Ethics support for GPs: what should it look like?

Monika Clark-Grill MD, PhD

ABSTRACT

INTRODUCTION: Ethics support services for hospital clinicians have become increasingly common globally but not as yet in New Zealand. However, an initiative to change this is gathering momentum. Its slogan 'Clinical ethics is everyone's business' indicates that the aim is to encompass all of health care, not just the hospital sector. General Practitioners (GPs) deal with ethical issues on a daily basis. These issues are often quite different from ethical issues in hospitals. To make future ethics support relevant for primary care, local GPs were interviewed to find out how they might envisage ethics support services that could be useful to them.

METHODS: A focus group interview with six GPs and semi-structured individual interviews with three GPs were conducted. Questions included how they made decisions on ethical issues at present, what they perceived as obstacles to ethical reflection and decision-making, and what support might be helpful.

FINDINGS: Three areas of ethics support were considered potentially useful: Formal ethics education during GP training, access to an ethicist for assistance with analysing an ethical issue, and professional guidance with structured ethics conversations in peer groups.

CONCLUSION: The complex nature of general practice requires GPs to be well educated and supported for handling ethical issues. The findings from this study could serve as input to the development of ethics support services.

KEYWORDS: General practice; primary care; ethics; support; education

Introduction

Good healthcare has always been founded on clinical skilfulness and sound ethics. Both have been profoundly affected in the last decades by medicine's advances and social developments, making new thinking about medical ethics necessary. Consequently, the discipline of Bioethics was established and has produced substantial research and literature.[1] Its main focus, however, has stayed on issues that arise in the 'high-price, high-tech, high-drama biomedical settings' of acute hospital care.[2] In contrast, the 'ethics of the ordinary', which is important to most healthcare interactions of primary healthcare clinicians and their patients, has had little attention so far.[3–6]

The little research that has been done identifies some crucial differences between the ethical challenges in primary care and those in hospitals. The

CORRESPONDENCE TO:
Dr Monika Clark-Grill
Department of Primary Health Care and General Practice, Wellington, University of Otago, 45 Melville Street, Dunedin 9016, New Zealand
monika.clark-grill@otago.ac.nz

The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

THIS ISSUE: Ethicist and GP Monika Clark-Grill reports her investigation of ethics support for GPs.

WHAT GAP THIS FILLS

What is already known: Primary care gives rise to many, often complex, ethical issues yet GPs lack formal ethics support to deal with them.

What this study adds: An initiative for a clinical ethics network in New Zealand is gathering momentum. Three potentially useful approaches and services for ethics support were identified by GPs in this study.

community setting of general practice itself has an influence on the kind of challenges that arise. The heightened relational nature of primary care practice, simultaneous responsibility for several family members, continuity of care and involvement with various health care problems over time are all factors creating different complexities from secondary medical care.[7] Confidentiality can be challenging to uphold due to a blurring of boundaries and the practical realities GPs have to deal with.[8] Encroachment of bureaucracy and growing resource constraints have also been held responsible for causing ethical problems.[9–12] In addition, what some GPs deem to be an 'ethical issue' is often coloured by the well-known and more dramatic ethical dilemmas arising in hospitals, whereas 'the subtle but complex ethical dimensions of everyday life' might be overlooked.[3,13] Limited collegial input, due to factors like time constraints, leaves GPs mostly on their own when dealing with ethical decision-making.[14–16]

While ethical issues in primary care might not have the same gravitas as those encountered in intensive care units, the sheer number of daily consultations taking place in primary care is reason enough to examine this area more closely for its specific ethical challenges, and to find ways to support its clinicians.[17]

Ethics support for clinicians has become increasingly common globally but is only in its beginnings in New Zealand.[18–20] An initiative led by Alastair Macdonald, renal physician and clinical ethics advisor, with the motto '*Clinical ethics is everyone's business*', has been formed to change this.[21] The idea behind this initiative is to create an inclusive ethics network for all levels of health care. As this is uncharted territory there is an opportunity to develop a comprehensive ethics support structure that will also be relevant for primary care practitioners.

This study is a first step to finding out what ethics support GPs consider useful for managing ethical challenges.

