ETHICS IN GENERAL PRACTICE

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INTRODUCTION

‘Lives are on the line. Our decisions and omissions are therefore moral in nature’
Better - Atul Gawande

Ethics is a very old field of study concerning thinking about and doing the right thing, often culminating in sets of principles that can guide us in trying to do the right (or good) thing.

In medicine, high expectations for the professional behaviour of doctors go back more than 2000 years to the Hippocratic Oath, and in current times enshrined in the GMC publication “Good Medical Practice” (GMP) (1). Despite these guidelines, the “right thing to do” can be far from clear, as often there are conflicting ethical principles promoting different or even opposing ends.

For instance, “continuity” (on-going personal care by a particular doctor) sits in tension with “ease of access” (the ability to see a doctor quickly when a problem arises). Generally, the easier it is for a patient to get an appointment, the less likely it is that this consultation will be with a particular doctor, such as their own doctor. In addition to patients, a GP has responsibilities to a wide range of other parties such as to patient’s families and to wider society. Trying to meet the needs of these different parties at the same time gives rise to interesting dilemmas.

For instance, a patient may disclose an alcohol addiction and admit to regularly driving under the influence. The GP has loyalty to their patient (the ethical principle of beneficence - doing good for our patients), but also the health of other road users, most of whom are not their patients (the principle of justice - the good of the many). Despite the lack of certainty in this field, by learning to recognise ethical problems in practice, decipher the basis of conflicts and balance competing demands, you will be more likely make well considered clinical decisions. Ethics is a good example therefore of where being able to use inductive or relative thinking (refer to 1A) is very important.
NEED TO KNOW

KEY CONCEPTS OF MEDICAL ETHICS

Here is a reminder of a few of the more important concepts in medical ethics that come up regularly in practice. The BMA’s “Ethics Toolkit for Students” is a free online handbook which covers these and other issues in an accessible format. (2) One very useful framework covered in this toolkit is the ‘four pillars approach’; four key ethical concepts often at play in medical cases:

1. **Respect for Autonomy** - autonomy can be defined as the ability of the person to make his or her own decisions regarding care, or participation in research. Related concepts concerned with autonomy are:
   a. **Informed Consent** - the need for patients to understand and specifically agree to under-going a medical treatment. Consent can be formal or implicit.
   b. **Mental capacity** - this is the ability of a patient to understand the nature of their medical needs, planned interventions and therefore to give informed consent.
   c. **Confidentiality** - dating back to the Hippocratic Oath, this is the obligation on doctors to keep secret certain types of information disclosed in clinical settings. Students may be asked to sign confidentiality agreements when on GP attachments.

2. **Beneficence** - a doctor should always try and do the best for patients. It sounds simple, but carrying this out in every consultation?

3. **Non-maleficence** - ‘first do no harm’. It is possible to see straightaway that beneficence and non-maleficence are often simultaneously at play and in tension in medicine. The decision to commence any investigation or treatment for the good of the patient, must be balanced against potential harms. Judgement is called for.

4. **Justice (fairness or equity)** - people should be treated fairly – people with equal needs should be given equal consideration - and should not be discriminated against in the provision of health services. This is an obligation of a publicly funded service like the NHS.

CORE VALUES IN PRIMARY CARE

Values are the things we hold dear that motivate for actions. The values of primary care arise from a blend of ethics (such as truthfulness), traditions (such as comprehensiveness) and more modern imperatives - such as being evidence-based) (3).

Many of the core values in general practice are addressed in this resource. They include principles such as a holistic approach to patients (the **biopsychosocial approach - 1B**), the centrality of **relationships 1D, continuity 1E, accessibility 1Di** and **evidence-based practice -1Ai**. These values seem incontestable when viewed singly, but again can easily fall into conflict with each other.
THE RESPONSIBILITIES OF THE GP

So far, we have covered ethical principles and professional values. There are also several responsibilities that GPs have. One might imagine that patients are the GP’s primary responsibility, and this is certainly the emphasis of “Good Medical Practice”. However, there are many other - often competing responsibilities such as:

**Partners and families:**
Often a problem presents that has major implications for those immediately connected to an individual patient. A good example is the needs of carers. If a GP refers a dependent patient for surgery, she must think of how to meet the increased burden upon that patient’s carer during the convalescence period.

