Ethical Decision Making by Family Physicians

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One hundred thirty-one Illinois family physicians, 53 general practitioners, and 65 general internists responded to a survey on medical ethics. From these data emerged a profile of the family physicians and an identification of the ethical problems they encounter most frequently in their practice: (1) issues about contraception, (2) pain control, (3) telling the patient the truth, (4) sexual issues, (5) informed consent, (6) confidentiality, (7) controlling patients' behavior with medication, (8) sterilization, (9) professional etiquette, (10) patients' rights, and (11) peer review.

Ethical decision making in the practice of medicine is an area of continuing interest to both the public and the medical profession. Ethicists in academic settings have generated a large volume of literature with emphasis on case analysis, but little attention has been given to the perceptions of physician practitioners. It is said that family practice, as a primary care field, provides a greater array of problems requiring ethical decision making with patients than any other specialty.[1] If this is so, then family physicians need to be able to recognize a wide spectrum of ethical issues.

This paper reports findings of a survey of Illinois family physicians about the ethical problems they encounter in practice. Family physicians are compared with two other primary care groups, general internists and the rapidly disappearing general practitioners.

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Methods

All 1,851 physicians on the continuing education mailing list of Southern Illinois University School of Medicine (SIU-SM) were sent a questionnaire that elicited anonymous responses. The questionnaire contained items dealing with both ethical problems that arise in the daily practice of medicine and items of biodemographic, educational, and practice information. The study population was limited to central and southern Illinois physicians for several reasons. First, the focus of the survey was to gain insights into everyday ethical decision making faced by physicians in the geographic area served by SIU-SM. Second, a long-term goal of the survey was to incorporate

the perspectives of practicing physicians into the validation process of the SIU-SM curriculum on medical ethics for medical students and residents and thus better prepare them for practice. Third, many SIU-SM graduates establish their practices in downstate Illinois.

Returns were received from 669 physicians, representing a 36 percent response rate. Because of financial constraints, no follow-up of nonrespondents was made. Respondents selected for the present study were the 131 physicians who identified their specialty as family practice, 53 general practitioners, and 65 general internists. The family practice group represented 52 percent of the active family physicians in the downstate area as determined by the American Academy of Family Physicians membership roster for 1981. Chi-square tests were used to determine significance of differences among the groups.

Results

Profile of the Family Physician

The typical family physician practicing in central and southern Illinois, as reflected by the data in this study, is a married (92 percent) man (95 percent) who is 50 years old and of Protestant faith (57 percent). He was graduated from a school in the state (49 percent), particularly the University of Illinois College of Medicine (31 percent), between 1936 and 1965 (68 percent). He has been in solo practice (51 percent) in a semirural (population, 2,500 to 10,000) or a semiurban (population, 10,000 to 50,000) area for 22 years. He has had 2.5 years of postgraduate training and sees 37 patients daily of whom 4 (11 percent) are welfare patients. He reports having daily interaction with other physicians (79 percent) and social interaction with friends once or more weekly (69 percent). He claims to have read carefully both the Hippocratic Oath (96 percent) and the American Medical Association's Principles of Medical Ethics (68 percent).

In resolving sample ethical conflicts, the family physician states that he would act as follows:

1. If a male patient contracted venereal disease and infected his wife but was unwilling to tell her himself and asked the physician to treat her without telling her about her condition, the physician would resist the request and favor telling the wife she had venereal disease and treating her openly.

2. If at 4:30 PM on a regular office day various patients telephoned or walked in, the physician would see them in the following order: first, a patient with a fever of 102° F; second, a patient who wanted to talk about a "serious personal problem"; third, a terminally ill patient; fourth, a hospitalized patient; fifth, a patient in an emergency room (provided an emergency room physician was on duty); and sixth, a patient needing a home visit.

3. If a family physician decided to act to prevent patient harm by another physician, he would first, confront the physician; second, stop referring patients to that physician; third, inform the hospital medical director; fourth, tell the patient; and last, inform the county medical society.

Comparison of Family Physicians, General Practitioners, and General Internists

On the average, general practitioners in the study are older (58 years) than the family physicians (50 years) and the general internists (48 years). With regard to practice characteristics, proportionately more family physicians and general practitioners than internists are in solo practice, with more general internists in group practice. Also, the majority (63 percent) of the internists practice in a small metropolitan city (population, 50,000 to 150,000), whereas only 20 percent of the family physicians and 15 percent of the general practitioners practice in the same-sized urban area.

Table 1 displays the most likely behavior reported by family physicians, general practitioners, and general internists in selected ethical situations dealing with contraception and abortion. Of the three groups, family physicians are most likely and internists least likely to provide contraceptive aids to a teenage patient who requests them with or without parental permission. If a woman requests an abortion, the behavior of each group of physicians does not vary substantially whatever the age or marital status of the patient. As to specific courses of action, family physicians and general practitioners are similar in that their most typical response is referring the patient to a clinic for the abortion. On the other hand, a substantially larger number of internists than family or general practitioners would choose to refer the patient to a colleague.

