How Family Physicians Approach Ethical Problems

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The defining features of family medicine as described in the literature have important ethical implications. In an attempt to study the day-to-day practice of family physicians regarding these ethical issues, a 28-item questionnaire was sent to 95 part-time and 17 full-time family physician teachers associated with the University of Western Ontario's Department of Family Medicine.

Of the 112 questionnaires mailed out, 97 were returned for a response rate of 86.6 percent. There was a significant spread of answers, suggesting there is no uniform opinion in the sample population.

The findings suggest that there are important differences between the description of family medicine in the literature and what the family physicians in this study do in their day-to-day practice. The family physicians in this study, while prepared to coerce patients, were not prepared to discharge from their practices patients who were noncompliant. Physician age is an important variable in some ethical decisions, but not in others.

Dickman[1] has stated that family medicine and medical ethics must form a "natural and necessary union." If this union is to have relevance to the practicing family physician, however, it must deal with ethical issues that are a familiar and recurring part of his or her practice experience. Most discussions of medical ethics focus on controversial "headline" issues. This approach produces a distorted picture of the field. More important, it may cause the family physician to conclude, erroneously, that discussions of medical ethics have little or no relevance to his daily practice.

References to ethics in the literature of family medicine do not usually relate to day-to-day reality of practice. Case studies used to illustrate ethical issues range from physicians who allow their students to practice pelvic examinations on comatose patients[2] to patients in intensive care units. Carson and Curry[3] use a case study that involves a nephrologist who denies chronic hemodialysis to a nursing home patient because the nephrologist felt that this was a misuse of facilities and money. These cases do little to clarify the ethical issues faced by the practicing family physician. Veatch[4] and Wallenmaier[5] admonish ethicists to study the straightforward and commonplace activities of physicians. Wallenmaier states, "a number of issues are being overlooked and a number of approaches to the issues are being missed because of an overconcentration in medical ethics on a small number of recent and dramatic problems." Further, empirical research on ethical decision making in medicine has focused on "telling" cancer patients about their disease[6,7] and the relative importance of clinical vs quality-of-life factors in decisions concerning manage-

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ment of malignant disease[8] or as a predictor of clinical performance of residents in pediatric residency programs.[9] This research sheds little light on ethical decision making common to the discipline of family medicine.

The defining characteristics of family medicine, such as commitment to the patient as a person, the provision of continuous and comprehensive care, and an interest in prevention, imply that a family physician may have a basis for acting paternalistically toward his patients. This paternalism might include such actions as withholding information from a patient when the physician considers it to be in the patient's best interest, attempting to change a patient's lifestyle when the physician believes it is in the patient's best interest, and even threatening to discharge a patient if the patient does not do what the physician wishes. The latter is a strong form of coercion and raises the question of what methods a family physician is morally entitled to use to influence a patient's decisions and actions.

There is a suggestion that the family physician's contractual relationship[10] with the patient implicitly permits him to interfere in patient lifestyle, both when that lifestyle is causing a medical problem, and when it is not causing a medical problem but is perceived by the physician not to be in the patient's best interest.

It is important to examine the ethical decisions made on a day-to-day basis by family physicians. The purpose of this study was to examine the responses of family physicians to a broad range of everyday practical problems that have important ethical implications.

The study had three broad aims: (1) to question family physicians about their usual practice and to study the ethical decisions reached by family physicians in the context of the concept of the ideal of family medicine as described in the literature, (2) to identify physician characteristics that affect the ethical decision-making process, and (3) to investigate patterns of ethical decision making to see whether there are correlations between the ethical decisions made for one issue and the decisions made for other ethical problems.

The study was also concerned with testing specific hypotheses. Certain physician characteristics were hypothesized to be important variables. The study was designed to test the following hypotheses: (1) physician age would be an important variable, and older family physicians would tend to act more paternalistically toward their patients than would their younger colleagues, (2) the sex of the physician would be another important variable, and female family physicians would demonstrate some different ethical decisions from their male counterparts, and (3) the ethical decisions reached by family physicians in full-time academic teaching positions would be different from the decisions reached by their colleagues who were engaged in full-time private community practice with a limited teaching commitment.

