to each case the general practitioners answered two structured questions. Figure 1 shows the questions for case F. Question 1 presented five courses of action that were ranked on a five-point scale according to degree of doctor control from low doctor control, that is, high patient control, at one end (score 1) to high doctor control (score 5) at the other. The scores for case F in the order shown in Figure 1 were 5, 4, 3, 1, 2. The assignments of scores for all cases were, with minor modifications, confirmed by a panel of doctors and philosophers whom we deemed experts in the area.

In question 2 the general practitioners were asked to choose reasons for the course of action they selected. Six reasons were presented for each case; some were intended to be distractors, and others were written to exemplify concerns about patient autonomy and patient welfare. The panel of experts again judged which reason best represented patient autonomy and which reason best represented patient welfare, and only these two items were scored for each case. When the 'patient autonomy' reason

Case F. A doctor receives an operative note regarding a vasectomy performed on a patient whom he had not referred. The doctor has cared for the family for 10 years and knows that the patient's wife had a tubal ligation two years ago.

1. *If you were the general practitioner in this case, which of the following courses of action would you consider most appropriate? Tick one response only.*

- Ring up Mr T and discuss the issue with him
- Raise the issue with Mr T at a subsequent consultation
- Raise the issue with Mr T at a subsequent consultation only if signs of marital conflict appear
- Throw the note away and forget about it
- Discuss the issue only if Mr T brings it up at a subsequent consultation

2. *Consider the following possible reasons for the decision, again assuming you are the general practitioner in this case.*

- (a) The confidentiality of information about Mr T
- (b) Whether Dr C feels comfortable discussing sexual matters with patients
- (c) The probability that Mr T is having an extra-marital affair which might cause trouble with his marriage
- (d) Whether Mr T has breached his trust with Dr C by bypassing him to get the vasectomy
- (e) The well-being of the T family
- (f) Mr T's freedom to make decisions about his own health care

From the list of considerations above, select three that were most important in choosing a course of action for this case and list them below in order of significance.

- Most important _____
- Second most important _____
- Third most important _____

Figure 1. Questionnaire for case F.

was chosen (response (f) on Figure 1) as the most important, second most important and third most important reason, scores of 3, 2 and 1 were assigned respectively. The 'patient welfare' reason (response (e) on Figure 1) was scored in the same manner.

Spearman rank correlation coefficients were calculated between each general practitioner's 'doctor control' score on course of action and his or her score on 'patient welfare' and on 'patient autonomy' reasons for action. These results allowed two hypotheses to be tested: that courses of action representing 'patient control' would be associated with 'patient autonomy' reasons, and that courses of action representing 'doctor control' would be associated with 'patient welfare' reasons.

Results

Respondents

The response rate from the 1187 doctors was 58.6% (696). Two hundred and thirty two envelopes were returned because the doctor had moved, ceased to practice, or retired. This information was not available at the sampling stage, and when these ineligible doctors were removed from the denominator, the response rate rose to 72.9% (696/955).

The 696 respondents were compared with the 491 who refused to reply or were ineligible. The two groups were similar in terms of sex and country of qualification. They were different with respect to year of graduation, with more non-responders graduating before 1946, probably because the non-respondent group contained a large number of retired general practitioners.

The respondents had been in practice for a mean of 14.7 years (standard deviation = 11.7); one-third were over 45 years of age; 82% were male; and 90% were married. Ninety four per cent were in group practices with 3.7 partners on average, and the majority practised in cities of under 250 000 inhabitants. One half had a teaching affiliation which was evenly divided between vocational and university teaching. Slightly more than one half were church attenders.

