GENERAL PRACTITIONERS DOING ETHICS: AN EMPIRICAL PERSPECTIVE ON BIOETHICAL METHODS

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TABLE OF CONTENTS

Abstract	vii
Declaration	ix
Acknowledgments	xi
1. Introduction	1
2. Principlism, casuistry and virtue theory in bioethics	14
3. Empirical studies of ethics in general practice	75
4. Study design and conduct	101
5. The social framework of general practice in Australia	133
6. The GPs and their ethical problems	185
7. Appealing to principles: principlism-in-use	205
8. The role of stories: casuistry-in-use	239
9. Being a good general practitioner: virtue theory-in-use	279
10. Managing ethical problems	307
11. Conclusion: moral theory and social context	341
Appendices	
Appendix 1: Invitation and reply paid card	357
Appendix 2: Letter of confirmation to GPs and information leaflet	359
Appendix 3: Interview guide	363
Appendix 4: Consent form	367
Appendix 5: A brief account of the context and sources for Chapter Five	369
Bibliography	379

LIST OF TABLES

Table 1:	Time and content based fee schedule 1995	158
Table 2:	Characteristics of GPs in the study	186
Table 3:	All ethical problems mentioned by GPs	192
Table 4:	Ethical problems discussed by GPs	193
Table 5:	Why is this an ethical problem? Responses by GPs	196
Table 6:	GPs' definitions of 'respect for autonomy'	221
Table 7:	Number of stories each GP recounted during interview	244
Table 8:	Principal actor in each story mentioned during interviews	245
Table 9:	Roles for stories	256
Table 10:	Moral purpose of stories and its relationship to stories' type and trump	257
Table 11:	The virtues of general practice articulated by the GPs	283
Table 12:	The virtues of general practice for 'rural' and 'urban' GPs	302
Table 13:	Tactics to resolve ethical dilemmas	309
Table 14:	GPs' use of time as a tactic and the urgency of problems	313
Table 15:	Talking tactics used by GPs	318
Table 16:	Use of 'talking it over with colleagues' as a tactic to resolve ethical dilemmas	325

LIST OF FIGURES

Figure 1:	Summary of Dr Dunt's actions and the reasons for those actions	126
Figure 2:	Respect for autonomy-in-use by the GPs	218
Figure 3:	Beneficence-in-use by the GPs	227
Figure 4:	Types of stories recounted	249
Figure 5:	Principal actor in each type of story	253
Figure 6:	Talking tactics used by GPs and their overlap	322

ABSTRACT

It is frequently asserted, but rarely demonstrated, that the forms, styles and approaches used in bioethics bear little relationship to the ways in which ordinary people describe and talk about moral problems. This thesis explores this assertion, by systematically describing and analysing the ethical problems that a group of general practitioners encountered in their work and the frameworks they used to explore, deal with and explain those ethical problems.

The thesis is built around two broad themes. First, I show that the moral frameworks and language of the general practitioners whom I interviewed shared some characteristics with three styles of moral reasoning - principlism, casuistry and virtue theory - without always sharing the rigour, logic or coherence normally associated with these approaches. On this basis, I suggest that mainstream bioethics has a role to play in ordinary moral decision-making but that this role must be tempered by an awareness of how social structures shape ethical deliberation, decision-making and action.

The second theme in this thesis relates to the impact of social structures of ethical deliberation. Social science critics have maintained that bioethics emphasises individualism and discounts the impact of social, structural and organisational factors on ethical decision-making in health care. I show how these extra-individual factors had a significant influence on the general practitioners' moral deliberation and actions. This impact can be seen most clearly in the general practitioners' discussion of the actions they took concerning their moral problems, which were shaped particularly by the professional ideology of general practice and by the way in which general practice work is structured, financed and organised in Australia. The influence of social structure was not limited to the general practitioners' actions, for the three styles of moral deliberation that they used were also influenced by the professional ideology of their work and the structure of their practice.

DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

December 1998

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The Royal Australian College of General Practitioners (South Australian Branch) sponsored the empirical research on which this thesis is based. Many other general practitioners around Australia have offered helpful ideas and material. In particular, I am deeply indebted to the 15 general practitioners I interviewed, who gave freely of their time and insight and were gracious in their dealings with a neophyte researcher.

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S.D.G.

1 INTRODUCTION

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This thesis is about how people describe ethical problems, how they report their actions in morally perplexing situations, and how they explain and interpret their responses.[1] It explores these questions using the experiences of a group of general practitioners working in suburban and rural South Australia, but the issues I discuss within that framework have implications that extend beyond those general practitioners.

There is, for example, a close relationship between debates about moral thought and action and appropriate methodology and content for teaching ethics. Throughout the period during which this thesis was written, I have also been a teacher of ethics to health professionals and students. For me, these two activities – reflecting on moral deliberation and action and teaching ethics – are inextricably intertwined. My concern to understand how and why people deal with moral problems as they do is important to the approaches I use as I teach ethics, and my teaching experiences shape my understanding of moral thought and action. The relationship between the two has been apparent in the responses third year medical students give when I ask them at the end of an introductory course in medical ethics: "How has the Clinical Ethics topic influenced the ways in which you resolve ethical problems?" Two of those responses are set out below:

> I believe that I, like most people, had some idea of what ethics was, and though I was probably never consciously aware of it, ethical principles certainly played (and hopefully still do) a role in determining many of the decisions I made and actions I took. The main benefit of the Clinical Ethics course has been to enable me to take this very basic foundation, expand and refine it, and help me to be more acutely mindful of the ethics of situations I find myself in. I never considered myself to be an unethical person, it's just that now I feel I can approach ethical problems from a larger knowledge base and analyse them more effectively, and hopefully this will enable me to make better decisions.
>
> Jane, third year medical student[2]

> With all due respect and in all honesty, this is how I feel...The third year medical course is really quite challenging. I just feel that I didn't have the time to fully understand the deeper issues the ethics course was trying to address and it's an awful feeling. I'm too busy learning to actually *understand* the big picture. Ethics is essential to the training medical student and an understanding of ethical analysis appears to be very important too. Unfortunately, it just doesn't gel with everything else we're learning at the moment. I think this turns many students off

---

[1] I use the terms 'ethics' and 'morality' and 'ethical' and 'moral' interchangeably throughout this thesis. My usage reflects the use of my research participants - a group of general practitioners – and my impression that, in every-day conversation, 'ethics' and 'morality' amount to the same things.