Methods

In an attempt to study the day-to-day practice of family physicians regarding ethical issues, a 28-item questionnaire that included questions on information giving, coercion, and effecting lifestyle change was developed. The questionnaire was used in a pilot study involving four family physicians and later in a pretest involving 22 family physicians. After changes to enhance clarity and reliability, the questionnaire was sent to 95 part-time and 17 full-time teachers associated with the University of Western Ontario's Department of Family Medicine. The family physicians were asked to answer the questions on the basis of their usual practice in dealing with these issues. The sample questions included the following:

Do you voluntarily give the details of prognosis to patients with a serious disease?

Do you voluntarily tell a patient's close relatives about alternatives to the treatment you are recommending in a serious illness?

If a patient were reluctant to accept necessary hospitalization, would you attempt to persuade the patient into changing his or her mind?

Do you attempt to change the lifestyle of a patient when that lifestyle is causing medical problems for the patient?

Would you discharge from your practice a patient who would not accept the treatment plan you were advocating?

Would you attempt to influence a patient's decision regarding termination of a pregnancy?

When counseling a patient, do you tell a patient what your own values are with respect to an issue?

Demographic data were collected regarding the age and sex of the physician, the year of graduation from medical school, and the number of years in family practice.

Twenty-five of the 28 questions were asked in both the pretest and the test. The answers to these questions were used to determine the reliability of the questions. Reliability determination was not possible for three of the questions for which the wording was altered as a result of criticisms of the pretest questionnaire.

Two questions designed to encourage the respondents to use the extreme ends of the scale were included. These questions were written so that most physicians, if they followed accepted practice, would use the lowest end of the scale on one question and the highest end of the scale on the other.

When a response to the questionnaire was not received approximately five weeks after it was sent out, a reminder was sent to the physician.

Results

Of the 112 questionnaires mailed out, 97 were returned within a two-month period for a response rate of 86.6 percent. The sample consisted of 91 male and six female physicians. Over one half of the respondents were men over 45 years old.

There did not appear to be any significant difference when the response group and the nonresponse group were compared as to the year of graduation from medical school and the geographic location of their undergraduate training.

The answers given by 22 physicians to the 25 questions asked in both the pretest and the test were used to determine reliability of the questions. Seventeen questions showed a high reliability with P values $<.05$. Two questions showed marginal reliability with P values of .07. Six questions were found to be unreliable with P values $>.26$.

The general responses to the questions are shown in Table 1. There was a significant spread of answers, which is reflected in the standard deviation from the mean being greater than 1.5 for 16 of the questions. The diversity of answers seen in all of the questions suggests that there is no uniform opinion in the sample population, except for the two questions designed to encourage the respondents to use the extremes of the scale.

Given that most respondents to questionnaires tend to give what they believe are "respectable" answers, the responses to the 28 questions showed a surprisingly broad distribution. The relatively high number of physicians who state that it is their usual practice to attempt to coerce patients into accepting investigations, treatments, and hospitalization is striking. This finding contrasted sharply with the very high number of family physicians who stated that they would not discharge patients who were not compliant in the same areas. This latter result is in keeping, however, with the literature's description of the family physician's strong commitment to the patient as a person. A substantial number of family physicians (84.3 percent) were prepared to attempt to change the lifestyle of a patient when that lifestyle seemed to be causing medical problems for the patient, but significantly fewer were prepared to attempt to alter the patient's lifestyle when the issue was a problem of living such as termination of a pregnancy, permanent contraception, termination of a marriage, or the use of marijuana.

Only 33 percent of the physicians surveyed stated that they usually revealed their own values to patients when counseling. It is also important to note that over 50 percent of the family physicians responded that they would likely minimize the seriousness of an illness if they thought that doing so was in the patient's best interest.