Methods

The perspectives of nine GPs (four males and five females) were explored. Six attended a focus group discussion and three were individually questioned in face-to-face semi-structured interviews. Participants were recruited from small town, semi-rural, and rural practices, and an academic centre. Their ages ranged from 39 to 72 years. All were in part-time general practice, and some were involved in undergraduate and graduate teaching or other healthcare-related activities. One participant worked in a clinic that identified as following Christian values. Participant selection was by purposive sampling. Participants were approached by the researcher through professional networks.

Discussions covered ethical issues in their practices, where they found ethical guidance to manage these issues, and the kinds of ethics support they considered potentially helpful. The focus group interview ended after an agreed two hours; the one-to-one interviews after saturation of information had been achieved. All interviews were audio-recorded, transcribed, coded and analysed.

The hermeneutic method was used for the analysis of this research material.[22] Hermeneutics is an interpretive approach to research data, which recognises that there is always some divergence between what is said by participants and what researchers perceive, and the impact this has on truth production.[23] The hermeneutic method therefore requires researchers to be particularly attentive to the interpretation process and vigilant towards their own subjectivity and its potential influence.

The study was approved by the University of Otago Human Ethics Committee (D13/360).

Findings

Barriers to ethical reflection and advice

All participants confirmed that they faced ethical issues every day but they were quick to point out barriers to ethical reflection or to asking for ethics advice. Time constraints were most frequently mentioned.

'We are practicing on the fly.' (GP6)

'.. and sometimes we make decisions that have quite profound influences on lives, and we have to do what seems right at the time. There may not be the luxury of time to discuss it with an ethical committee or with a group.' (GP7)

Managing ethical issues and getting advice was also not considered as straightforward as it was for clinical problems.

'The clinical side of general practice, it's complex but it is learnable. You can always look up medical facts; you can always look up advice on treatment and very easily get advice on managing clinical problems.... The ethical side of things I think is more complex. First you have to recognize what the ethical problems are, and then to get advice about it or to get support is probably quite difficult because you can't ask a quick, simple question. Often it's going to be a complex situation. There may be conflicting influences perhaps, or conflicting issues...' (GP7)

The solitary work-setting and the individualistic nature of GPs were identified as significant factors, and also as causes for mixed feelings about involving expert ethicists.

'One of the problems is that we practice in a very isolated way...We are not very used to somebody looking over our shoulder saying: have you considered the wider implications of what you are doing?' (GP4)

'Doctors as a whole are individualistic people, and want to practice in their own way and don't like oversight very much.' (GP3)

'I trust that my moral code is sufficiently strong that I practice in an ethical way most of the time, and I don't want anybody to come in and unpick it too much' (Doc 5)

Another barrier was that ethics itself had an 'image problem' (GP6) with GPs.

'With ethics there isn't always an absolute of what is right, it's more about weighing up the better things or weighing up the pros and cons, and maybe that's why ethics may not have such a good image, because it could be seen as being so woolly that it doesn't give you a practical solution.' (GP7)

The idea that GPs should be conscious of the ethical dimensions of every consultation was seen as yet another burdensome demand in the already stressful life of GPs:

'It makes me feel tired. The number of other ways I have to assess everything I do and fulfil requirements, you know. There is a wariness about scrutiny. And that I find is quite consistent with GPs.' (GP6)

'Do we even realize that there is an ethical issue? That would be another test. Here you do your blood test; and then: 'have you done your ethics test?" (GP4)

Despite these guarded and cautioning responses there was a general consensus that ethics support services could potentially be helpful.

Where ethical guidance is found

Ethics teaching has become a core part of the undergraduate medical curriculum but because this is only a relatively recent development, none of the interviewees had received formal ethics teaching as medical students. The two youngest GPs could remember having had discussions on ethical issues during their GP training.

'When looking back there was certainly some ethics when I did my general practice training, but it was not under the title of ethics, it came in the discussions we had' (GP7)

When asked how they made decisions when ethical issues came up, reliance on an internal moral code was the most common response.

