A systematic review of empirical research into ethics in general practice

WENDY A ROGERS

SUMMARY

Much of the bioethical literature addresses the problems of tertiary medicine, with little attention to the daily concerns of general practitioners (GPs). The present review assesses the current state of research into the range and nature of ethical issues for GPs, looking specifically at the content of the research, the methods employed, and the philosophical framework of the research.

A systematic search of MEDLINE, CINAHL, and Sociofile identified nine articles which form the basis for this review. The majority of the research reviewed here is quantitative in nature, using hypothetical cases with closed questions and categorical responses. No consistently significant variables were identified. Decisions appear to be inconsistent in terms of theoretical models and moral psychology. Ethical issues of concern to GPs differed from those commonly reported in the bioethical literature.

There is a paucity of research into the ethical concerns of general practice. The existing body of research is quantitative in nature, leaving many unanswered questions concerning the reasons behind the decisions of GPs. There is a need for qualitative studies to further our understanding of this area.

Keywords: ethics, empirical research.

Introduction

MEDICAL ethics has developed into a flourishing sub-specialty over the past 20 years. Despite this development, it has been noted[1-5] that general practice remains largely unexamined by much of the bioethical literature, which often focuses on high-profile tertiary medical problems such as euthanasia, issues arising from assisted reproductive technologies, informed consent, and abortion. This is important for general practitioners (GPs) for two reasons. First, the reported concerns of GPs; for example, allocation of time to patients, provision of contraceptive services, lack of resources compromising patient compliance, and inappropriate use of services,[6,7] appear to be largely ignored by the standard medical ethics literature. Secondly, the unique features of general practice, which differentiate it as a medical specialty, raise specific ethical questions that require elucidation and elaboration as part of the continuing development of general practice.

The present literature review seeks to assess the current state of empirical research into the range and nature of ethical issues occurring in general practice with respect to three areas: the research methods, the findings of the research, and the philosophical frameworks within which these are located. Identifying the strengths and weaknesses of the existent research will clarify the issues and identify directions for future research in this area.

W A Rogers, BMBS, MRCGP, doctoral candidate, Department of Evidence-Based Care and General Practice, The Flinders University of South Australia, Adelaide.

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Methods

Studies of empirical research into the field of ethical issues and decision making in family medicine or general practice were identified by the following methods:

- An English-language MEDLINE search of the years 1980–1994 using the search terms 'ethical/ethics/moral' and 'family practice/primary care/primary health care'
- An English-language MEDLINE search of the years 1990–1995 using the search terms 'ethics/ethical/moral' and 'decision-making', combined with terms aimed at selecting research articles, i.e. 'questionnaire/research/interviews/survey/review'
- An English-language CINAHL search of the years 1982–95 using the same search terms as used in the second MEDLINE search
- An English-language Sociofile search of the years 1974–1995 using the search terms 'ethics/professional ethics/research ethics/codes of conduct' combined with 'practitioner/patient relationship/primary health care' combined with 'qualitative methods'
- A review of the bibliographies of the articles identified by the searches, and
- Personal communication with experts in the field.

The following inclusion criteria were used

- Written in English;
- Based in either family medicine, general practice, or primary medical health care
- The number of research subjects was greater than one, and
- Presence of an empirical study in which the research aims included describing or evaluating ethical issues.

Articles focusing on single ethical issues[8-13] were excluded as this review specifically sought research of a foundational nature to provide an overview of the field.

Results

In excess of 1000 citations were identified by these search methods. Out of these, the present author examined approximately 400 abstracts and 40 full articles for further study; nine of which, repeatedly identified by the multiple search methods, met the inclusion criteria. These articles form the basis of this review.[1-6,14-16] The majority of the rejected articles did not contain empirical research, were discursive, or anecdotal in nature, or were related to research into a single issue.

Methodological characteristics of studies

The methodological characteristics and aims of the studies are summarized in Table 1. Most of the studies are descriptive and evaluative, making use of brief scenarios or statements, and offering a closed set of responses.[1,3-6,14-16] Secundy used eight hypothetical cases in interviews with physicians.[2] In these cases, neither the method of recording the responses nor the method used for analysing the interviews were stated.