**The practice population:**
GPs are often thinking about how best to organise their appointment system, improving access for special groups (such as teenagers), and improving their prescribing systems. As we shall see, sometimes the needs of the practice population can conflict with the needs of individual patients.

**The wider public:**
GPs are often now involved in *commissioning* services for a geographical region. Though most GPs are not “commissioners” they are all responsible for spending large amounts of the public purse and most GPs consider they have a responsibility not to waste public resources on unnecessary interventions.

**The environment:**
Healthcare uses a lot of resources and creates a lot of waste. Some medical waste creates environmental hazards - for instance hormone medications that enter the water supply can disrupt endocrine systems in animals. Many doctors feel it is part of the duty of the doctor to protect the global environment from iatrogenic harm as much as possible. (4)

**Teaching others:**
The word ‘doctor’ is derived from the Latin ‘docere’ meaning to teach. This implies that doctors have always been thought of as teachers - especially to those learning the profession and this is again reflected in the Hippocratic Oath. Teaching is an explicit expectation of “Good Medical Practice” (para 39, 2013).

Good teaching placements require considerable time and energy to organise, implement and review and this can impact on patient care by reducing doctor availability.

**Self-care:**
Being a GP is a demanding occupation. Many of us rather like the sense of being busy but at times this can get too intense and our enjoyment and effectiveness can suffer. GPs have a duty to themselves therefore to avoid getting over-stressed through taking adequate holidays and having lives outside of work - all of which takes them away from being accessible to patients. This can create tensions.
Other doctors:
Within existing GP partnerships, each partner is responsible for the success of the practice and being willing to fairly share the workload. GP income is not fixed but depends on the communal efforts of the practice and hence GPs have financial responsibilities to each other. Many GPs are employees, rather than partners, but share many of the same obligations.

Staff:
A GP practice of for example 8000 patients might employ 30 or more people including doctors, nurses, health care assistants, managers, administrators, receptionists, cleaners etc. The GP partners therefore have major responsibilities as an employer for things such as creating a safe and pleasant work environment and ensuring sustainable long-term employment.

Meeting these diverse duties brings a lot of variety and satisfaction to our work and creates interesting tensions. The ability to be aware of these competing tensions and to use judgement in considering all the relevant principles is therefore a key attribute of professional practice. Having some approaches to thinking about this can be useful.

A PRACTICAL APPROACH TO ETHICS

You can develop awareness of the ethics of everyday practice by observing consultations and also when you are conducting your own consultations under supervision. A challenge is that only the starkest issues may be flagged up by your trainer as overtly "ethical" due to time constraints. However, as we shall see, ethical issues lurk in many guises. Here are some strategies for approaching them:

Be open to the ethical dimension:
Pay attention to any sense of dissonance you feel in a consultation. By dissonance we mean a mismatch between what you sense is right and what is unfolding in the consultation (for instance a 10-year-old child translating the health problems of a non-English speaking parent somehow feels wrong). Where feasible, ask clarifying questions within the consultation. Record an ethical issue for later consideration, otherwise they will easily get lost in the mayhem of clinical life.

A good way to develop ethical sensitivity is to keep a place for the humanities in your personal life. Good art, novels and films distil the essence of an ethical situation and through exposure to these sources we become better at appreciating them in the clinic. Bristol University has an on-line collection, www.outofourheads.net of art, much of which tackles ethical issues.

Discuss ethical issues with colleagues:
It is very difficult to develop a nuanced ethical understanding on one's own. We seem to need to voice various perspectives in coming to a mature one. Most tutors will enjoy exploring ethical issues with students. When discussing with other students be sure to scrupulously protect the anonymity of all parties.
Aim for clarity on the ethical issues at stake:
You will now be familiar with the “four principles” approach to identifying what is at stake in any given predicament. Try and apply these principles consistently to ethical scenarios. However, beware that these four principles focus mainly on care of individual patients and, as we have seen, the GP is called on to consider a wider constituency.