Physician Age

The correlation of physician age with responses to the questions was performed. The results indicate a mixed response from older physicians. In some areas they tended to be less paternalistic; they were more likely to allow their patients to die at home if they wished and more likely to provide information to relatives regarding prognosis. Contrasting with this, older physicians were more likely to coerce their patients into accepting a treatment plan and more likely to coerce them into accepting hospitalization, both directly and through relatives. Older family physicians also tended to be more active in attempting to alter the patient's lifestyle regarding sexual practices, extramarital affairs, and the use of marijuana.

Physician Experience

Because of the high correlation between years in practice and physician age, the same questions that were identified in the analysis of age were significant in the years of practice analysis.

Table 1. Responses to Questions (n = 97)

Question	Unlikely or Rarely (%)	Inter-mediate (%)	Likely or Usually (%)
1. Give information to patient regarding prognosis	11.4	10.3	78.3
2. Give information to patient regarding alternatives to treatment	4.1	4.1	91.8
3. Give information to patient regarding complications	8.2	9.3	82.5
4. Give information to patient regarding investigations	2.1	4.1	93.8
5. Allow patient to die at home	2.1	1.0	96.9
6. Give information to relatives regarding prognosis	4.1	1.0	94.9
7. Give information to relatives regarding alternatives to treatment	9.3	14.4	76.3
8. Give information to relatives regarding investigations	33.0	21.6	45.4
9. Give information to relatives regarding complications	36.5	17.7	45.8
10. Coerce patient regarding investigations	21.5	14.0	64.5
11. Coerce patient regarding treatment	23.2	21.1	55.8
12. Require parental consent for contraception	98.0	0	2.1
13. Coerce patient regarding hospitalization	13.5	12.5	73.9
14. Interfere in patient lifestyle regarding medical problem	6.2	9.4	84.3
15. Coerce patient using relatives regarding investigations	47.4	14.4	38.1
16. Coerce patient using relatives regarding treatment	47.4	12.4	40.1
17. Coerce patient using relatives regarding hospitalization	38.2	13.4	48.5
18. Discharge patient refusing investigation	95.9	1.0	3.1
19. Discharge patient refusing treatment	85.4	6.3	8.4
20. Discharge patient refusing hospitalization	86.6	7.2	6.2
21. Interfere in lifestyle regarding sexual practices	84.2	11.6	4.2
22. Interfere in lifestyle regarding extramarital practices	86.0	4.3	9.6
23. Interfere in lifestyle regarding abortion	51.1	17.0	31.9
24. Interfere in lifestyle regarding sterilization	60.3	16.7	22.9
25. Interfere in lifestyle regarding divorce	64.6	21.9	13.5
26. Interfere in lifestyle regarding use of marijuana	50.0	7.3	42.7
27. Minimize seriousness of an illness	30.2	16.7	53.1
28. Tell patient physician's own values during counseling	54.6	12.4	33.0

Response Groupings
1, 2, 3—Unlikely or rarely
4—Intermediate
5, 6, 7—Likely or usually

Sex of the Physician

Even though there were few female physicians in the sample population, it was considered important to compare the answers received from the female physicians with the answers received from the male physicians. There was no significant difference between the answers received from the female physicians and those received from their male counterparts. It was especially of interest that in the questions relating to sexual and marital problems, there was no significant difference between the male and female portions of the sample population.

Response of Full-Time Academic Family Physicians Compared with Part-Time Teachers

The answers to the questions given by the group of 16 full-time academic family physicians were compared with the answers received from the 75 physicians who were in private practice with a part-time teaching commitment. In no case did the responses from the full-time academic family physicians show significant difference from the responses given by the family physicians in private practice.

Discussion

This was an exploratory study in an area that has received no previous research attention. The study identified physician age as an important variable for several ethical decisions.

