Guest Editorial

Empirical Studies of Ethics in Family Medicine

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That family physicians ought to attend to the ethical implications of their practice and their specialty is a message heard increasingly of late in the family medicine literature. The message has taken the form of arguments stressing the importance of ethical issues in family practice,[1-3] suggestions for teaching ethical analysis in family medicine programs,[4-7] and analyses of special topics of particular concern to family physicians.[8,9] The report by Christie and colleagues beginning on page 1133 of this issue adds a welcome dimension by offering empirical data about how a group of family physicians approach ethical decisions in their practices, as measured by questionnaire responses. This study joins other preliminary attempts to assess the behavior of family physicians around ethical issues[10,11] as well as similar surveys in other specialties.[12-15]

The philosophical disclaimer that one can never resolve an ethical or a value question by gathering empirical data remains true but is beside the point in assessing the importance of this mode of research. Since much of the literature of medical ethics over the past decade has focused on the "neon" issues of the tertiary care and high-technology setting, we are still in need of a sound, epidemiological understanding of the less-appreciated ethical issues that arise in day-to-day primary care. How practicing physicians deal with or fail to deal with various ethical problems has obvious implications for residency curriculum planning. Finally, empirical surveys can sometimes serve as a valuable corrective to the pronouncements of "ethics experts" whose views are largely restricted to the classroom and teaching hospital. If the textbook wisdom is that in certain sorts of cases, patients should be encouraged to make their own choices, and a methodologically sound survey reveals that physicians uniformly exclude patients from making such decisions, then there is a good chance that the academic analysis of the issue has left out some crucial factor or circumstance that is very much on the physicians' minds. It may still be the case that this factor is of very limited moral weight and the physicians are indeed caring for their patients in a manner that is ethically suboptimal. But arguments directed to these physicians to encourage them to alter their habits are much more likely to succeed if this factor is explicitly addressed and if it can be shown in general that the "ethics experts" are aware of the

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real-life setting in which the ethical decision must be made.

Having argued for the importance of the work of Christie and associates, I must now express some reservations about the conclusions of their investigation. These reservations have less to do with the study design in any technical sense, and more to do with the meaning of various concepts that they have employed in phrasing their questions and interpreting their data. These concepts are of major importance to the relationship between the family physician and his or her patient, and I trust they will receive extended treatment in the book currently in preparation by two of the co-authors of the present study.[16]

A central theme of the study is how willing family physicians are to "coerce" their patients into various medical treatments and lifestyle changes. No clear definition of "coercion" is offered. One authority includes two sorts of actions under the label of coercion—direct physical force or restraint, or threatening to use force or restraint when one clearly has the power to do so.[17] Since a fundamental feature of the medical context is the vulnerability of the ill person,[18] we need to add an additional form of coercion peculiar to this setting in which the physician plays on his or her authority role and manipulates the patient by biased presentations of data or options or by withholding crucial information. Going to the other extreme, coercion is clearly absent when the physician merely describes the alternatives in a value-neutral manner and allows the patient to make a decision. But all ethical and behavioral studies to date are essentially agreed that no such value-neutral communication is practicably possible; nor do patients seem to want such a relationship. What we then see, in the more usual case, is the physician explaining the various alternatives to the patient and then trying to persuade the patient that one particular course of action is in his best interests.

Is trying to persuade the patient in such a manner to be viewed as coercion? The use of terms such as *persuade, cajole,* or *exhort* implies that one recognizes the right and ability of the other party to make his own choice; it is precisely because one foresees the possibility that he might choose the "wrong" option that one puts so much effort into arguing for the "right" one. Therefore, persuading, cajoling, and exhorting, as well as simply offering information, recognize and indirectly reinforce the patient's free choice and are not properly considered coercive. Rather than adopt a definition of "coercion" that is so broad as to encompass all physician-patient encounters, it seems much more appropriate to restrict the term to instances of threatening, deceiving, or manipulating that clearly stand in need of ethical scrutiny.

But Christie and his colleagues seem to have in mind a much broader definition of "coercion." For example, question 13 in their survey reads, "If a patient were reluctant to accept necessary hospitalization, would you attempt to persuade the patient into changing his or her mind?" Their Table 1 categorizes a positive answer to this question as indicating one would "coerce patient concerning hospitalization." The same physician who answered that he would "attempt to persuade" the patient could consistently answer, in reply to another question, that he would *not* "coerce" the patient. The overly broad definition of "coercion" leads the authors to conclude that family physicians are more paternalistic toward their patients than is actually supported by their data.

A similar confusion may be involved in the ethical assessment of discharging a patient from one's practice, an action these authors seem to regard as highly coercive and paternalistic. *Threatening* to discharge a patient because of noncompliance—where one hopes that the patient will thus be scared into more compliant behavior—is a coercive action by the definition considered above. But *actually* discharging a patient may not be manipulative or coercive at all; it may rather reflect a realistic view that because of personality or other differences this patient may receive better care from another physician. The opprobrium attached to discharging a patient may be based on a naive belief that every physician can form a positive working relationship with any patient and that the failure to form such a relationship indicates either physician incompetence or patient sabotage.

These critical comments are not intended to disparage the valuable work of these authors or to discourage other family physician investigators from carrying out similar research in the future. They are rather intended to argue that the strongest and most useful approach to medical ethics involves *both* empirical awareness of physicians' attitudes and studies of how decisions are made on a case-by-case basis *and* careful theoretical anal-

ysis of the crucial concepts involved in ethical behavior and in the nature of the physician-patient (and physician-family) relationship. The Western Ontario group showed their appreciation for this two-pronged approach by including a philosopher in the design of their study. The willingness to engage in multidisciplinary collaborative research, which has been a strength of the family practice community in the past, should stand us in good stead as we seek a theoretically sound and practically useful approach to the ethical problems of family medicine and primary care.

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