'I never had any formal teaching in ethics, but I do have an inherent honesty that I grew up with...I also got a bit of ethical stuff from watching colleagues.. I can't really put words to it. I just have a sense I know what's right.' (GP1)

Some GPs from the focus group interview were also tutors at the local medical school, which introduced them to ethics teaching. The Four Ethical Principles[24] were known to all participants and were seen as useful for justifying a particular course of action taken:

'It's a really good framework for justification. I know what I am going to do anyway, I know what feels right. And then I can say 'for the reasons of beneficence or for the reasons of non-maleficence, or for the reasons of justice, this is a justifiable action... It doesn't change my decisions, but it gives me a reason for it.' (GP6)

The four principles were also considered useful for providing a thinking structure when trying to solve an ethical problem:

'It would have helped me to call the ethical principles by their name, because when you don't have a name you don't know what it is. Like 'this force, or this factor is pulling this way, and this factor is pulling that way, and then to balance it out'...' (GP8)

On the question of whether ethical guidelines from professional bodies were helpful in decision-making, the consensus was that they were hardly used as reference points and were not in the forefront of participants' minds.

'They seemed quite good. I agreed when I read it, but I couldn't tell you what they said.' (GP1)

'I am not sure how much knowledge people have of those specifically. I suppose some of those are fairly clear, like a doctor shouldn't have a relationship with a patient. ... But I think often the ethical issues that we are dealing with are more complex than could be or would be supported by the guidelines. Although I know that the Medical Council has put out information about that dilemma about advocating for the patient and working within a restricted environment funding-wise. But I am not sure if I could quite recall what they said in those. You

know, it is another piece of paper and I have got it filed somewhere at home. But how much I would refer to it I don't know.' (GP7)

In contrast, all participants agreed about the usefulness of being able to access medico-legal advice on ethical issues through their Medical Protection Society (MPS) membership. It seemed that the motivation to contact MPS was in part self-protective. Termination of professional relationships with difficult patients was the example given by one of the participants. Having been able to discuss the issues and getting help for that process was viewed as '*exceedingly helpful*' (GP5). While useful for finding practical solutions to problems, it was also clear to these GPs that medico-legal opinions would have their limitations with regard to ethics.

'With a medico-legal opinion, that is one opinion. It is not necessarily an ethical opinion but it maybe the safer thing to do.' (GP7)

The most help with ethical dilemmas seemed to be found in the GPs' peer groups. Here they could air ethical issues, discuss them, and pool the various opinions.

'I love my peer group. It is all about ethics and problems and issues and self-care... It really solves a lot of issues that we are bringing up. And there is tremendous experience... So I think there is a lot of value in that kind of reflection when you do it with colleagues' (GP2).

Peer groups were useful for unloading, and at times helped members to '*be[ing] absolved*' *(GP2)*. One example brought up as ethically troubling was about giving medical certificates to patients where there was doubt about the genuineness of the sickness but where the wider social context seemed to provide no other viable option for the patient.

'In the current climate we are just not able to send people back to work.' (GP4)

'And I feel I have to be on the patient's side... these people are being treated, in an ethical sense [badly], their human rights are being eroded by the attitude of the WINZ people.... I feel a bit like a Robin Hood' (GP3).

While this statement received support from most of the group, one participant expressed an equally strong argument for the just distribution of public funds. The conflict of wanting to be patient-centred on the one hand, but also honest and in-line with the professional expectation of taking responsibility for the public purse caused unease for these GPs. Therefore hearing from other peer group members that *'we would have done the same thing. It's actually okay because we all do that' (GP3)* was admitted as a relief.

Some reservations were expressed about a lack of structure in peer group discussions, and whether affirming each other's *'bad behaviour' (GP4)* was a way forward to more ethical conduct.

> 'It is all very amorphous what goes on in those.' (GP3)

> 'What do we do when we come together in a peer review situation to discuss ethical issues? Do we then confess all the bad things we have done, because we all do the same things? ... We just establish a new set of rules that we live by, unwritten. We just lower the bar...' (GP4)

This opinion was countered by others saying that reflecting together and looking at the ethical principles in the context of the whole system did make a big difference, at least for becoming more certain about one's own motivations and reasons.

> 'So you then might come back to that patient with a very clear reason as to why you continue the sickness benefit, having had the conversation.... before the conversation you are sitting with the discomfort of being dishonest, but after the conversation you go in there and you go: I know completely why I am doing this' (GP6) 'Yes, to maximize honesty...' (GP4)

Mutual affirmation and discussing opposing opinions about difficult ethical decisions was an important function of GP peer groups. It was stressed that there had to be trust between peer group members to be able to talk freely about these issues. One interviewee who worked in a practice that identified as having Christian values said he regularly turned to a nun for ethics advice. With her he found a spiritual dimension that he felt was essential for the kind of clinic

he was involved in and the particular kind of patients this clinic attracted.