[2] Pseudonyms are used throughout this thesis.

> ethics. In lectures I'm learning about blood cells, fevers and drug interactions – kids' stuff in many ways compared to ethics.
>
> Peter, third year medical student

These quotations from students' essays are representative of two themes in their responses to the question about the influence of ethics teaching. The first implies that teaching medical students ethics can make explicit the thought processes that students believe they use to resolve moral dilemmas and that this is helpful, in so far as it makes for better decisions. The second quotation suggests that any ethics education is overwhelmed by the dominant medical culture that focuses on learning about "blood cells, fevers and drug interactions". The implication is that no ethics course can hope to ensure better decisions, because other, more powerful factors, are at work.

These two themes in the students' responses are reflected in the scholarly literature about moral decision making. Moral theorists and, in particular, the bioethicists discussed in this thesis tend toward the view that moral theory offers a more rational account of the sort of moral reasoning we all do on a daily basis.[3] While moral theorists do not, for the most part, deal at length with the empirical correlates of their work, they do take an interest in the implications of their theories for every-day morality. Most assert that the theories they articulate do match real-life moral decision-making, in the sense that their task as moral theorists is, in part, to systematise every-day moral activity. Their views are not far removed from those of the first student quoted above: learning ethics is about bringing to the surface and refining intuitions about moral decision making.

There is a body of scholarly work that stands in tension with this view. Critics of mainstream bioethics, particularly from the social sciences, argue that the forms, language and style of bioethics bear little relationship to the ways in which ordinary people (such as the medical students) describe and explain their moral problems.[4] They

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[3] See, for example, Green RM, Gert B & Clouser KD. 1993 The method of public morality versus the method of principlism. *Journal of Medicine and Philosophy* 18:477-89. Their views on this topic, and those of other bioethicists, are discussed in Chapter Two.

[4] The phrase 'ordinary people' comes from Elliott C. 1992 Where ethics comes from and what to do about it. *Hastings Center Report* 22: 28-35. Elliott argues that "the practical difficulty with applying ethical

suggest that social, structural and organisational factors have a significant impact on the analysis and resolution of ethical problems and that this impact is ignored by mainstream bioethics. The second student quoted above offers an example of how these structural factors influence his every-day ethics: he is, of necessity, focused on anatomy, histology, physiology, pharmacology and pathology, and he thinks the development of ethical sensitivity is pushed aside by the more pressing work required for these other disciplines. The organisation and structure of medical education seems almost to bracket out the development of ethical awareness.

The questions addressed below relate to these two themes in the students' responses and in the scholarly literature:

- How do the styles and approaches used in bioethics scholarship relate to moral deliberation?
- To what extent and how do social structures shape moral deliberation and action?

These two questions are explored by means of a critical review of writing in bioethics and general practice and through interviews conducted during 1994 with 15 general practitioners who were working in suburban and rural South Australia. The analysis of those interviews is set within a broader framework that draws on a number of disciplines.

1.1 FRAMEWORK AND RATIONALE

The concerns and orientations of this thesis bear the imprint, as any significant activity in one's life must, of my life and work. I have already noted the relationship between teaching ethics and an interest in how and why people deal with moral problems as they do. My interest in how people deal with difficult situations in their lives and the influences that shape their responses is a long-standing one, fostered initially by studies in theology. More recently, the challenges of raising children have

theories is that ordinary people pay little attention to theories when they make their moral decisions" (30). See also Hoffmaster B. 1992 Can ethnography save the life of medical ethics? *Social Science and Medicine* 35: 1421-1431. Hoffmaster's view is that "moral philosophy simply does not fit the experience of those who have spent time in clinical settings" (1424). I use the phrase 'ordinary people' to refer to all those who are not specialists or formally trained in moral philosophy, bioethics or like disciplines.

returned me again and again to the question of how we come to be the sort of people we are and to hold the values we do. Influences such as these are significant, but their impact is also diffuse and difficult to describe. I introduce them here only to flag the general environment in which this thesis has been written.

A number of other, more readily articulated, aspects of my professional and personal life have been important for this thesis.[5] In particular, this thesis reflects the public health environment in which it was conceived, researched and written. Public health is, by definition, a multi-disciplinary endeavour; its goal is the health of the public, and it draws on a wide range of disciplines and perspectives to achieve that goal. The multi-disciplinarity of public health can create something of an identity problem for its practitioners, as they draw on methods, insights and findings in a number of fields without situating themselves in any one field exclusively.

This thesis has been, likewise, a multi-disciplinary endeavour, and in researching and writing it I have also encountered the identity problem. The thesis is both a 'bioethics thesis' and a thesis 'about bioethics' and, as a consequence, it sits in a somewhat uncomfortable intellectual space on the borders between critique of and activity within bioethics.

