Between professional values, social regulations and patient preferences: Medical doctors' perceptions of ethical dilemmas

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Abstract

Background. *We present and discuss the results of a Norwegian survey of medical doctors' views on potential ethical dilemmas in professional practice.*

Methods. *The study was conducted in 2015 as a postal questionnaire to a representative sample of 1612 doctors, among which 1261 responded (78%). We provided a list of 41 potential ethical dilemmas and asked whether each was considered a dilemma, and whether the doctor would perform the task, if in a position to do so. Conceptually, dilemmas arise because of tensions between two or more of four doctor roles: the patient's advocate, a steward of societal interests, a member of a profession, and a private individual.*

Results. *27 of the potential dilemmas were considered dilemmas by at least 50% of the respondents. For more than half of the dilemmas the anticipated course of action varied substantially within the professional group, with at least 20% choosing a different course than their colleagues, indicating low consensus in the profession.*

Conclusions. *Doctors experience a large range of ethical dilemmas, of which many have been given little attention by academic medical ethics. The less discussed dilemmas are characterized by a low degree of consensus in the profession about how to handle them. There is a need for medical ethicists, medical education, postgraduate courses and clinical ethics support to address common dilemmas in clinical practice. Viewing dilemmas as role conflicts can be a fruitful approach to these discussions.*

Introduction

In academic medical ethics, the more mundane dilemmas are typically not paid much attention to. Traditionally, the academic literature focuses disproportionally on the 'classical', highly visible, dilemmas of life and death. In daily clinical practice, however, medical doctors regularly face a range of ethical dilemmas, both mundane and dramatic. Furthermore, some dilemmas are readily acknowledged and much discussed – others less so. Abortion, limiting life-prolonging treatment and cases of conscientious objection are examples of the former, while whether to prescribe drugs to colleagues or family members, or receive gifts from patients, are examples of the latter. Being more frequent, such mundane dilemmas can be at least as challenging in daily work.

Oxford Dictionary defines an ethical dilemma as *"a situation in which a person must choose between two courses of action of (apparent) equal moral importance, so that the choice necessarily entails the transgression of an important moral principle"*. For professional activity in general, and medical practice in particular, giving up one important principle for the sake of another is sometimes unavoidable, due to the complexity of the principles and interests that the doctor is expected to accommodate.

Dilemmas are not only conflicts between moral values, they might also be conflicts between role obligations. The conflict between serving as the patient's advocate versus maintaining societal responsibilities is an example of a role conflict. Thus, dilemmas might be characterized by both conflicting duties and conflicting values. In this article, we present the results from a survey investigating how Norwegian doctors think about a wide range of ethical dilemmas – dilemmas more or less common and more or less dramatic. We wanted to know whether they perceived each situation as a dilemma at all, and how they claim that they would act. Our aim is to provide an overview of the results, not to discuss each dilemma in detail.

The Norwegian context

Whether a dilemma occurs, or indeed is considered a dilemma at all, varies between health care systems. A culture where hard paternalism is valued may not give rise to tensions between professional judgment and patient autonomy. Private systems need not involve the same restrictions regarding gifts, or secular societies may be less restrictive to abortion.

The vast majority of Norwegian doctors work in a single payer, universal access, public system. All hospital doctors are employed, and the hospitals are funded by the government. Although most primary care doctors are self-employed in private businesses, their income depends to a large extent on public sources: Remuneration based on the number of patients on their list (public, municipal), fee for service (state), plus out of pocket co-payments by patients. Public sources cover annual co-payments above 300 Euros. GPs are gate-keepers of specialist care. Every citizen is granted a primary care doctor.

The Norwegian Medical Association has a rather strong influence on medical practice, as a powerful negotiator of fees, salaries, and working hours, and in questions of medical professionalism. Its Council for Medical Ethics bases its work on a Code of Ethics in which patient interests, collegial issues, and societal interests are integrated.[1]

Despite international differences there is probably a core of shared professional values in most Western health care systems, as expressed in universal declarations like WMAs Declaration of Geneva and The Helsinki Declaration, or ABIMs charter on medical professionalism.[2,3] [4]

On the other hand, not all doctors are the same. Variations in how codes of ethics are integrated in the opinion and conduct of the individual doctor are to be expected.[5] This study will also throw light on such variation.

