The informal curriculum

General practitioner perceptions of ethics in clinical practice

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Background

Australian medical students should graduate with an understanding of the principles of medical law and ethics, and their application to clinical settings. Although student perspectives have been studied previously, the teacher experience of ethical issues also needs to be understood, particularly in the general practice setting.

Methods

Interviews were conducted with a convenience sample of 13 general practitioner teachers. They were asked to reflect on common and/or important ethical issues in their day-to-day practice. An inductive thematic analysis of the data was performed by two investigators, who reached a consensus on major themes using an iterative, dialogic process.

Results

Participants reported negotiating ethical issues frequently. Major themes included patient-doctor relationships, professional differences, truth-telling, ethically 'grey' areas and the personal demands of ethical decision making.

Discussion

General practitioners in this study describe sometimes needing to apply judgement and compromise in situations involving legal or ethical issues, in order to act in the best interests of patients and to successfully negotiate the patient-doctor relationship. Students learning in this clinical context may perceive mixed messages and ethical lapses in these challenging 'grey' areas. The ethical acumen and emotional resilience of both students and clinical teachers may be enhanced by ongoing reflective discussion with colleagues.

Keywords

ethics; education, medical, undergraduate

Australian medical students should graduate with an understanding of medical law and ethics, and be prepared for 'ethical decision making within the context of an appreciation of ethical issues related to human life and death'.[1] The informal curriculum of inter-personal learning in clinical environments is likely to be more important in the process of moral enculturation of students than formally structured medical student teaching in the domain of ethics.[2]

There is some evidence that the ability of medical students to recognise, and respond to, professional lapses and ethically problematic behaviour decreases over their clinical years[3] as a result of their experience of learning in 'real world' healthcare settings, where they may see professional role models behaving in ways they perceive to be unethical.[4] This has been described as an 'ethical erosion' of medical student moral sensitivity.[4] This informal curriculum has been explored through thematic analyses of reflective student essays about their experiences, predominantly in hospital settings.[5–7] However, to enhance our understanding of the ethical environment of clinical practice and clinical teaching, the teacher experience of ethical issues also needs to be understood. Furthering our understanding in this area has the potential to improve ethics teaching in general practice by acknowledging real-life ethical confrontations and challenges, and by addressing any tendency to ethical erosion in this setting.

In this study, general practitioner teacher clinical role models were invited to reflect on their experience of common and/or important ethical issues in general practice.

Methods

Thirteen GP teachers from a convenience sample of 13 different teaching general practices (*Table 1*) were invited to participate in individual, face-to-face interviews with the principal investigator. Participants were asked to identify, and reflect on, the ethical issues they encounter. The opening question was: 'If you were to think about some of the common, and/or important ethical issues you encounter in your general practice, what would come to mind?' Reflective listening techniques were used to clarify responses. Participants were encouraged to recount specific examples from their personal experience in order to provide authentic insights into their experience of ethical issues, rather than 'familiar narrative constructs',[8] such as general moral precepts. The interviewer did not prompt for any pre-identified topics. No issues raised by participants were excluded from discussion or analysis, to minimise the impact of researcher preconceptions about the parameters of the ethical domain.

Interviews took place between September 2010 and June 2011. All interviews were audio-recorded and transcribed by the principal investigator. Transcripts were not returned to participants for comment. An inductive thematic analysis of the data was performed by two investigators, who independently assigned descriptive tags or labels to narrative and other segments of the interview data and reached a consensus on major themes through the use of an iterative, dialogic process, according to the principles of grounded theory.[9] These investigators are both practising GP teachers and academics.

The study was approved by the University of Queensland Behavioural and Social Sciences Ethical Review Committee.

Results

All 13 GP clinical teachers invited to participate consented to be interviewed. Interview duration was between 15 and 48 minutes, with an average

Table 1. Characteristics of participants and practices		
Teaching practices	Socioeconomic status (by location)	Low (3)
		Medium (6)
		High (4)
	Special interests	Aboriginal health (2)
		Sexual health (1)
		Student health (2)
Participants	Ethnicity	Caucasian (13)
	Training	Australia (13)
	Gender	Female (7)
		Male (6)
	GP experience	<10 years (3)
		10–20 years (4)
		>20 years (6)

duration of 26 minutes. Saturation was achieved for the major themes.