Responses to case vignettes

Table 1 shows that there were varying patterns of response to the six cases. In cases A and B, dealing with control of information, the responses are spread across the spectrum from low doctor control (high patient control) to high doctor control, although they tend to cluster at the ends. In contrast, for cases C, D and E, dealing with intervening in lifestyle, large proportions of doctors chose the course of action assigned a score of 2 (at the patient control end). Cases C and E produced more clear cut decisions because doctors overwhelmingly preferred the course of action with a score of 2 in these cases. Case F elicited a bimodal distribution of responses, that is, there were two preferred courses of action: discuss the issue only if the husband brings it up at a subsequent consultation (score 2) and raise the issue with the patient at a subsequent consultation (score 4).

Table 2 shows the reasons that were selected for the decisions. As the percentage of doctors scoring 3 demonstrates, doctors generally did not select a 'patient autonomy' or a 'patient welfare' reason as the most important reason for their chosen course of action. The one exception was case C, dealing with smoking and asthma, where 79.1% of doctors said that the welfare of the patient was the most important consideration.

Table 3 shows the correlations between the general practitioner's course of action and his or her reasons for it. 'Doctor control' courses of action were significantly related to 'patient welfare' reasons for the three cases dealing with intervening in lifestyle as well as in case F dealing with the patient who had had a vasectomy. 'Patient autonomy' reasons were not generally

Table 1. Percentage distribution of general practitioners' responses: course of action for the six cases.

Degree of doctor control	Score	Case A	Case B	Case C	Case D	Case E	Case F
		[control of information]; possible multiple sclerosis (n = 690)	[control of information]; possible cancer (n = 682)	[intervening in lifestyle]; smoking and asthma (n = 686)	[intervening in lifestyle]; VD from anal swab (n = 675)	[intervening in lifestyle]; vaginal lacerations (n = 690)	[family as patient]; vasectomy note (n = 689)
Low ^a ↑ ↓ High	1	11.7	28.4	8.7	5.8	0.7	1.5
	2	32.3	17.2	84.4	41.9	79.7	41.4
	3	14.8	2.8	4.7	37.2	6.8	12.5
	4	11.4	34.4	0.7	14.1	12.8	39.9
	5	29.7	17.3	1.5	1.0	0.0	4.8

n = total number of respondents. ^a ie Patient control.

associated with low 'doctor control' (that is, 'patient control') courses of action. Only one control of information case, about possible multiple sclerosis, and one intervening in lifestyle case, about venereal disease, showed a significant negative relationship between 'doctor control' course of action and 'patient autonomy' reasons, with the case of venereal disease having the highest correlation in the table.

Discussion

This study was designed to apply empirical research techniques to an area that has been the focus of increasing theoretical discussion but little formal measurement. Clinical decision making is never straightforward to analyse and studying the ethical components of decision making is particularly difficult. The questionnaire used here was the product of several stages of testing and refinement.

The numbers and pattern of doctors who returned completed questionnaires provide an encouraging basis for interpreting the data. The results are consistent with those of the Canadian study³ which did not support the assumption held by many ethicists and philosophers that ethical decision making is based upon consistently applying a set of independent, discrete moral principles. No uniform pattern emerged from the responses of the general practitioners, which suggests that decisions about courses of action and reasons are more likely to be influenced by the particular circumstances of a clinical situation. This does not mean that ethical considerations do not influence the decision making of family doctors, only that they do not prevail over other relevant considerations.

These conclusions are unlikely to surprise practising doctors or those familiar with other types of research into decision-making;⁵ nevertheless, the results are of more than academic in-

Table 3. Association between the general practitioner's scores on course of action and on the reasons chosen for the action.

		Spearman rank correlations between:	
		'Doctor control' course of action and 'patient welfare' reason ^a	'Doctor control' course of action and 'patient autonomy' reason ^b
Case A	[control of information]; possible multiple sclerosis	0.06	- 0.38**
Case B	[control of information]; possible cancer	0.16	- 0.12
Case C	[intervening in lifestyle]; smoking and asthma	0.35**	- 0.03
Case D	[intervening in lifestyle]; VD from anal swab	0.34**	- 0.53**
Case E	[intervening in lifestyle]; vaginal lacerations	0.26**	- 0.11
Case F	[family as patient]; vasectomy note	0.21**	- 0.13

^a Correlations with the 'patient welfare' score are positive because high welfare scores were associated with high scores on 'doctor control' course of action.