The distinction between activity within bioethics and critique of bioethics is analogous to the well-known distinction in sociology between sociology in and sociology of medicine.[6] Activity within bioethics takes as its object of interest the analysis of bioethical problems and the development of ethical theory. What separates this activity from other forms of moral description and analysis in the way in which it takes for granted the tasks, purposes and language of bioethics. The critique of bioethics is an outsider's critique that challenges assumptions about what counts as legitimate in morality and about the traditions and foundations on of moral judgments.

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[5] The influence of some of these aspects on the design and conduct of the empirical part of this thesis, in particular, is discussed in Chapter Four.
[6] Freidson E. 1970 *Professional Dominance.* Atherton Press.

Jane's comments above are indicative of activity within bioethics and Peter's of critique of bioethics.

This summary of activity within and critique of bioethics implies a tidy distinction between the two endeavours but the distinction, in reality, is far from tidy. Bioethics encompasses a plethora of approaches and an extraordinary amount of self-criticism. As Fox notes in her analysis of the state of bioethics in the United States, principles-oriented approaches compete for space with a wide range of alternative perspectives:

> Casuistry, virtue ethics, narrative ethics, hermeneutics, and phenomenology are all being advanced as philosophical systems... Proposals to elevate the values of caring, solidarity, reciprocity, trust, and love above the principles of autonomy, beneficence, nonmaleficence, and justice are repeatedly set forth. Enjoinders to incorporate feminist, literary, religious, social scientific, contextualist, relational, subcultural and cross-cultural perspectives and interpretations more fully...profilerate. Detailed, thickly descriptive case stories...are being held up as antidotes...[7]

Whether any or all of these alternatives to principles-oriented bioethics are in or out of the bioethics fold is debatable, and it is probably a debate not worth having. It makes more sense to suggest that the boundary between activity in bioethics and critique of that activity is a permeable one, with particular disciplines and perspectives mostly on one side or the other of the fence, but with a developing exchange between them.

This thesis contributes to that exchange but, rather than doing so from one side of the fence or the other, it attempts to draw on both sides, using the methods and insights of a range of disciplines, perspectives and approaches. Here I want to acknowledge the disciplines and approaches to which I owe the greatest debt and, in the process, make clear what this thesis is not. This thesis is a 'bioethics thesis', in the sense that it selects three of the dominant approaches within bioethics - principlism, casuistry, and virtue theory - for closer examination, on the basis of their relation to the ethical frameworks used by the general practitioners I interviewed. That examination involves description and analysis of the ways in which these approaches define themselves, of the internal disputes between them, and of the criticisms offered by scholars who place themselves outside all three. The thesis is not, however, a study in principlism, casuistry or virtue

[7] Fox RC. 1994 The entry of U.S. bioethics into the 1990s. in DuBose ER, Hamel RP and O'Connell LJ. (eds.) *A Matter of Principles? Ferment in U.S. Bioethics.* Trinity Press International, 57.

theory. I am primarily concerned with the relationship between these approaches and the ways in which ordinary people, in this case, a group of general practitioners, describe, interpret and deal with moral problems.

My interest in ethical reasoning among general practitioners has led my research into a number of fields of scholarship. First, I have made use of the general practice literature about morality, values and ethics, drawing particularly on those accounts that develop theories of general practice ethics. My concern, there, is not particularly with the ethics of general practice, or with the ethical practice of medicine by general practitioners, both of which tend to focus our attention on what general practice and general practitioners ought to be like. Rather, I am more interested in ethics as it is done by ordinary general practitioners, although I recognise that the distinction between the 'is' and 'ought' of morality is a debatable one. I acknowledge the importance of 'ought' questions in the conclusion, when I take up the implications of my research for education in ethics.

Second, my concern to amplify, in bioethical debate, the voice of ordinary people doing everyday ethics in mundane settings has brought me into contact with a number of other disciplines and perspectives, in particular narrative analysis and sociology. Narrative ethics focuses on the place of particular human experiences in moral life and the meanings accorded to these experiences.[8] Narrative ethics is, nonetheless, not so much a discipline as it is a way of approaching the study of the moral life, for, in fact, a wide range of disciplines contribute to narrative understandings of morality:

> ...members of these disciplines can help to contextualize and particularize the conflicts faced in medical ethics, contributing methods with which to generate telling descriptions grounded in evidence, and then to choose trustworthy readings of those descriptions. Sometimes called narrative ethics, these activities are more appropriately conceptualised as narrative contributions to the trustworthiness of medical ethics.[9]

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[8] Charon R. 1994 Narrative contributions to medical ethics: recognition, formulation, interpretation, and validation in the practice of the ethicist. In DuBose ER, Hamel RP & O'Connell LJ. (eds.) *A Matter of Principles? Ferment in US Bioethics.* Trinity Press International. See also Lindemann Nelson H. (ed.) 1997 *Stories and Their Limits. Narrative Approaches to Bioethics.* Routledge. This helpful and comprehensive volume came to my attention very late in the writing of this thesis. Undoubtedly, I have not gained as much from it as I might have had I encountered it earlier.