Material and method

The data were collected in 2014/15 through a postal survey to an age, gender and specialty representative panel[6] of approximately 1600 members of the Norwegian Medical Association, conducted biannually.

Based on our knowledge of medical ethics, clinical experience, and discussions with colleagues, we compiled a list of 41 potential ethical dilemmas that doctors may encounter (Table 1). We asked whether the doctor perceived the situation as an ethical dilemma, and whether s/he would perform the task. Response alternatives were “yes”, “don’t know” and “no”.

In addition to ethical dilemmas, the questionnaire included questions about priority setting, personal responsibility for health, and doctors' work and health. The complete questionnaire

(in Norwegian) is provided on request.

Ethics approval

Participation was voluntary. Completing the questionnaire was considered consent. The front page included a statement on the right to withdraw at any time. The Regional Committee for Medical Research Ethics has exempted the survey from review since it does not include patient data (IRB 0000 1870).

Results

1612 doctors received the questionnaire and 1261 responded (response rate 78%). Results are displayed in Table 1.

Table 1. Responses to a list of potential ethical dilemmas. N=1261.
Dilemmas ranked by proportion who claim they would not perform the task.
Dilemmas where 20-80% would not perform the task are highlighted.

(Not shown: Percentage who would perform the task; percentage who do not consider the situation as a dilemma.)

	Would not perform if in a position to do so		**Considered a dilemma**		**Δ Male-female**	**Δ GP-other**
	Would not perform %	Don´t know %	**Yes %**	Don´t know %	Pearson Chi-Square α=0.01	Pearson Chi-Square α=0.01
Conceal or extenuate a major error	94	4	65	1		
Provide sick-leave certification for a healthy patient (e.g. to cancel flight tickets)	88	7	61	2		
Purposefully trivialize a malignant diagnosis or risky intervention	86	8	63	3		

Doctor-assisted suicide if this becomes legal	68	***23***	83	6		
Prescribe antibiotics on patient's request	68	14	57	2		x
Prescribe placebo drugs	63	18	65	7		
Under-dosing of painkiller due to risk of addiction	60	19	49	8	x	
Euthanasia if this becomes legal	58	***30***	82	7		
Ritual circumcision of boys	56	***23***	72	8	x	
Coercive sterilization of an intellectually disabled patient	55	***31***	78	5	x	
Social contact with patients	54	19	58	7	x	x
Prescribe addictive drugs (e.g. valium) to a patient known to be addicted	52	***24***	71	4		x
Conceal or extenuate a less significant error	51	19	57	5		
Accept gifts from the medical industry	47	***22***	62	5		x
Prescribe addictive drugs to yourself or family members	45	13	55	3	x	
Continue tough curative treatment when the prognosis is poor	43	***34***	80	5		
Force feed a person on hunger strike	42	***39***	76	8	x	
Prescribe narcotic drugs to addicted patient as ‘emergency solution’	40	***29***	68	7		
Prescribe addictive drugs to a colleague	38	18	55	3	x	x
Provide sick-leave certification with a strategic diagnosis	37	***26***	60	12		x
Overrule a patient's living will on professional grounds	34	***55***	59	25		