^b Correlations with the 'patient autonomy' score are negative because high autonomy scores were associated with low scores on 'doctor control' course of action.

** P<0.01.

Table 2. Percentage distribution of general practitioners' responses: reasons for decision about the six cases.

Importance of patient welfare or autonomy	Score ^a	Case A		Case B		Case C		Case D		Case E		Case F	
		[control of information]; possible multiple sclerosis		[control of information]; possible cancer		[intervening in lifestyle]; smoking and asthma		[intervening in lifestyle]; VD from anal swab		[intervening in lifestyle]; vaginal lacerations		[family as patient]; vasectomy note	
		Welfare (n=678)	Autonomy (n=678)	Welfare (n=637)	Autonomy (n=637)	Welfare (n=661)	Autonomy (n=661)	Welfare (n=656)	Autonomy (n=656)	Welfare (n=685)	Autonomy (n=685)	Welfare (n=669)	Autonomy (n=669)
Low ↑ ↓ High	0	38.9	55.9	42.7	48.0	4.1	39.6	63.4	29.4	37.7	60.3	22.4	28.4
	1	24.8	17.8	34.4	13.8	3.3	30.9	22.1	15.4	26.6	17.8	22.9	27.5
	2	20.5	12.8	18.1	11.9	13.5	20.6	10.7	20.7	17.2	8.3	31.7	22.4
	3	15.8	13.4	4.9	26.2	79.1	8.9	3.8	34.5	18.5	13.6	23.0	21.7

^a When a 'patient welfare' or 'patient autonomy' reason was chosen as the most important reason a score of 3 was given.

n = total number of respondents.

terest. Now that biomedical ethics is increasingly taught in medical student and postgraduate courses, its rationale needs to be clearly stated. This research suggests that the appropriate strategy is to recognize and incorporate ethical considerations into the set of factors already regarded as relevant to clinical decision making, rather than attempting to reorient clinical decision making around a fixed ethical framework.

This study suggests several possibilities for future research. The questionnaire was designed to concentrate on the potential conflict between two particular values — respect for patient autonomy and concern for patient welfare. Other conflicts would be interesting to investigate, such as that between maintaining confidentiality and promoting public health, an area of topical concern because of the acquired immune deficiency syndrome. The technique used in this study involved presenting cases that raise a general issue, for example, control of information and intervening in lifestyle, in different ways. Varying the features of a single case, as has occurred, for instance, in research on sore throat management and treatment,⁶ would probably delineate more precisely the ways in which ethical considerations contribute to clinical decision making. In any event, if theoretical contributions from ethicists and philosophers are to be relevant to those involved in the practice of medicine, measurement studies like this will be necessary to ensure that theory recognizes the realities of everyday clinical practice.

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Written papers: Wednesday 9 May 1990 at centres in London, Manchester, Edinburgh, Newcastle, Cardiff, Belfast, Dublin, Liverpool, Ripon, Birmingham, Bristol and Sennelager. Oral examinations: in Edinburgh from Monday 25 to Wednesday 27 June inclusive and in London from Thursday 28 June to Saturday 7 July inclusive. The closing date for the receipt of applications is Friday 23 February 1990.

October/December 1990

Written papers: Tuesday 30 October 1990. Oral examinations: in Edinburgh on Monday and Tuesday, 10-11 December and in London from Wednesday to Saturday, 12-15 December inclusive. The closing date for the receipt of applications is Friday 7 September 1990.

Proficiency in basic cardiopulmonary resuscitation is now an entrance requirement for the MRCGP examination. Further details about the examination and an application form can be obtained from the Examination Department, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.

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