Consult formal guidelines:
These exist for many common presentations. For instance, the Fraser Guidelines aid good practice in the provision of contraception services to under 16s without parental consent. Students should also be aware of some key legislation including the Mental Capacity Act (2005) and the Equality Act (2010) that have direct implications for medical practice.

Find reasoned resolutions:
There is no “right” response to a dilemma but there can be a reasoned one. This often involves a recognition of the principles and parties at odds (e.g. maintaining confidentiality versus fulfilling duties to family members at risk) and striving for a reasonable compromise or explaining why a certain position is an absolute that should not be compromised. For instance, you might argue that it is important to be both truthful and compassionate and thus hold back certain information that, whilst true, would be unnecessarily distressing. But you might also argue it is always wrong to lie to a patient when they ask you a direct (and clearly answerable) question about their health.

ACTIVE LEARNING

✓ Try thinking about an ethical question - for example What is a good life? How would you go about thinking about this?
✓ Sit in on a surgery and try to spot the ethical principles and dilemmas at play by using this resource. Ask your tutor for help in flagging ethical dimensions as they arise.
✓ Before that, practise by trying some of our cases first.

Read the case presentations and try (with or without your placement partners) to identify the ethical principles and professional values at play and where they may be tensions. There are various, non-specialist, resources to help you approach ethical issues including those written for students, and those specific to primary care (5,6,7). When you have done this, look at the analysis and potential resolutions. What do you think of the analysis and resolution? Have you anything more to add?
**Case 1**

**Presentation:**
A female patient is aggrieved because you revealed personal information in a letter to the Council asking you to judge the patient’s suitability to become a foster carer. Two years previously the patient was having difficulties in their marriage and you had recorded “couple rowing a lot at present”. The patient says she “will never tell a doctor anything personal again”.

**Analysis:**
Here the conflict is between the doctor's duties to the patient and to wider society and children who might be fostered by your patient. The patient feels what was said in private has been revealed out of context (her marriage, she says, is now fine). The defensiveness of the patient rings some alarm bells. Confidentiality of medical records is relative but not absolute.

**Resolution:**
The doctor must fairly report the medical record and not edit it at the request of the patient. The conflict can be mitigated by ensuring that the patient has a chance to see any report before it is sent, gaining the opportunity to offer clarifications (this is standard practice). Patients should know that the doctor is required to make a record of consultations - but can show discretion. Patient and doctor should trust the fairness of the fostering assessment process - historical rows alone would not prevent fostering.

**Case 2**

**Presentation:**
A male GP is consulted when “duty doctor” by a female patient with a complex query over her contraceptive medication. The GP advises the patient but with a sense of “dissonance” - he knows he is not fully up to date with the latest contraceptive guidelines.

**Analysis:**
Here the imperative of competence is in tension with the values of accessibility, comprehensiveness and continuity. All practices offer urgent care. Any GP sees any problem. Some practices, which place value on continuity of care, operate “personal lists” where the patient sees the same doctor for routine problems. Especially with “gendered” health problems, GPs can become deskilled in certain areas.

**Resolution:**
GMP requires GPs to be familiar with the latest guidelines. A good GP will keep a running list of topics they need to brush up on, by reading or going on a course. Here the GP could check the guidelines after the clinic or discuss informally with a GP colleague. If an error has been made the GP should contact the patient promptly, explain the error, apologise, and put matters right. This paper is extracted from the book *Essential Primary Care* edited by Andrew Blythe and Jessica Buchan. Wiley-Blackwell 2016.
FURTHER LEARNING

RESOURCES

Medicine is awash with philosophical and ethical issues - further information can be found in:

- **Sophie's World** by Jostein Gaarder. A beguiling story that also introduced readers to basic philosophical concepts at the same time. The world’s bestselling book in 1995.
- **Philosophy for Medicine: Applications in a clinical context**. Martyn Evans, Pekka Louhiala and Raimo Puustinen. Radcliffe, Abingdon, 2004. Applies philosophical principles to medicine (including ethics)

REFERENCES


The following resources have been developed in conjunction with SAPC Heads of GP Teaching. If you have any queries or questions regarding the resources on offer, please contact **Prof. Joe Rosenthal** or **Prof. Alex Harding**, Co-Chairs of SAPC’s Heads of GP Teaching Group.