Life sustaining treatment of dying patient	34	***31***	77	6	x	
Accept gifts from patients and/or their dependents	32	***25***	56	5		x
Prescribe narcotic drugs to a substance addicted patient as substitution therapy	26	18	40	6	x	
Coercive bathing of a patient	25	***34***	66	9		
Refer to specialist care without a medical reason (defensive medicine)	22	8	45	6		x
Perform surgical or medical abortion	19	13	34	5		
Assist authorities in determining characteristics (e.g., age) of asylum seekers	13	26	36	11	x	
Perform surgery on patients who refuse blood transfusion	11	***30***	60	10	x	
Refer a lesbian couple to in vitro fertilization	11	15	31	8	x	x
Ensure patient receives referral for abortion by another doctor	10	8	19	6	x	
Force feed an anorexic patient	9	***29***	61	8	x	
Referral for abortion	6	6	22	2	x	
Prescribe an IUD that may prevent a fertilized egg to implant	5	6	10	5	x	x
Prescribe non-addictive drugs to yourself or family members	5	4	11	2		
Serve as expert witness in a court	5	17	27	10		
Volunteer in a medical emergency in public (e.g. at an airport)	4	5	20	3		

Report an incompetent colleague	4	***32***	63	5		
Report a patient as a potential child- or partner abuser	3	8	37	2		
Constrain an uneasy or threatening patient	3	16	56	4		
Coercive medication of a psychotic patient	3	7	40	3		

The table is sorted according to the percentage of doctors who say no to performing each task. We were interested in seeing which dilemmas would lead to the largest differences in (claimed) practice among the doctors. We pragmatically chose those where 20% to 80% indicated that they would not perform the task (highlighted mid-section). In these cases, at least 20% were either unsure or chose a different course of action than their colleagues, indicating low consensus on how to resolve these dilemmas.

In 14 dilemmas, more than 20% responded "don't know" to whether they would perform the task (italicized numbers in 2nd column). This too indicates low consensus.

Variations between doctors

The two rightmost columns denote statistically significant different responses between male and female doctors, and GPs and non-GPs. There is no variation in the top 20% (would not perform), whereas responses in the lower 20% vary more, in particular between male and female doctors.

There is more variation according to gender and position (GP or not) in the mid-section of table 1. Even though overall variation is smaller in the lower part of the table, we find significant gender differences concerning handling asylum seekers, performing surgery when blood transfusion is refused, force feeding anorexic patients, referring lesbian couples to in vitro fertilization, abortion referrals, ensuring abortion referral by another doctor and prescribing an IUD with abortive capacity. In the four dilemmas related to pregnancy and abortion female doctors are more often willing to perform the tasks.

Considering the nature of the work, it is not surprising that GPs more often report that they

would prescribe antibiotics on patient request, refer to specialist care without a medical reason (defensive medicine), accept gifts from patients, or engage in social contact with them. Barriers between the GP and the patient are generally fewer and the relationship longer lasting.

Discussion

The study shows that doctors experience many ethical dilemmas. 41 were assessed in this study; the list could no doubt have been made longer.

The top three dilemmas in table 1, where >80% would refuse to perform the task in question, are not only contrary to professional ethics, but also arguably illegal. By contrast, all the 15 tasks which <20% would not do, involve lawful and/or sometimes legally obligatory courses of action. Further, some of these involve legal rights to services, such as the right to abortion and lesbian couples' right to in vitro fertilization.

Several dilemmas involve morally challenging actions that can nevertheless sometimes be professionally and/or morally obligatory (e.g. coercive treatment in psychiatry, reporting to authorities). Notably, among the tasks that doctors were least likely to refuse, several touch on controversies often discussed in academic bioethics: abortion, prescription of contraception with suspected abortifacient side-effects, referrals for assisted reproduction for lesbian couples, and conscientious objection. Although most doctors will not refuse to provide abortion-related tasks, we found a statistically significant gender difference, also shown in previous studies.[7,8]

Paradoxically, many situations that the majority perceive as ethical dilemmas are less often discussed in the bioethics literature (e.g. prescription of addictive drugs, or antibiotics on request; social contact with-, and accepting gifts from patients; providing a strategic diagnosis for sick-leave certificates; withholding information about less important adverse events; the practice of "defensive medicine" with a low threshold for specialist referral). Broadly speaking, bioethical debate has focused on a limited set of high-profile topics. In a predominantly secular profession, our study shows that many of these topics are experienced as dilemmatic only by a smaller minority. Other issues are merely hypothetical for many doctors (e.g. assisted dying) and have thus little bearing on their common experiences.