[9] Charon, Narrative contribution to medical ethics..., 261. There are other interpretations of narrative ethics. Frank, for example, without wanting to minimise the importance of narrative ethics as critic of and adjunct to work in bioethics, suggests that narrative ethics really begins when it leaves behind the

The central element in narrative scholarship is the story.[10] Scholars working within a narrative framework tend to employ the methods and techniques of literary criticism to make sense of these stories, focusing on the features of narrative (for example, narrative frame, time, plot and desire) and on the ways in which stories are recognised, formulated, interpreted and validated.[11] Many questions that a narrative scholar might ask of the text are similar to those that I ask in this thesis. For example, I am concerned with how ethical problems come to be ethical problems, and with the way in which accounts and interpretations of ethical problems are developed and solutions are arrived at. However, I have put to one side some of the narrative scholar's questions, such as those related to temporal order, textual coherence and structure. This thesis is not a narrative analysis of general practitioners' talk about ethical problems in general practice; it shares with narrative ethics an interest in every-day accounts of the moral life, and makes some use of narrative techniques where they seem appropriate.[12] It also draws on the prominent role that narrative ethics accords the narrator, for I devote some attention to the way in which my own interests and concerns have shaped this thesis.

One of the features of narrative ethics is that it can direct our attention to the socially situated features and effects of stories[13] and the important role that institutions of power and influence play in the narratives of our lives. Indeed, one of the more radical features of narrative ethics is the way it questions how some voices and

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pre-occupation with clinical medical encounters between doctors and patients and enters the world of ill people "when they are *not* being patients". Frank AW. 1995 *The Wounded Storyteller: Body, Illness and Ethics.* University of Chicago Press, 156. See also Mishler EG. 1995 Models of narrative analysis: a typology. *Journal of Narrative and Life History* 5: 87-123, for an account of the forms of narrative analysis. Mishler agrees that narrative analysis is not a distinct discipline; he finds its current state to be characterised by eclecticism and "near-anarchy".

[10] For examples of "narrative contributions to medical ethics" that use stories see, in addition, Hunter KM. 1986 "There was this one guy..." The uses of anecdote in medicine. *Perspectives in Biology and Medicine* 29: 619-630; Nicholas B & Gillet G. 1997 Doctors' stories, patients' stories: A narrative approach to teaching medical ethics. *Journal of Medical Ethics* 23: 295-99; Kleinman A. 1988 *The Illness Narratives: Suffering, Healing, and the Human Condition.* Basic Books, particularly chapter 14: The healers: Varieties of experience in doctoring.

[11] Charon R *et al.* 1996 Literature and ethical medicine: five cases from common practice. *Journal of Medicine and Philosophy* 21: 243-265, and Charon, Narrative contribution to medical ethics...

[12] So, for example, Chapter Eight on the role of stories and in ethical reasoning uses a number of the tools of narrative analysis.

[13] Mishler, Models of narrative analysis..., 107ff.

narratives come to dominate and others are ignored.[14] There is a close link here to discourse analysis, to the extent that I argue that the structure and organisation of society shape moral deliberation and action. A major effort in discourse analysis would have resulted in a rather different thesis that may not have maintained the same commitment to multi-disciplinarity.

An interest in the impact of social structure on human life is the central concern of sociology, which examines the relationship between individuals and society in a manner that seeks "to locate the individual in the larger social scheme of things".[15] This concern for the ways in which social structures influence moral deliberation and decision-making is a central theme of this thesis; I owe, therefore, a large debt to sociological ways of thinking about morality. Taking a sociological view of bioethics means that I accept that people's moral decisions, actions and ways of living are shaped by where they are in the social structure and by the social context in which their decisions are made and their lives are lived out.[16] However, this thesis is not a sociological study of moral decision-making, in the sense that such studies focus principally on the ways in which social structures influence ethical decision-making.[17] For examples of work within this genre the reader is referred to a number of excellent studies, for example, Anspach's study of decision-making in the neonatal intensive care unit,[18] Bosk's study of the training of surgeons[19] and, more recently, Chamblis' work on how ethics is 'done' in hospitals[20]. Such studies are not particularly concerned, as I am, with the contribution that bioethics can make to our understanding of how ordinary people do ethics.

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[14] Nicholas & Gillet, Doctors' stories, patients' stories..., 296-7. Narrative ethics shares this concern with feminist approaches to bioethics. See, for example, Sherwin S. 1992 *No Longer Patient: Feminist Ethics and Health Care*. Temple University Press.

[15] Willis E. 1995 *The Sociological Quest: An Introduction to the Study of Social Life*. Allen and Unwin, 1-43, and quoted at 43.

[16] See Anspach R. 1993 *Deciding Who Lives: Fateful Choices in the Intensive Care Nursery.* University of California Press, particularly pp20-23, for a similar perspective on decision-making in neonatal intensive care units.

[17] Willis, for example, describes the hallmark of sociology as granting *primacy* to group level analysis of the activities of individuals. See Willis, *The Sociological Quest...*, 36.

[18] Anspach, *Deciding Who Lives: Fateful Choices in the Intensive Care Nursery...*

[19] Bosk CL. 1979 *Forgive and Remember*. University of Chicago Press.

[20] Chambliss DF. 1996 *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics.* University of Chicago Press. For earlier work in the same genre, see Fox RC. 1979 *Essays in Medical Sociology: Journeys into the Field.* John Wiley and Sons.

Sociology has been interested primarily in the context of moral decision-making, and bioethics mainly with its content. My interest is in both.

My debt to sociological ways of thinking about morality extends beyond some general assumptions about 'how things are' to that arm of social science concerned with empirical investigation of people and their social settings. This thesis is a piece of qualitative research, using qualitative methods to study ethical decision-making by general practitioners. In general terms, I draw my methodological orientation from the qualitative literature and assume, with this literature, that researchers are active participants in their research, influencing the conduct and outcomes of their work. I have resisted placing myself within any one of the huge varieties of traditions or disciplines that employ qualitative research approaches. The thesis is not an ethnography of general practice (although several of these are discussed in the thesis), a hermeneutic study of general practice reasoning (although I rely on hermeneutic understandings of the analytical process), or an example of grounded theory at work (although I work with concepts and themes 'in the data').