Table 2 allows comparison of the groups with regard to the frequency of encountering various

Table 1. Percentages of Reported Behaviors of the Physicians in Selected Ethical Situations

	Family Physicians %	General Practitioners %	General Internists %	Total No. (%)
What would you be most likely to do if:				
1. A teenage patient requests contraception *with* parents' permission?				
Provide it	94	82	68	206 (84)
Refer to Planned Parenthood	4	8	15	19 (8)
*Refer to a colleague	0	2	12	9 (4)
*Refuse to become involved	2	8	5	9 (4)
(χ^2=17.13, *df*=4, P < .01)				
2. A teenage patient requests contraception *without* parents' permission?				
Provide it	76	59	46	154 (64)
Refer to Planned Parenthood	13	12	33	44 (19)
*Refer to a colleague	0	6	14	12 (5)
*Refuse to become involved	11	23	7	29 (2)
(χ^2=39.78, *df*=6, P < .001)				
3. An unwed teeneager requests an abortion?				
Perform the operation	6	8	5	15 (6)
Refer to a colleague	12	2	32	37 (15)
Refer to a clinic	59	59	40	132 (54)
Refuse to become involved	6	12	6	18 (8)
Counsel against abortion	17	19	17	42 (17)
(χ^2=25.11, *df*=8, P < .01)				
4. A married woman not impregnated by husband requests an abortion?				
Perform the operation	6	6	5	14 (6)
Refer to a colleague	19	6	32	48 (20)
Refer to a clinic	54	61	35	123 (50)
Refuse to become involved	6	12	9	20 (8)
Counsel against abortion	15	15	19	39 (16)
(χ^2=16.60, *df*=8, P < .05)				
5. A mother of six requests an abortion?				
Perform the operation	7	8	6	17 (7)
Refer to a colleague	16	6	37	48 (20)
Refer to a clinic	51	49	31	110 (45)
Refuse to become involved	6	14	8	19 (8)
Counsel against abortion	20	23	18	50 (20)
(χ^2=23.18, *df*=8, P < .01)				

*Categories combined for the calculation of the chi-square test
Note: Although chi-squares are based on raw frequencies, data are presented in percentages to facilitate interpretation

ethical problems in medical practice. As expected, family physicians report confronting problems related to reproduction more often than either the general practitioners or the general internists. These problems include abortion, artificial insemination, birth defects, contraception, genetic coun-

Table 2. Percentage of Frequency With Which the Three Physician Groups Encountered Various Ethical Problems

	Family Physicians %	General Practitioners %	General Internists %	Total No. (%)
Abortion				
Very commonly	14	6	0	21 (9)
Commonly	20	12	3	33 (14)
Occasionally	59	68	67	152 (63)
Never	7	14	30	35 (14)
(χ^2=35.05, df=6, P < .001)				
Artificial insemination				
*Very commonly	0	0	0	0 (0)
*Commonly	0	0	2	1 **
*Occasionally	38	16	12	65 (27)
Never	62	84	86	177 (73)
(χ^2=16.94, df=2, P < .001)				
Birth defects				
*Very commonly	1	0	0	1 **
*Commonly	8	2	2	12 (5)
Occasionally	84	76	42	174 (72)
Never	7	22	56	56 (23)
(χ^2=61.05, df=4, P < .001)				
Contraception				
Very commonly	62	46	16	113 (47)
Commonly	27	36	41	78 (32)
Occasionally	7	10	34	36 (15)
Never	4	8	9	15 (6)
(χ^2=47.82, df=6, P < .001)				
Genetic counseling				
*Very commonly	2	0	0	2 (1)
*Commonly	5	0	3	9 (4)
Occasionally	76	53	50	156 (64)
Never	17	47	47	75 (31)
(χ^2=19.88, df=4, P < .001)				
Informed consent				
Very commonly	27	18	25	59 (24)
Commonly	41	32	37	91 (38)
Occasionally	29	34	35	76 (32)
Never	3	16	3	14 (6)
(χ^2=13.69, df=6, P < .05)				
Professional etiquette				
Very commonly	23	18	20	51 (21)
Commonly	38	25	30	80 (33)
Occasionally	34	35	44	90 (37)
Never	5	22	6	22 (9)
(χ^2=14.59, df=6, P < .05)				

*Categories combined for the calculation of the chi-square test
**Less than 1 percent

Table 2. Percentage of Frequency With Which the Three Physician Groups Encountered Various Ethical Problems (Continued)

	Family Physicians %	General Practitioners %	General Internists %	Total No. (%)
Sexual issues				
Very commonly	25	14	5	42 (17)
Commonly	43	29	26	86 (36)
*Occasionally	30	51	64	105 (44)
*Never	2	6	5	8 (3)
(χ^2=28.59, *df*=4, P < .001)				
Sterilization				
Very commonly	23	14	2	37 (15)
Commonly	43	29	9	76 (31)
Occasionally	27	37	59	92 (38)
Never	7	20	30	38 (16)
(χ^2=54.26, *df*=6, P < .001)				

*Categories combined for the calculation of the chi-square test
**Less than 1 percent

seling, sexual issues in general, and sterilization. Family physicians and internists do not differ markedly as to how often they deal with informed consent and professional etiquette problems, but both report encountering them with more frequency than general practitioners.