All participants readily identified multiple ethical issues, although some expressed uncertainty about whether particular issues were 'ethical', 'professional' or 'differences of opinion'. For example:

> 'Where ... the financial side of things has perhaps been emphasised more than it might be, or more than I would emphasise it, you know.' [GP 1]

One participant reported difficulty finding an appropriate ethical vocabulary to describe common ethical experiences:

> 'Writing medical certificates every day, it's hard to know the ethical label for that but um, ah, writing medical certificates when you're unsure in your mind whether something really does limit that person's ability to participate in their work or whatever on that day ... that's an ethical issue but I don't actually know the term for that.' [GP 2]

Participants reported encountering ethical issues frequently in their practice:

> 'You know it's huge, our work life is so bound up with ethical decisions.' [GP 10]

> 'I think it's there in everything we do ... It's there, and it creeps up in a consultation.' [GP 9]

A number of key themes emerged from the data (*Table 2*).

Table 2. Major themes that emerged from qualitative analysis of the interview data

- Patient-doctor relationships
- Professional differences
- Truth telling
- Ethically 'grey' areas
- The personal demands of ethical decision making

Patient-doctor relationships

An imperative to preserve the patient-doctor relationship was explicitly recognised by participants as a key factor in negotiating ethical issues, which at times justified uncomfortable decisions or compromises:

> 'So do we just run off this whole list of tests that the naturopath has recommended in order to preserve the patient relationship? You know, 'No' is my answer but I say that as if it's definite, and it's not, because often I will order tests that I don't think are necessarily required but the patient really wants them, so I guess it's a matter of judgement and I try to walk a middle path.' [GP 10]

Several participants suggested that it might be morally justified to break the law on occasions for the patient's benefit, for example to preserve a therapeutic relationship:

> 'I won't admit it absolutely publically but there's been a number of cases that I've chosen not to [report under-age consensual sexual activity with a young partner over the age of 16] and yet you need to recognise as a practitioner if you choose that path you're technically against the law because of the mandatory reporting um sometimes it's in the best interest to be working with that young person rather than ah than reporting.' [GP 3]

The role of personal feelings in the patient-doctor relationship was explored by several participants, including the obligation to continue (or the justification for discontinuing) treatment of patients disliked by the GP (or other practice staff). On the other hand, patients particularly liked by the GP raised issues about pursuing friendships with patients. One participant reflected on subtle sexualisation within the patient-doctor relationship:

> 'When you are examining someone, are you able to be, is it possible to be absolutely detached, is there always a very small element of discomfort or inappropriateness or, particularly if you're the other gender ... You know in some cultures there's very definitely women's business and men's business and that and it's very very strong in some cultures and traditions and do we just pretend in our society you know that it's all okay then maybe it's actually not.' [GP 6]

Additional difficulties were reported in treating patients who were also practice staff or colleagues, and their family members.

Professional differences

A respect for other therapeutic clinical relationships emerged from participant responses, even when patients were openly critical:

> 'They say 'I saw doctor so-and-so and he was absolutely awful and he did this and he did that and he said that' ... I think patients often ask you to collude in that sort of stuff, and I find it very uncomfortable ... it's certainly not the right place to make any comment about anybody else.' [GP 6]

One participant described taking care when changing management in recently inherited patients:

> 'I mean we all come across patients we take over, and most of the time there's things in their past management we don't agree with, but it's just a case of changing them, you just move them over, and the only ethical difficulty there is trying to negotiate with the patient without necessarily being disrespectful of their previous practitioner.' [GP 12]

However, difficulties sometimes arose when the patient was unwilling to change:

> 'They come in on a huge number of medications

that we in our country wouldn't normally be putting them on, they come here in the expectation that we'll keep giving them a combination of an upper and a downer and an atypical and an antidepressant and a sleeping tablet ... They're quite resistant "oh but I need this" and you know without drug-seeking, with full on doctor shopping you say "no" and that's it, but these are students, they're trying to do well, they've come from a system where any specialist probably thinks it's okay and so whether you say, look I don't agree with your psychiatrist back home.' [GP 8]

Covering for a colleague was raised by several participants:

'I've had occasions not uncommonly where another colleague in the practice I believe has not been as thorough as they might have been, the patient's been to see them in the past and you look up the notes and there's nothing [laughs] nothing that's written or like "amoxil" and you've got no idea what's going on ... if the patient said "I saw doctor so-and-so last week" and I say "okay let's look up the records" and you're embarrassed, huge embarrassment and you have to cover up and you say "oh look he's not written terribly much there so tell me more about it," so you can get away with it a bit with the patient.' [GP 11]

Participants also alluded to inter-professional tensions, often in relation to other health professionals advising patients to make inappropriate requests of the GP.

Truth-telling

Participants described managing uncertainty about patient truthfulness by 'giving them the benefit of the doubt' (GP 8) at times, but also acknowledged the privileging of the patient's perspective in situations such as patient allegations of workplace harassment or relationship tensions. Participants talked about 'just considering the weight of your words' (GP 9) because of the powerful influence these might have on the patient. Making a distinction between the GP's personal opinion and medical consensus was seen as important by one participant, for example in responding to a patient's request for advice about parenting. Another participant described situations in which she was unable to pursue what in her clinical judgement were the patient's best interests, because of a conflicting and more powerful contemporary medical consensus, including other specialist opinion and/or evidence based guidelines:

'Because you know the powerful medical player in her mind was a specialist and in fact my attempts to persuade her ... simply undermined in her eyes my competence as a doctor.' [GP 10]

One participant admitted to bending the truth if this secured necessary treatment for the patient:

'You know, fudging things to get Medicare rebates for um, not necessarily fudging, but people have to have the right conditions before you can get it done or what's another example? A script they have to have a certain condition and they don't quite fit, and you say they've got such and such and you might actually be breaking the law and yet we're actually acting for our patients and in a way they have a genuine disease, they need it, they couldn't afford it privately so we're making these decisions that are a very grey area ... Who are we acting for, our patient or the system? I think they're very tricky those areas, don't have the easy answers always.' [GP 8]

Ethically grey areas

Many participants commented that the appropriate response to some ethical issues was 'obvious' or 'straightforward':

'Well, most of the common ones are fairly straightforward, just things such as people wanting things that are inappropriate and usually they can be sorted out by a good consultation.' [GP 12]

However, ethical uncertainty or ambivalence also emerged frequently from the data, often expressed in terms of decisions being 'grey' or 'not black and white'. For example, participants acknowledged the importance of maintaining patient-doctor boundaries in facilitating refusal to accede to inappropriate patient requests. However, value was also seen in being flexible with boundary rules:

'[Patients] might ask for information about you, or things like gifts and those sorts of things can be quite difficult, sometimes you don't know what to do or say ... the closer you get, I can see how that can make the therapeutic relationship perhaps a little bit more difficult, I can see that, and I guess I was always told you shouldn't cross that boundary, but at the same time, sometimes giving a little bit of yourself can be incredibly valuable, and sometimes for a for a patient to give you something, or say thank you for something that you've done can be quite valuable for them as well.' [GP 1]

This participant described recognising in her early career that ethical guidelines previously thought to be appropriate were at times unhelpful or inappropriate, and an ensuing sense of bewilderment and isolation:

'I found general practice even more complicated because you're often there on your own and, um, until you really have that ongoing relationship with the patient as well, I think, I just think before you start practising it seems like there are going to be relatively clear guidelines.' [GP 1]

The personal demands of ethical decision making

Participants indicated that vigilance, effort and personal cost were sometimes involved in negotiating ethical issues. Costs included personal vulnerability to clinical error (eg. a missed diagnosis) when deciding to limit investigation costs in line with the GP gatekeeper role:

'Some doctors do a lot more tests that I do, and whether to take that risk, not that it's a big risk, but that depends; we're being asked to take a small risk on behalf of the health dollar, but not being covered for it if something goes wrong.' [GP 8]

This participant also emphasised the personal effort involved in denying inappropriate patient requests:

'Whether people really need a referral to a dermatologist for a skin check, something we can do ourselves ... and it takes longer, a lot longer to talk and convince them rather than just say "here you go" and get them out the door, and you can earn money ... [when I'm] tired or busy or worn out by having explained the same thing to numerous other people that day ... it's easiest to say "okay have it this time".' [GP 8]

Several participants described an emotional cost:

'I tend to anguish a bit over these kinds of ah, ethical decisions, I don't know too many GPs who never worry.' [GP 10]

'I do sometimes feel irritated at being put in the position of being the one who has to tell someone that the rule doesn't apply to them and they've been sent along effectively with a kind of promise that it is for them ... none of us really like denying patients things they want, and um

could probably justify morally.' [GP 12]

Patient pressure was at times significant:

'I've had people storm out of the consulting room because I've refused to do a thyroid tissue antibody because they've just had their mercury removed from their teeth.' [GP 10]

Workload pressures also made timely identification of, and reflection on, ethical issues difficult:

'I think, I think I'd say all of us want to do the right thing, but it's sort of surfacing out of the business of the day, and the pressures within the consultation, so the time pressures and the you know your own emotional stuff, it's surfacing up out of that to think clearly.' [GP 10]

Both relatively inexperienced and experienced participants reported having benefitted from discussions about ethical issues with colleagues.

Discussion

General practitioner teachers in this study identified a wide range of ethical issues and dilemmas that face them in day-to-day clinical practice. A number of contexts increase the perceived difficulty of ethical decision making, including professional and clinical differences, patient insistence, compelling patient need and reservations about the appropriateness of clinical, ethical or legal guidelines to specific patients or situations. In contrast to previous research in hospital settings, which suggested that senior clinicians are unaware of everyday situations or practices which students may perceive as ethically problematic,[6] responses from GP teacher participants in this study suggest that they recognise the existence of an informal curriculum of ethical issues in general practice. Some participants divulged personal stories of moral struggle and admitted to actions which might be characterised by students as ethical lapses, including ordering unnecessary tests, failing to report under-age sexual activity, 'fudging' indications for subsidised medication, or accepting gifts. Participants perceived 'grey' areas and challenges, rather than 'black and white' ethical lapses or contradictions between fromal teaching and actual practice. Importantly, as a practising GP teacher colleague of the participants, the interviewer's group membership is likely to have facilitated 'the achievement of inter-subjective depth and mutual understanding' from which knowledge of social worlds emerges.[8] The principal investigator experienced the interviews largely as authentic reflections about the practical GP experience of ethical issues, particularly when participants recounted personal experiences. A research methodology using audio-diary recordings may have facilitated recall of ethical issues, but low uptake in a similar student study[10] suggests this may have had limited appeal to potential participants.

Although the participants worked in diverse urban general practices, their personal demographic details are less diverse. All participants were Australian-trained and Caucasian. Also, the fact that the participants were all from urban rather than rural locations may have influenced their experience of ethical issues. As such, there is no way of knowing whether the experiences described by of our relatively homogenous group of urban Australian GP teacher participants would be representative of other Australian GPs, particularly those who may be overseas-trained, from rural or ethnically-diverse communities, or not involved in teaching.

These findings suggest that GPs may find ethical, clinical and legal guidelines unconvincing at times and need to apply judgement and compromise to pursue their patients' best interests and guide the negotiation of patient-doctor relationships. These GP teacher perceptions of ethical decision-making in general practice may contrast with those of students. Further research is needed to identify any student perceptions of the informal curriculum, which might trigger the ethically erosive responses of moral cynicism or apathy, or unnecessary feelings of guilt.

Even experienced GPs appear to struggle with the challenges of this 'micro-ethical' environment.[11] The ethical acumen and emotional resilience of both GP teachers and students may be enhanced by ongoing reflective discussions with colleagues.

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