1.2 STRUCTURE, CONTENT AND ARGUMENT OF THE THESIS

As a result of the multi-disciplinary character discussed above, the argument of this thesis depends on a broad range of scholarship. Chapters Two to Five bring together literature from the fields of bioethics, general practice ethics, qualitative research methods and general practice policy in ways that underpin the empirical work presented in Chapters Six to Ten. The final chapter broadens the focus of the research by returning to the issues posed at the beginning of this chapter concerning the teaching of ethics.

This thesis is an account of the practice of bioethics. There are a number of questions that I address repeatedly throughout the thesis, even though they emerge in different forms at different points in the narrative. They can be summarised as generalisations of the two questions posed earlier in this chapter:

- What are the main characteristics of the moral deliberation displayed here?
- What influences shape this moral deliberation?

Chapter Two begins by examining recent scholarship in bioethics, from the perspective of how its principlist, casuist and virtue theorist practitioners carry out the 'work' of bioethics. It has two related aims. First, I offer a description of principlism, casuistry and virtue theory, focusing on the work of the principal theorists in each field. Later in the thesis I return to these descriptions to compare them with the forms of principlism, casuistry and virtue theory of the general practitioners I interviewed. Second, Chapter Two provides an account of the relationship between these three approaches in bioethics. I employ a history of ideas approach to develop the argument that principlists, casuists and virtue theorists have a shared view of the nature of moral phenomena, grounded in an individualist paradigm. This paradigm is contrasted with a sociological approach to moral deliberation that attends to the ways in which social and structural forces influence ethical decision-making. The individualist paradigm that many of them share has allowed moral theorists to interpret each other's work in ways that are supportive and it has also coloured the way in which they understand empirical work in bioethics. Principlists and casuists, in particular, appear to hold that their own experiences of dealing with ethical problems are relevant examples of ordinary moral reasoning.

Chapter Three develops the discussion of empirical work in bioethics by taking general practice ethics as its subject. I ask similar questions to those I asked in chapter two: what forms of moral reasoning prevail in research in ethics in general practice? What paradigms shape the description and analysis of ethical problems in general practice? I argue that studies of ethics in general practice are of three types – surveys, case reports and sociological accounts of general practice – and all are informed, to greater or lesser degree, by two paradigms. Surveys and case reports, in particular, seem to be shaped by a mainstream bioethics paradigm and a general practice paradigm. The mainstream bioethics paradigm focuses attention on 'neon' dilemmas and on the principlist preoccupation with the conflict between respect for autonomy and

beneficence. The general practice paradigm defines the nature and content of ethical problems in general practice in terms of their congruence with a professional model of general practice. Sociological accounts of general practice, although concerned in a general way with how social structures and individuals and groups influence each other and offering a range of perspectives on general practice, also tend to focus on general practitioners' views of themselves. Furthermore, sociological studies are not particularly concerned with the ethical aspects of general practice work, and this limits their relevance for a study of moral deliberation and action.

Chapter Four provides a narrative of the design and conduct of the empirical research for this thesis from two perspectives. First, it offers a temporal account of the research process. Second, in keeping with my interest in the factors that shape moral deliberation, it also analyses the way in which my own perspectives and orientations have influenced the conduct of this research.

Chapter Five sets out the social framework of general practice in Australia. I introduce two models– an altruistic professional model and a business model - which can be used to describe general practice. Both models are developed in the general practice literature, with the altruistic professional model occupying a more dominant position. There is a tension between the two models that reflects the tension between professional accounts of the nature of general practice and the structure and organisation of general practice work.

Chapter Six introduces the general practitioners I interviewed and describes the ethical problems they discussed and why they thought their problems were ethical ones. It suggests that the way the bioethical literature defines ethical problems (in terms of choice and conflict between values and options) matches some of the general practitioners' explanations of the nature of ethical problems, but that it can not account for all of them.

Chapters Seven, Eight and Nine deal with how the general practitioners described and analysed their ethical problems. I assert that there are links between moral theories, as described by bioethicists, and the general practitioners' experiences of doing ethics, but that social and structural factors also influence the general practitioners' moral deliberation. Drawing on Kaplan's distinction between logic-in-use and reconstructed logic, I argue that the moral theories of principlists, casuists and virtue theorists are reconstructed logics: they are idealisations of moral deliberation. The account I develop of the general practitioners' moral deliberation provides a window on moral theory-in-use.

Each of Chapters Seven, Eight and Nine deals with a discrete cognitive style that the general practitioners used in their moral deliberation. In each case, there are similarities between the general practitioners' moral theory-in-use and bioethicists' account of moral theory, but, also in each case, the general practitioners did not articulate their cognitive styles with the sophistication and intellectual rigour that bioethicists assert hold for their own work. The answer that these chapters provide to the first of the two questions posed at the beginning of this section is that the general practitioners' moral deliberation displayed some of the characteristics of principlist, casuist and virtuist reasoning, but it did not always share the rigour, logic and coherence of those approaches.

The ways in which general practitioners' moral deliberation reflects the social and organisational context of their work is also discussed in these chapters. I use the account of general practice developed in Chapter Five to argue that both the altruistic professional and the business models of general practice had a significant impact on the general practitioners' moral deliberation. The links between these models and the general practitioners' moral deliberation is weakest in Chapter Seven (which deals with principlist reasoning), stronger in Chapter Eight (dealing with casuistic reasoning) and most apparent in Chapter Nine (dealing with virtuist reasoning).