Several of the authors described the evolution of these scenarios through dialogue with practising GPs, grounding the research within general practice.[2,3,5,15,16] The sources of the other scenarios

Table 1. Characteristics and aims of studies.*

Paper	Country	Study population	Response rate	Gender	Total responses	Study design and format	Aims of study as stated in introduction
Dayringer, Paiva and Davidson 1983[1]	USA	Mixed family physicians	36%	95% male	669	Self-administered postal survey with two parts: (1) Closed questions with choice of four or five categorical responses to selected ethical situations; and (2) Statements of frequency of encountering dilemmas.	Descriptive study: ● to gain insights into physician responses to everyday ethical dilemmas of family practice, and ● to identify the frequency of such dilemmas.
Christie, Hoffmaster, Bass and McCracken 1983[5]	Canada	Family Physician teachers	86%	94% male	97	Self-administered postal survey containing 28 closed questions with respondents asked to state their usual practice in terms of rarely/sometimes/usually.	Descriptive and evaluative study: ● to identify responses to ethical questions about usual practice, ● to identify significant physician characteristics, and ● to investigate patterns of responses for correlations and consistency of ethical decisionmaking.
Dunn and Shaw 1983[14]	Scotland	Royal College of General Practitioners	60%	86% male	301	Self-administered postal survey containing closed questions on selected ethical issues with which respondents could agree, disagree, or abstain.	Descriptive study: ● to map areas of agreement and disagreement on ethical issues, ● to identify significant physician characteristics, and ● to asses desire for legislative changes.
Secundy 1985[2]	USA	Mixed family physicians	77%	79% male	98	Personal interviews presenting eight hypothetical cases. Respondents asked to describe preferred action and give reasons for choice.	Descriptive and evaluative study: ● to identify physician responses to ethical dilemmas, and ● to evaluate decision-making process in terms of moral reasoning.
Christie, Hoffmaster and Stewart 1987[15]	Canada	College of Family Physicians of Canada	74%	77% male	918	Self-administered postal survey containing six hypothetical cases with closed questions. Respondents offered five categorical responses plus a choice of six categorical reasons for responses.	Descriptive and hypothesis-testing study: ● to identify significant physician characteristics, ● to determine consistency of physician responses to ethical cases, and ● to assess theoretical model of ethical decision making.
Robillard *et al* 1989[6]	USA	Mixed primary care practitioners	30%	84% male	172	Self-administered postal survey containing 30 closed statements with respondents asked to indicate frequency with which issues were encountered using a four-point frequency scale for responses	Descriptive study: ● to measure perceived frequency of ethical issues, and ● to identify significant physician characteristics.

*The 1991 paper by Hoffmaster, Stewart and Christie[3] has been omitted from this table as it contains the three surveys written up separately in their other articles.

Table 1. continued.

Paper	Country	Study population	Response rate	Gender	Total responses	Study design and format	Aims of study as stated in introduction
Christie, Freer, Hoffmaster and Stewart 1989[16]	UK	Royal College of General Practitioners	72%	82% male	696	Self-administered postal survey containing six hypothetical cases with closed questions. Respondents offered five categorical responses plus choice of six categorical reasons for responses.	Descriptive and hypothesis-testing study: ● to determine consistency of physician responses to ethical cases, and ● to assess theoretical model of ethical decisionmaking.
Hoffmaster, Stewart and Christie 1992[4]	USA	American Academy of Family Physicians	53%	88% male	674	Self-administered postal survey containing six hypothetical cases with closed questions. Respondents offered five categorical responses plus choice of six categorical reasons for responses.	Descriptive and hypothesis-testing study: ● to describe method for analysing ethical decisions in family practice, ● to determine consistency of physician responses to ethical cases, and ● to assess theoretical model of ethical decision making.

and statements were not explicitly identified.[1,6,14]

The methods of recruitment varied between the studies. Four of the papers used random sampling from the total identified population of GPs in a given location.[4,6,15,16] Other authors used the total population of primary care physicians or GPs in a geographical area,[1,2] or a selected subsection of such a population.[5,14]

Findings of the research

Broadly speaking, four main issues were covered by this body of research, each of which will be discussed in turn.

Frequency of ethical dilemmas

Two of the studies looked at the frequency with which GPs encountered various ethical dilemmas, as defined by the authors.[1,6] The commonly or very commonly identified issues are presented in Table 2. In one study, respondents also spontaneously identified several other issues of ethical concern, including excessive regulations, professionals' excessive interest in financial gain, inadequacy of care for indigent patients, falsification of records, and theft from physicians' offices.[6]

Significance of physician characteristics

Several studies addressed the significance of physician characteristics such as gender, age, academic affiliation, church attendance, and geographic location with regard to ethical decision making. Again, the results were mixed, with two studies finding that age, sex, nationality, certification in family medicine, church attendance, type of practice, and size of community were important variables, but no clear pattern emerged.[3,15] However, another study did not find gender and academic affiliation to be important variables.[5]

Three studies identified physician age as an important variable

Table 2. Issues reported as occurring commonly or very commonly.