A potential problem with a study population for which some preselection has occurred is how representative the study population is of a wider physician population. It was recognized from the beginning that there were disadvantages in using family physicians with some association with the Department of Family Medicine, University of Western Ontario. It was felt important, however, as a first step to investigate a group of family physicians who had been evaluated and assessed as being appropriate models for undergraduate and graduate students. Since a large subgroup of the study population consisted of family physicians in private practice with a limited teaching commitment, it was felt that at least this subgroup had the potential of being representative of peer-approved family physicians. Further information with a representative population will be required before one can generalize to all family physicians.

Six questions had poor test-retest reliability, with P values ranging from .26 to .60. With the exception of question 20, which asks about discharging a patient who refuses hospitalization, the questions all deal with the issue of attempting to influence a patient's lifestyle. Two explanations are possible. The first is that the questions are "poor questions" and thus the respondents had difficulty in answering them reliably. This criticism is difficult, if not impossible, to refute, although the reasonable reliability of the other 19 questions suggests that other reasons should at least be entertained. The second is that the questions deal with an issue that produces problems for family physicians. Family physicians may be confused and uncertain about when they should intervene in a patient's lifestyle. It is striking that the reliability of these six questions differs so radically from all of the others. While convincing evidence cannot be offered, the inconsistencies surrounding answers to these questions seem to reflect a deep and unresolved problem area for family physicians. If this supposition is correct, it has significant implications for the future training and continuing medical education of family physicians.

The results show that family physicians do not generally avail themselves of the broad warrant to intervene in the lives of their patients, which the definition of family medicine suggests they theoretically possess. The data show the majority of family physicians would attempt to influence a patient's lifestyle when it is causing a medical problem but would not attempt to influence it when it is not causing a medical problem. While practicing family physicians may be concerned with "complex problems of physical, behavioral and social factors,"[11] they are not prepared to influence or interfere in a patient's decision regarding abortion, sterilization, or divorce. This reluctance to modify decisions about "problems of living"[12] suggests that other factors, such as physician comfort, absence of effective techniques, and potential adverse patient reaction, may be important. The family physician's role in managing "problems of living" requires further research.

This study demonstrates that the definition of

the ideal family physician is at some variance with the practice patterns of the family physicians who responded. This disparity is an important finding and should be of concern to family medicine educators. Since much of the literature defining family medicine emanates from academic departments of family medicine, there may be a significant difference between academic family physicians and family physicians in active practice in their understanding of the nature of their discipline.

The hypothesis that older family physicians would behave more paternalistically is not supported by the findings. In the responses to reliable questions in which age was statistically significant, older physicians tended to behave less paternalistically than their younger colleagues when the issue was allowing patients to die at home or providing information to relatives regarding prognosis. Older physicians were, however, more likely to coerce a patient into accepting hospitalization either directly or through relatives.

The relevance of age when the issue is interfering in a patient's lifestyle requires further study. It is important to know whether older family physicians act more paternalistically in lifestyle issues when these questions are answered with greater reliability.

No statistically significant difference could be found between the answers given by the 16 full-time academic teachers and the answers received from the 75 physicians who were in private practice with a part-time teaching commitment. It had been expected that there would be measurable differences.

Conclusions

This study represents a beginning in the field of ethical decision making in family medicine. It has produced interesting new information but also has raised new questions:

1. The findings suggest that there are important differences between the description of family medicine in the literature and what the family physicians in this study say they do in their day-to-day practice.

2. The family physicians in this study, while prepared to coerce patients, were not prepared to discharge from their practices patients who were noncompliant.

3. The finding that the five questions dealing with interference in patient lifestyle had low reliability suggests that this is a vexatious area for family physicians.

4. Physician age is an important variable in some ethical decisions, but not in others.

5. The role that the sex of the physician plays in ethical decision making requires further study.

It is hoped that this study will lead to research that will further clarify ethical issues in family medicine. Such research is in keeping with Veatch's view[4] that "it is only by moving beyond the specific issues to more basic underlying ethical themes that the real ethical problems in medicine can be dealt with." This study has begun to explore some of these basic underlying ethical themes. It is hoped the resulting knowledge will provide a more realistic view of ethical problems in family medicine and a conceptual framework that will enable a more critical evaluation of ethical decisions.

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