Ethics support that could be useful

Picking up from statements about not having received ethics training, some participants suggested that there should be formal ethics education within GP vocational training. All participants were GPs with many years' experience but could remember how much less certain they had been when faced with ethical problems in their early practice years, how anxious that had made them at times, and that they might have found it easier had they been better equipped.

> 'I can easily picture a junior doctor in Part One of GP training, there isn't really the ethics part in it. It would definitely help younger doctors.' (GP8)

Contrary to calling up a medical lawyer, which had been mentioned as being valuable support, the question whether the same would apply to an expert ethicist was met with some scepticism.

> 'You can't expect to have a hotline where you dial a number and access an ethics opinion and get an answer straight away. And that's the difficulty about it.' (GP7)

One reason for this was that it would be difficult to convey all the nuances of a situation and the unconscious knowledge GPs have of patients.

> 'I think some of the things are so subtle or historical even. So when you are dealing with an individual patient you've got a lot of knowledge, that general practice thing of having gotten to know someone in short snippets over a long period of time, but also snippets from other family members, from things that you piece together that may influence you rightly or wrongly on what you think is right for that patient. What we don't want to do is make assumptions, as making assumptions about what someone may think or believe is really dangerous, but equally ignoring the body of knowledge that you have got about that person in that situation – sometimes you know that past events will be influencing the situation – and I think it is a question of balancing all that. Yeah, to convey that to someone else or to a group of people to discuss it, it's not something you can do easily, and

it's not something you will be conscious of a lot of it.' (GP7)

Another was the fear that an expert ethicist might prescribe solutions or sit in judgment.

'What we don't want, I guess, is someone 'mightier than thou' telling you that you have done the wrong thing or making you feel as though you have done the wrong thing, or the right thing, or whatever, but judging. That maybe where it wouldn't sit comfortably if feel that I am going to be judged, because it is only that individual in that circumstance who knows as much as they know, and that is all they can work on.' (GP7)

Despite these reservations, some participants felt that access to expert ethicists would be useful. One focus group member referred to a situation where his entire peer group disagreed with the way he had handled an ethical issue and access to an ethicist would have been an advantage in that situation. Generally, to be able to *'sit down with an ethicist and actually nut out a very specific problem' (GP7)* was seen as a good learning opportunity, especially if done together in the peer group.

'... if you did that for a peer group, if you are comfortable with a peer group or with a small group of GPs then that would be a learning situation for everyone, rather than just for the person who was involved in the issue. So, from my perspective that would be very interesting.' (GP7)

Using the peer group with the help of an ethicist as an advanced learning platform was suggested as a potentially very useful form of ethics support, a kind of *'pre-emptive education' (GP7)* where GPs could develop their own framework for the many situations when they had to act promptly and without the time for much reflection or for seeking advice.

Conclusion

This study has led to three suggestions for ethics support that could be useful to GPs. It also gave some insights into the general practice context, how it affects the nature of ethical issues that arise, and how GPs handle them. Ethical issues were described as often being subtle and complex and at times difficult to recognise. GPs work in relative isolation, in time-pressured circumstances, needing to respond on the spot, and are frequently faced with professional requirements that pull them in opposing directions. All participants were experienced GPs and had adapted their ethical decision-making processes to these conditions by mostly relying on their internal moral guide and their own ethical framework. Ethical guidelines from professional bodies were not considered helpful for the specific dilemmas they had to deal with. Support was found in peer groups and at times by seeking out medico-legal opinions. There was notable unease about some issues, with a lingering uncertainty about the best ethical decision.

Suggestions for ethics support that held the greatest traction for participants were: ethics education during GP training; ready access to an expert ethicist; guided ethics conversations in existing peer groups or small GP groups.

Because general practice is so different from the working environment of hospitals, with its own specific ethical challenges, undergraduate ethics teaching does not appear to sufficiently prepare clinicians for working in this field. Ethics courses tailored to primary care during general practice training would save junior doctors angst and uncertainty, and may make their care safer for patients.

There was definitely no interest in an expert ethicist prescribing solutions or making judgements. However, as ethical issues in general practice are frequently complex and difficult to evaluate, being able to contact somebody with expertise to help analyse and clarify was regarded a potentially valuable resource. Having an ethicist present in peer groups to facilitate the analysing process and the weighing off between the various options may be very useful. It could be a good way of practicing ethical thinking and learning from each other, and would provide an opportunity to develop a solid clinical ethics framework. Because GPs lack the luxury of time and also practice in a solitary way, sound ethics skills are of particular importance.