Authors	Issues occurring commonly or very commonly
Dayringer *et al*[1]	(1) Contraception (2) Informed consent (3) Professional etiquette (4) Pain control (5) Telling patients the truth (6) Confidentiality (7) Controlling patients' behaviour with drugs (8) Peer review
Robillard *et al*[6]	(1) Allocation of time to patients (2) Lack of patient funds leading to non-compliance (3) Reduced quality of care and inability to attend referrals (4) Unnecessary treatment for legal protection reasons (5) Patients making inappropriate use of services, including requests for unnecessary services (6) Inadequate patient follow-up (7) Inadequate patient education causing non-compliance (8) Patients complaining about incompetence or negligence (9) Lack of service continuity compromising care

for several ethical decisions.[2,5,14] However, there was no clear association between age and a consistent orientation towards ethical decision making in terms of either respect for patient autonomy or acting for patient welfare reasons.

Physician attitudes towards ethical issues

The third issue arising from this research concerned GPs' attitudes towards various ethical dilemmas or practices. One study[5] examined issues of information giving, coercion, and influencing patient's lifestyles, finding that family physicians would often attempt to influence a patient's lifestyle if this was causing a medical problem such as asthma, but not in cases in which there were no perceived medical problems, such as abortion or marital counselling. Between 55% and 75% of respondents would usually coerce patients regarding investigations, treatment, and hospitalization. Fifty per cent would minimize the seriousness of an illness when discussing this with the patient if they thought that this would be in the patient's best interests.[5]

A survey examining attitudes of GPs towards selected ethical issues found a generally high level of acceptance of artificial insemination, contemporary contraception, and withholding of treatment from severely handicapped newborns.[14] Attitudes towards abortion varied with the situation, generally being accepted for reasons such as pregnancy resulting from rape, threat to the mother's life, or for a schoolgirl without a steady boyfriend, but not accepted to accommodate the mother's career. Respondents did not generally accept euthanasia.

Reasons for moral choices

The final area examined by these studies concerned the reasons that GPs gave for their moral choices.[2-4,15,16] Secundy[2] found that respondents usually gave more than one reason for their proposed action, with concern for patient welfare and acting according to a personal code of morality predominant among the stated reasons, concluding that respondents appeared to report 'inconsistent, non universal, individualistic methods of decision making without evidence of specific models or criteria.' However, respondents were strongly oriented towards institutional and legal expectations.

Four studies examined the reasons given by GPs for choosing various courses of action.[3,4,15,16] These also looked for correlations between the choices and the reasons to try to determine any underlying moral frameworks for the decisions. Courses of action were defined as patient-control versus doctor-control, with the corresponding reasons being respect for patient autonomy versus concern for patient welfare, respectively. Findings differed between countries; the majority of physicians chose patient-control courses of action in the United States of America and Canada, but this was not the case in the United Kingdom.

The authors expected that the choice of physician-control courses of action would correlate with patient welfare reasons, i.e. the physician would make the decisions for the patient based on the premise that the physician knows what is best for the patient, rather than for morally irrelevant or self-interested reasons. This correlation was significant in only two out of the six cases for British GPs and one out of the six cases for Canadian GPs. The authors also expected some correlation between patient-control choices of action with patient autonomy reasons, i.e. respecting the patient's autonomy leads to giving patients control over decisions in the consultation. This hypothesis was upheld by the responses from the American doctors in that five out of the six cases had significant correlations, as did three out of the six Canadian responses. British responses indicated support for this hypothesis in only two out of six cases.

One of the major conclusions from these studies was that the ethical decision making of GPs appeared to relate to particular features of the clinical situation. The findings did not support decision making as a function of allegiance to a general moral stance, such as always respecting the autonomy of the patient.[3]

Philosophical characteristics of studies

The authors of the research under review here did not address the somewhat diverse theoretical literature,[17-24] with the exception of the Western Ontario group, who stated explicitly that they sought to address the 'widely accepted theoretical model that sees ethical problems in medicine as conflicts between the value of respecting patient autonomy and the value of promoting patient welfare.'[3] Other authors described their work as concerned with ethical dilemmas, but did not offer any further definition of what actually constitutes an ethical dilemma, nor did they offer any theoretical commentary within which to locate the work.[1,2,14]