This academic myopia has led to a relative neglect of other topics, including some of the dilemmas frequently experienced by doctors in daily practice. Many of them are dilemmas where attitudes and practices vary the most, with sizeable proportions of respondents indicating that they would either perform or refuse to perform the task. New medical knowledge, increased regulation (e.g. new laws, patient rights), rapid development of new drugs and treatment possibilities, and new expectations from patients and doctors (e.g. work-life balance), are some of the factors that actualize these dilemmas. Examples of such "ethics of the ordinary" have been discussed among general practitioners in the UK, who call for increased awareness of the moral dimensions underpinning interactions and relationships between clinicians and patients.[9,10] These "ordinary" ethical dilemmas can be perceived as more challenging because they occur more often, and because there is less consensus, and professional guidance, on how to handle them. Hence, the dilemmas in Table 1's highlighted section are arguably in the greatest need of awareness, clarification and guidance.

As described in the Introduction, dilemmas arise because of conflicts between moral values as well as between conflicting roles. Some particularly vital, yet potentially conflicting, moral imperatives are: to provide the patient with the best possible care; to make sure that the care is in line with the patient's preferences; to adhere to legal regulations and other system requirements; to act in accordance with professional ethics; and not to act contrary to one’s own personal beliefs and values. he moral imperatives are not easily separated from one another. For instance, "best possible care" can reasonably be defined as good medical quality combined with treatment according to the patient’s preferences. We make the distinction for analytical purposes only.

Structural changes in healthcare, in particular the increased influence from policy makers, managers, and patients, are likely to increase tensions between doctors’ roles. The roles have changed considerably during the last century. Historically, the profession held almost unrestricted power over the contents of medical care – a situation gradually changing as power shifted to politicians, managers, and patients.[11,12] The patients are better educated and expect their voices to be heard; and the society wants more insight into and control over what takes place in healthcare. Thus, the doctor is expected to fulfill the role of the patient's advocate as well as a steward of societal interests.[4,13] Further, s/he is part of a profession, and a private individual. Hence, professional choices can be influenced by the need to secure professional privileges, or uphold positions in a social hierarchy. Finally, as an individual, the

doctor has personal interests, beliefs, preferences, and social obligations that go beyond the professional role.[14,15]

Thus described, conflicts between moral obligations can be seen as role conflicts: ethical dilemmas arise because there are inherent, and unavoidable, tensions between the different roles the doctor is expected to fulfill. This is summarized in table 2.

Table 2. Doctors' professional roles and accountabilities

Role	Administrator and gatekeeper	Professional	Patient's advocate	Private, individual
Accountable to	Society Health authorities	Medical quality Professional association Peers	Patient Next of kin	Self, incl. personal core moral values
Core moral norm(s)	Act in accordance with laws and system requirements. Take responsibility for population health and for fair distribution of resources.	Adhere to good practice and professional ethics	Ensure care is in line with patient's views and interests	Do not act contrary to personal core values and interests

Structuring discussions of dilemmas according to the conflicts that arise between two or more of the roles described above can be a fruitful way to handle demanding situations. The tensions could warrant an exhaustive discussion for each of these dilemmas, yet for the sake of space we will exemplify by commenting only on three.