Chapter Ten moves from an account of moral deliberation as a cognitive activity to an account of what the general practitioners said they did about their moral problems. Across the wide range of ethical dilemmas they had described, the general practitioners dealt with their problems in a relatively small number of ways. In particular, all used either of two tactics - the passage of time or conversation with patients - and most used both tactics to help them resolve ethical problems. These tactics reflect two important aspects of general practice work – the practice of 'ten-minute medicine' and the centrality of communication skills – and they also indicate the important role that the social and structural organisation of general practice played in the strategies the general practitioners adopted to manage their moral problems.

Chapter Eleven summarises the findings of the thesis and discusses the potential for and difficulties in generalising from my empirical findings to other actors and other settings. I conclude by returning to the issue I introduced at the beginning of this chapter – ethics education for medical students – in order to indicate the implications of my research for a different area of activity in bioethics.

2 PRINCIPLISM, CASUISTRY AND VIRTUE THEORY IN BIOETHICS

2.1 INTRODUCTION

This thesis is an account of bioethics as it is practised. In later chapters of the thesis, general practitioners doing bioethics are the principal focus. The questions that I address in those chapters relate to how the GPs 'did ethics': what they defined as ethical problems; the ways they described, analysed and dealt with those problems; and the forms of moral reasoning they used. In this chapter, the focus is on bioethics as it is done by bioethicists, but the questions I address are similar. What are the principal characteristics of bioethical problems and reasoning? What forms of moral reasoning dominate in bioethical debate and discussion? What forces shape the outlook of bioethics? My answer to these questions, developed below, is that principlists, casuists and virtue theorists have fashioned interpretations of their theories in ways that have allowed them to accommodate each others' views. Their theory modification is grounded in a shared individualist paradigm, which sees the moral life primarily as the province of individuals.

Questions like these stand in a tradition that, outside of bioethics, is well developed and clearly articulated.[1] Charlesworth *et al*'s study of science as it is done, in an Australian context, by scientists at the Walter and Eliza Hall Institute[2] and Ashmore

[1] Within bioethics, there are relatively few accounts of bioethics that have attempted to review its practice in this way. Fox's discussion, from a sociological perspective, of the "major characteristics of the discourse and outlook of US bioethics" (48) in Fox RC. 1994 The entry of U.S. bioethics into the 1990s. In DuBose ER, Hamel RP & O'Connell L.J (eds) *A Matter of Principles? Ferment in U.S. Bioethics.* Trinity Press International, 21-71; and in Fox RC. 1989 The Sociology of Bioethics. In Fox RC. *The Sociology of Medicine: A Participant Observer's View.* Prentice-Hall, 224-76: and Hoffmaster's critique of medical ethics (Hoffmaster B. 1994 The forms and limits of medical ethics. *Social Science and Medicine* 39: 1155-64) are helpful introductions to the field.
Several of the papers in Weisz' *Social Science Perspectives on Medical Ethics* also begin the task of describing the world of bioethics, and there have been forays in the field from feminist perspectives. See Weisz G. (ed) 1990 *Social Science Perspectives on Medical Ethics.* Kluwer Academic Publishers, particularly Jennings' paper on 'Ethics and ethnography in neonatal intensive care', 261-272. For the feminist perspective, see Sherwin S. 1992 *No Longer Patient: Feminist Ethics and Health Care.* Temple University Press.

[2] Charlesworth M *et al.* 1989 *Life among the Scientists: An Anthropological Study of an Australian*

et al's work on economists doing health economics[3], provide descriptions of practitioners working in their disciplines. These works share a focus on how ideas and practice develop and are transmitted within and beyond a field of inquiry, an approach that can be characterised as a history of ideas approach. Schon's book, *The Reflective Practitioner: How Professionals Think in Action,* is often cited as a seminal work in this arena. Schon is concerned with how practitioners understand and develop their work, not with how ideas and practices in professional work gain currency and change.[4]

This chapter is an account of bioethics as practised by its professionals, using a history of ideas approach as a model and drawing on Thomas Kuhn's work in the history and philosophy of science. In *The Structure of Scientific Revolutions,* Kuhn argued that the history of western science is the history of a series of discontinuous world-views or paradigms.[5] Kuhn used the term "paradigm" to mean a set of beliefs, values, techniques and practices that are shared by a given scientific community at any one time.[6] The paradigm is an accepted and agreed model that provides the basis for articulation and specification in an area of scientific practice. Work within the paradigm is "normal science", or "mop-up" work that extends, clarifies and explores the paradigm in which it is grounded.[7] Normal science, when closely examined, consists in "an attempt to force nature into the preformed and relatively inflexible box that the paradigm supplies".[8]

The scientist working within a paradigm works in clearly delineated and specified

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Scientific Community. Oxford University Press.

[3] Ashmore M *et al.* 1989 *Health and Efficiency: A Sociology of Health Economics.* Open University Press.

[4] Schon DA. 1983 *The Reflective Practitioner: How Professionals Think in Action.* Basic Books.

[5] Kuhn TS. 1970 *The Structure of Scientific Revolutions.* (2nd edn) University of Chicago Press.

[6] In the postscript to the second edition, Kuhn acknowledged that his use of the term "paradigm" was confusing. He suggested that he had used it in two distinct ways, the first referring to the entire constellation of values, beliefs and techniques held by a scientific community, and the second to those solutions to scientific puzzles that function as exemplary achievements for the scientific community. I have taken the wider, sociological, version of paradigm.

[7] Kuhn, *The Structure of Scientific Revolutions...,* 24.