This study has added insights into how GPs approach ethical issues, what guides their decision-making, and what is viewed as potentially helpful ethics support. The findings could inform the planning of a clinical ethics network. As this is qualitative research and limited by the small number of participants, follow-up studies and surveys are recommended to provide a more complete picture.

References

1. Callahan D. Bioethics. In: Post SG, editor. Encyclopedia of Bioethics (3rd edition). New York: Macmillan Reference USA; 2004. pp. 278–87.
2. Kleinman A. Writing at the margin. Discourse between anthropology and medicine. London: University of California Press; 1995. (p 51).
3. Papanikitas A. Ethics of the ordinary: a meeting run by the Royal Society of Medicine with the Royal College of General Practitioners. London J Prim Care. 2011;4:70–72.
4. Papanikitas A, Toon P. Primary care ethics: a body of literature and a community of scholars? J R Soc Med. 2011;104:94–96.
5. Rogers WA. A systematic review of empirical research into ethics in general practice. BJGP. 1997;47:733–737.
6. Doyal L, Doyal L, Sokol D. General practitioners face ethico-legal problems too! Postgrad Med J. 2009;8:393–394.
7. Sturman NJ, Parker M, van Driel ML. The informal curriculum: General practitioner perceptions of ethics in clinical practice. Aust Fam Physician. 2012;41(12):981–984.
8. Papanikitas A. Ethicality and confidentiality: Is there an inverse-care issue in general practice ethics? Clin Ethics. 2011;6:186–90. doi:10.1258/ce.2011.011036
9. Armstrong D. Clinical autonomy, individual and collective: the problem of changing doctors' behaviour. Soc Sci Med. 2002;55:1771–1777.
10. Berney L, Kelly M, Doyal L, Feder G, Griffiths C, Rees Jones I. Ethical principles and the rationing of health care: a qualitative study on general practice. Br J Gen Pract. 2005;55:620–625.
11. Førde R, Aasland OG. Moral distress among Norwegian doctors. J Med Ethics. 2008;34:521–525.
12. Martin R. Rethinking primary health care ethics: ethics in contemporary primary health care in the United Kingdom. Prim Health Care Res Dev. 2004;5:317–328.
13. Braunack-Mayer AJ. What makes a problem an ethical problem? An empirical perspective on the nature of ethical problems in general practice. J Med Ethics. 2001;27:98–103. doi:10.1136/jme.27.2.98
14. Gardner J, Papanikitas A, Owens J, Engward H. Emerging themes in the everyday ethics of primary care: a report from an interdisciplinary workshop. Clin Ethics. 2011;6:211–214.
15. Mintzker Y, Rogers W. General practice ethics: text messages and boundaries in the GP–patient relationship: AFP. 2015;44(8):593–595
16. Rogers WA, Braunack-Mayer AJ. Practical ethics for general practice. Oxford: Oxford University Press; 2009.
17. Slowther A. Ethics case consultation in primary care: Contextual challenges for clinical ethicists. Camb. Q Healthc Ethics. 2009;18:397–405. doi:10.1017/S0963180109090598
18. Fox E, Myers S, Pearlman RA. Ethics Consultation in United States Hospitals: A National Survey. Am J Bioeth. 2007;7(2):13–25. doi:10.1080/15265160601109085
19. Slowther, A. Embedding clinical ethics in a health care system: The experience of the UK clinical ethics network. Bioethics Forum. 2008;1(1):40–4.
20. Macdonald A, Worthington R. The Role of Clinical Ethics in the Health Care System of New Zealand. Capital and Coast District Health Board, New Zealand, in association with the Health Quality and Safety Commission (NZ); September 2012.
21. Macdonald, A. http://www.rcw.org.nz/uploaded/file/downloads/Clinical_ethics_almacdonald.pdf; accessed 12.11.2015
22. Byrne, M. Hermeneutics as a methodology for textual analysis. AORN J. 2001;73:968–70. doi:10.1016/S0001-2092(06)61749-3
23. Ezzy, D. Qualitative Analysis. Hoboken: Taylor and Francis; 2013.
24. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. (7th edition). New York: Oxford University Press; 2013.

COMPETING INTERESTS
None declared.