Prescribing antibiotics on patient request demonstrates a conflict between at least three roles. New laws and regulations emphasize the professional obligation to heed the patient's wishes and interests, and quality of care is increasingly measured by patient satisfaction. Acting as the patient's advocate, GPs are, we find, more often than other doctors willing to prescribe antibiotics on patient request only. This can come into conflict with the gatekeeping role, the risks of extensive antibiotic use for future patients and society at large is increasingly appreciated.[16] The doctor also needs to choose the course of action in accordance with existing norms for good professional practice. The three roles can be hard, even impossible, to combine in a satisfactory way in the treatment of one patient. Resource constraints may add to

this challenge, since how much time the doctor disposes for discussing the issue with the patient is reported to influence the doctor's handling of this dilemma.[17]

Engaging in social contact with patients can pose a dilemma between heeding professional considerations, respecting the patient´s wishes, and the doctor´s individual interests. According to the NMA's Code of Ethics, the general principle should be not to pursue or accept social contact with patients (though acknowledging situations where this is impossible). Respecting the patient and the patient's needs may, however, result in a conflict with this principle. The wish to offer good care may require a more informal social contact (e.g. informal follow-ups). There are indications that female doctors feel stronger obligations than male doctors to follow up, check and ensure the effects of individual treatment.[18] As the number of female doctors increases, this dilemma may also increase. How the dilemma can be resolved will also vary according to location of the practice. In small communities, where the doctor practices alone, s/he will naturally need to engage socially with members of the community, of whom many will be patients.

Whether to continue tough curative treatment when prognosis is poor also creates tensions between roles. There is a rapid development of new cancer drugs. Patients as well as next of kin can harbor unrealistic expectations and demand treatment despite poor prognoses. Both professional standards and societal considerations regarding fair distribution of resources can come into conflict with extensive or full-scale treatment in these cases. On the other hand, the same medical developments can lead the medical profession itself to advocate aggressive treatment with side-effects, in potential conflict with both patient interests and societal considerations. Among others, Atul Gawande has discussed these dilemmas with examples from the United States.[19]

Since dilemmas are value- as well as role conflicts, discussions and clarifications of their moral and substantive contents should include both elements. This may contribute to a clearer understanding of what is at stake in each case, not only for the professionals themselves, but also for patients and health authorities.

As discussed above, current developments in healthcare seem to increase the prevalence and intensity of value and role conflicts. We recognize similar tendencies across the Western world, despite differences in health care organizations. On this background, in addition to the

lack of professional consensus and few discussions in the literature, increased awareness and ethical reasoning is called for. In medical education, both for medical students and in postgraduate training, role awareness and role understanding should be taught and discussed in relation to different kinds of ethical dilemmas. Physicians also need clinical fora where ethical dilemmas encountered in their clinical work are discussed in systematic ways. In Norwegian hospitals, the clinical ethics committees[20] have a potential for being utilized more often by clinicians, especially in cases involving "ethics of the ordinary". Fora for discussing ethical dilemmas are also needed in general practice; one path forward could be to develop material for discussion in the supervision groups that Norwegian GPs attend. There is also a need for broadening the discussion in academic medical ethics, not only through the required inclusion of ordinary situations, but also through a widening of theoretical and methodological approaches.

Strengths and weaknesses

The survey includes doctors who practice in Norway, and findings might therefore be valid for Norwegian doctors only, or for doctors in culturally similar countries. A case in point is the attitude towards ritual circumcision of boys. As is well known, attitudes towards this intervention varies between countries, with US doctors, for instance, generally being more positive than their European colleagues.[21,22]

However, the conception of medical professionalism is shared by doctors throughout the Western world and even in the World Medical Association. The Physician Charter[4] has gained broad support since its publication in 2002, and is today endorsed by 130 organizations. Further, many national guidelines are similar, as is the case for the Norwegian ethical guidelines. It is likely that shared conceptions of medical professionalism also lead to similar attitudes towards ethical dilemmas.

The data are based on a quantitative study. More insight into the reasons why the doctors responded as they did could be obtained by qualitative methods, which should be considered in further research. Relatedly, the doctors were only asked whether they would or would not perform the action in question. More nuanced answers would be provided by a qualitative design where context and more detail could be discussed.

Finally, it should be noted that one of the aims of this article was to provide an overview of

the full set of the dilemmas we surveyed. Such a broad description has the flip side that particular dilemmas and role tensions are superficially, if at all, discussed – for the sake of space. We intend to discuss subsets of the dilemmas in more detail in forthcoming papers.

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