Other data not shown in the tables indicate that all three groups of physicians encounter with equally high frequency problems relating to pain control, telling patients the truth, confidentiality, controlling patients' behavior with medication, and peer review. In addition, family physicians and general internists identify patients' rights as an issue they need to consider very often in their practices. On the average, these two groups of physicians report facing more situations involving ethical conflict than do general practitioners.

Discussion

The ages, year of medical school graduation, and average number of years in specialty training indicate that a number of the family physicians in this survey were already practicing medicine on February 9, 1969, when family practice was recognized as the 20th medical specialty by the American Board of Medical Specialties. These physicians, particularly the foreign medical school graduates (nearly 20 percent of the family practice sample) probably took the board-certifying examination after that date.

There is indeed the possibility that some general practitioners may have reported family practice as their specialty without having taken or passed the examination. Board certification information would have allowed better matching of the physicians with their specialty; however, such information could not have been gathered while maintaining anonymity of the physicians. The questionnaire solicited anonymous responses, and the physicians were repeatedly urged to provide candid, honest answers to all items throughout the instrument. The authors, therefore, trust that specialty was correctly reported by most respondents and that, consequently, the data obtained from the family physician sample are representative of the specialty.

An additional caveat relating to the findings is that some items in the survey instrument tap attitudes rather than actual behaviors. The majority of those items are aimed at determining attitudes toward actions rather than attitudes toward objects. Research has shown that the strength of the relationship between the attitude expressed and the behavior forecasted is largely dependent upon two

conditions: the similarity between the target of the attitude and that of the behavior (eg, the patient), and the similarity between the action implicit in the attitude and the actual behavior forecasted (eg, providing contraceptive aids).[2] Therefore, it can be expected that the physicians' responses represent a fairly accurate estimate of their most probable behavior when confronted with situations comparable to those presented in the items.

Family physicians report seeing more patients daily (37, or about 5 per hour) than the general practitioners or the general internists, who indicate 32 and 26 patients, respectively. Even with a heavy patient load, a large majority of the family physicians report giving high priority to counseling. According to a 1981 survey conducted in North Carolina and Ohio, 207 family physicians stated they had an average of nine counseling sessions per month with patients.[3] The data from the present study in Illinois indicate that family physicians not only are willing to devote time to counseling their patients when needed, but also rank counseling as their second highest priority when allocating their services as a scarce medical resource.

At variance with the general practitioners and the general internists, family physicians are almost unanimous (94 percent) in reporting that they would provide contraceptive means for a teenager who had parental permission. Also, 76 percent of the family physicians, as opposed to only 59 and 46 percent of the general practitioners and internists, respectively, indicate that they would provide contraceptive means to a teenager even without parental permission. That family physicians rate contraception as the ethical problem most frequently encountered in their practices may indicate that they both recognize and perhaps struggle with value conflicts in arriving at their decisions.

Comparison of the ethical problems that the three groups of physicians confront most frequently indicates a variety of concerns involved in the practice of family medicine. The family physicians' interest in medical ethics is further suggested by the fact that they volunteered to write in more ethical issues not listed on the questionnaire than did general internists or general practitioners. Family physicians also made more suggestions than the other primary care physicians for the teaching of medical ethics to medical students and residents.

Overall, the responses to the questionnaire highlight family practice as a specialty that crosses traditional disciplinary lines: "a specialty in breadth which builds on a core of knowledge derived from other disciplines—drawing most heavily on internal medicine, pediatrics, obstetrics and gynecology, surgery and psychiatry," as defined by the Academy of Family Physicians.[4] The results of the survey support Dickman's contention[1] that not only does ethical decision making for family physicians call for more intensive involvement than for other specialists but also that family practice as a specialty must be prepared to face a wider spectrum of issues than any other specialty.

The data from this study are valuable for identifying both the issues of ethics and the frequency with which the physician encounters moral dilemmas, and thereby the data are of help for determining what ought to be included in a medical school curriculum. However, as Tiberius has pointed out, to teach only about ethical dilemmas is not enough: "A course may teach *knowledge* about ethics, or *understanding* of ethical systems, or moral reasoning, but all the moral reasoning in the world is useless in the head of a student who lacks good moral reflexes."[5] Teaching about ethics does not guarantee ethical behavior. Medical faculties also need to select students who place high value on ethical conduct and to identify preceptors who exhibit both the knowledge of ethics and the moral reflexes in practice to serve as models for students. These tasks must be priorities for all specialties.

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