Discussion

There are several themes which emerge from this literature review. The most striking feature is the paucity of research in this area, despite long-standing pleas for research that specifically addresses the issues of general practice.[25,26] The findings of the research reported here raises many questions. Why is it that GPs are in favour of withholding life support from severely disabled newborns, yet generally against euthanasia?[14] Why will GPs intervene in the lifestyle of an asthmatic patient, but not in the case of marital problems?[5] It is claimed that GPs make many decisions with ethical dimensions,[27] yet the moral reasons for their decisions remain poorly understood. Decisions appear to be inconsistent in terms of theoretical models, such as that proposed by Beauchamp and Childress.[18] Several studies suggest a lack of empirical support for the widely accepted theoretical model in which respect for patient autonomy and concern for patient welfare are said to be prime motivating factors.[3,4,15,16]

The majority of the bioethical literature is generic in nature; the practice of medicine is treated as a single practice, largely understood to be that of tertiary hospitals in which doctor and patient are strangers. (There have only been two serious full-length attempts at examining the ethical features of general practice.[28,29]) This bioethical literature addresses issues such as euthanasia, assisted reproductive technologies, abortion, informed consent, and 'do not resuscitate' orders, issues which are reflected in the reported empirical research.[30] The issues reviewed here do share some concerns with this body of work; for example, informed consent. However, many of the issues, such as allocation of time to patients, the influences of social and legal factors, and dealing with inappropriate requests by patients, have not been previously reported or discussed widely. This finding highlights differences between the various branches of medicine that have implications for recognizing and dealing with ethical issues. Whilst it may be possible to subsume all of these differences within a single ethical framework, it is clear that the emphasis differs between medical specialties, and that the context of ethical decisions is significant.

The methodology of the research reviewed here raises several important issues. All of the studies have adopted a researcher-driven quantitative approach in which GPs are asked to respond to a pre-determined set of cases or statements. The evolution of these cases is well-documented in some studies, thus grounding the work within general practice.[2-5,15,16] However, we are lacking foundational studies that map out the terrain of ethical issues in general practice in a systematic way. There are many articles approaching this anecdotally,[31] but as yet, no published research

is sufficiently flexible to allow expression of the respondents' own understanding of the ethical dilemmas encountered in daily practice. Thus, we have results demonstrating a wide variety of responses to ethical dilemmas, but with little understanding of why this may be so.

The use of brief clinical scenarios in ethics research is problematic.[32] If ethical assessments and decision making occur in a contextual manner, as is suggested by the findings of one group of authors,[3,4,15,16] brief scenarios offer little insight into what occurs in real life. It is very difficult to provide sufficient detail in surveys to make the scenario plausible or rich enough to resemble real life.

Furthermore, evaluation of research based on self-reports of action in hypothetical situations may generalize poorly to actual behaviour. Physicians are well able to judge the most desirable responses in terms of moral stature and choose these ahead of those choices that may more realistically reflect their actual practices. This problem may be overcome by the use of research techniques that are prospective or involve the study of actual cases. However, such an approach makes standardization and hypothesis testing more difficult because of the variation between patients. Increasing use of research techniques involving standardized patients may provide a compromise solution.

The relationship between research into ethics in family practice and theories of bioethics also needs further clarification. It has been noted that medical ethics is currently in a state of disarray with numerous competing traditions.[33,34] While it may be unrealistic to expect medical researchers to be experts in the field of bioethics, it is important that researchers are aware of the various philosophical positions[17-24] and are able to locate their work accordingly, or to use their research to question theoretical approaches.

The present review suggests that a number of areas require further research. Qualitative studies that describe the ethical concerns of GPs and the ways in which decisions are made may help to clarify some of these issues. Studies grounded in daily practice will be able to take account of other possibly significant variables, such as the length of the GP–patient relationship, the influence of evidence-based medicine, the role of the patient in determining the ethical agenda, and the impact of third-party interests in the consultation. The holistic patient-centred approach, such as that of McWhinney,[35] entails an ethic of ongoing responsibility which as yet remains largely unexplored. The processes of the consultation also bear an ethical weight: How is respect for the autonomy of the patient to be understood within the on-going negotiation and dialogue that characterizes much of general practice?

Empirical research in this area has much to offer, both in terms of acting as a corrective to purely theoretical work and to open actual practice to ethical scrutiny, thus enriching both theoretical ethics and general practice.[25,36]

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Address for correspondence

Wendy A Rogers, Department of Evidence-Based Care and General Practice, The Flinders University of South Australia, GPO Box 2100, Adelaide SA 5001, Australia.