[8] Kuhn, *The Structure of Scientific Revolutions...,* 24.

ways.[9] Fact-gathering in normal science proceeds along routes that the paradigm dictates. The scientist may investigate facts that the paradigm makes significant, increasing the scope and accuracy with which these facts are known. Alternatively, he may investigate those facts that can be predicted from the paradigm, or he may carry out work that will refine the paradigm and resolve difficulties or ambiguities. This may involve defining the paradigm's constants, articulating the paradigm's laws, or extrapolating the paradigm to phenomena in nearby fields. Theoretical work within normal science occurs along similar lines. One sort of theoretical work concerns manipulating existing theory to predict the correct factual information, in other words, improving the match between nature and theory. Another sort consists in reformulating theory to make it clearer and more satisfying to work with.

Whether it is fact-gathering or theory development, or a combination of both, activity in normal science assumes that the world looks a certain way. Scientists working within the paradigm assume a great deal in their daily work and they are prepared to defend their views against new and different approaches and understandings, sometimes at considerable cost. Nonetheless, novelties, anomalies and unexplainable phenomena are forever arising in normal science. For the scientist working within a paradigm, these anomalies are tolerated, explained away, or even not seen at all. However, eventually the number and extent of unexplainable phenomena become too great to tolerate, and the scientists working in the arena of controversy begin a process of change that leads to a totally new way to see and explain scientific phenomena and activities. This change in orientation can only be described as a revolution in understanding. A shift to a new paradigm, and thus a new set of normal science activities, requires a shift in the understanding of 'old' facts. Prior theory is reconstructed in different ways, and prior facts are re-evaluated in the light of the new paradigm.

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[9] This paragraph is based on Kuhn, *The Structure of Scientific Revolutions...*, 25-34.

The account of the practice of bioethics by its professionals presented in this chapter focuses on the work of bioethicists writing from three perspectives - principlism, casuistry and virtue theory.[10] I argue that the debates between bioethicists in these three domains resemble the activities of scientists in a period of normal science. Over a period of about twenty years, these three initially disparate perspectives have begun to converge, in a way that parallels the consolidation of normal science within a paradigm. From relatively incommensurate positions, principlists, casuists and virtuists have found ways to accommodate each others' perspectives, by identifying common ground and interests, and subtly shifting the ways in which they define each approach. They have functioned as a dialogic community, in which theories and positions are stated, responded to and restated in new, more accommodating, forms.

This convergence and accommodation has been possible because all three perspectives share much common ground. In particular, they all share the view that the primary unit of analysis in ethical problem solving is the individual. In Kuhnian terms, they work within a paradigm that assumes an individualist view of human nature and society.

In the same way that a paradigm ensures that certain kinds of fact gathering and theory development dominate in normal science, so in bioethics the individualist paradigm has meant that attention has been focused on certain aspects of bioethical work. Indeed, the process of accommodation and convergence between principlism, casuistry and virtue theory has been possible, at least in part, because writers in each of

[10] These three approaches to moral reasoning contribute significantly to the theoretical background for the empirical chapters of this thesis. Chapters Seven, Eight and Nine discuss the three styles of moral reasoning that the GPs used to describe, understand and deal with their ethical problems and the similarities between these styles and principlism, casuistry, and virtue theory respectively. I treat each style separately in those chapters, even though the separation is a largely artificial one, chosen for reasons of clarity. This introductory chapter provides an opportunity to establish some formal links between principlism, casuistry and virtue theory, in a way that sets the scene for the thesis.

these domains have emphasised some aspects of their work at the expense of others.[11]

The sections that follow discuss these changing emphases in writing in bioethics, focusing particularly on Beauchamp and Childress' principlism and the responses to it. The chapter is set out as follows. First, I discuss the development of principlism, based on the four editions of Beauchamp and Childress' *Principles of Biomedical Ethics*. I turn then to critics of Beauchamp and Childress' work, presenting first the 'traditional' moral theorists' critique, and then the casuists' response, using the work of Jonsen and Toulmin. The discussion of casuistry incorporates an analysis of the way in which casuistry has also developed over time, and considers the parallels with the changes in approach in principlism. Contemporary virtue theory, which is considered next, is a relative latecomer to the field, and so I do not attempt to construct an account of its development over time. Nonetheless, I offer some speculative comments on the developing relationship between virtue theory and principlism. The chapter concludes with a discussion of the individualist paradigm and of the way in which individualism shapes the orientation and activities within all three domains in bioethics, particularly the approach taken to empirical work.

2.2 PRINCIPLISM

2.2.1 The changing character of principlism

Many commentators have argued that, until very recently, principlism has provided the dominant framework in bioethics.[12] Perhaps the best example of this

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[11] This chapter uses published writing, which it takes as one, significant, indicator of scholarly activity within a field of inquiry. I am following Kuhn's lead in *The Structure of Scientific Revolutions*. There are other indicators (for example, presentations and meetings, informal contact) to which I have not had access. My analysis is thus an incomplete one.

[12] This statement is now almost a truism in critiques of bioethics, both from within and without. For a selection of the different disciplines and approaches that all offer essentially the same assessment, see the following: Fox RC. 1994 The entry of U.S. bioethics into the 1990s..., 21-71; Brody B. 1990 Quality of scholarship in bioethics. *Journal of Medicine and Philosophy* 15: 161-78; Clouser KD & Gert B. 1990 A critique of principlism. *Journal of Medicine and Philosophy* 15: 219-36; Hoffmaster B. 1992 Can ethnography save the life of medical ethics? *Social Science and Medicine* 35: 1421-1431; Sherwin, *No Longer Patient...*; Johnson M. 1993 *Moral Imagination. Implications of Cognitive Science for Ethics*. University of Chicago Press.

The dominance of principlist approaches has not extended to European 'bioethics' (see ten Have H. 1994

framework, and certainly the most quoted, is Tom Beauchamp and James Childress' *Principles of Biomedical Ethics*, first published in 1979 and now in its fourth edition.[13] Because of its widely quoted and influential status, *Principles of Biomedical Ethics* is a good starting point for a discussion of the principles-oriented approach.[14] Following most commentators, I will use the shorthand form 'principlism' to refer to the range of principles-oriented approaches.[15] This summarises the changing nature and content of principlism. I assert that Beauchamp and Childress' principlism has moved over time from a top-down deductivist approach to moral deliberation in the first edition of *Principles of Biomedical Ethics*, in which principles are applied to cases, to a coherentist theory of moral deliberation, which makes far more of the dialectical relationship between theory and practice. Even in the fourth edition, however, the coherentism they espouse is stronger in the introductory chapters than it is in the central chapters of the text.

The first edition of *Principles of Biomedical Ethics* begins by claiming that this work "offers a systematic analysis of the moral principles that should apply to

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Principlism – A western European appraisal. in DuBose ER, Hamel R & O'Connell LJ. *A Matter of Principles? Ferment in US Bioethics.* Trinity Press International, 101-120). The European influence has been felt relatively little in Australia.

[13] Beauchamp TL & Childress JF. 1979/1983/1989/1994 *Principles of Biomedical Ethics.* Oxford University Press. Beauchamp and Childress are not the only proponents of a principles-oriented bioethics – Veatch's and Engelhardt's theories are also principlist. See Veatch RM. 1981 *A Theory of Medical Ethics.* Basic Books, and Engelhardt HT. 1986 *Foundations of Bioethics.* Oxford University Press. Earlier 'principlist' antecedents are Frankena WK. 1973 *Ethics.* (2nd edition) Prentice-Hall, and Ross WD. 1930 *The Right and the Good.* Clarendon Press and 1939 *The Foundations of Ethics.* Clarendon Press. In the United Kingdom, Raanon Gillon has been an enthusiastic supporter of the four principles approach. See Gillon R. 1985 *Philosophical Medical Ethics.* John Wiley and Sons.

[14] I also make use of two papers written around the same time that the fourth edition of *Principles of Biomedical Ethics* was published - Childress J. 1994 Principles-oriented bioethics - An analysis and assessment from within. In DuBose ER, Hamel R & O'Connell LJ. *A Matter of Principles? Ferment in US Bioethics.* Trinity Press International, 72-98, and Beauchamp TL. 1995 Principlism and its alleged competitors. *Kennedy Institute of Ethics Journal* 5: 181-198 – since these papers offer an explicit defence of their position against their critics.

Principles of Biomedical Ethics has been revised for each edition. In a few areas, there have been incremental shifts in orientation and content across the four editions. In general, however, the changes in the second and third editions are relatively minor when compared with the substantial reworking of the text for the fourth edition. Accordingly, my discussion of the development in Beauchamp and Childress' theory draws mainly on the first and fourth editions.

[15] The term 'principlism' first appeared in Clouser and Gert's A critique of principlism..., used there as a pejorative label. It has been widely adopted since then, including by Beauchamp and Childress themselves. See Childress, Principles-oriented bioethics..., and Beauchamp, Principlism and its alleged

medicine".[16] Against the prevailing interest, at that time, in problems and issues (for example abortion, euthanasia, and resource allocation) Beauchamp and Childress were concerned to develop an account of moral decision-making that would hold across a wide range of moral problems. They suggested that the four moral principles that constitute the core of the book - autonomy, beneficence, nonmaleficence and justice - "are intended to provide an integrated framework of principles through which diverse moral problems can be handled".[17] *Principles of Biomedical Ethics* is, therefore, a text on bioethical method, rather than a text on moral solutions: it is intended to provide a toolkit for the resolution of moral problems in medicine and health care.

In the first edition, Beauchamp and Childress define biomedical ethics as a branch of applied ethics, and in this it is like any other branch of applied ethics, in which general moral action-guides are applied to medical problems. Those moral action-guides are grounded in more general principles and, in turn, the principles are grounded in moral theories. Beauchamp and Childress' approach to moral justification and deliberation is therefore a hierarchical one. In this hierarchy, "judgments about what ought to be done in particular situations are justified by moral rules, which in turn are grounded in principles and ultimately in ethical theories".[18]

Beauchamp and Childress suggest that we test the adequacy of the moral principles and theories in this hierarchy by judging them against criteria of internal consistency and coherence, comprehensiveness, simplicity, and compatibility with our ordinary judgments.[19] The last criterion is potentially troubling for them because, if there is disagreement between our moral experience and judgments derived from moral theories, we will not necessarily know if the theory is in error or whether our ordinary

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competitors...

[16] Beauchamp & Childress, *Principles* (1st edn)..., vii.
[17] Beauchamp & Childress, *Principles* (1st edn)..., viii.
[18] Beauchamp & Childress, *Principles* (1st edn)..., 5.
[19] Beauchamp & Childress, *Principles* (1st edn)..., 13.

judgments are wrong. The procedure that Beauchamp and Childress suggest to bring moral theory and ordinary judgments into line is a "dialectical" one, in which principles are modified in the light of ordinary judgment and *vice versa.*

Beauchamp and Childress' reference to dialecticism warrants only a paragraph in the first edition, and it is largely absent from the core of the book. For example, their discussion of the "principle of autonomy" begins by developing a definition of the concept of autonomy, principally by reference to two figures, Immanuel Kant and John Stuart Mill.[20] To respect others' autonomy is to recognise "with due appreciation their own considered value judgments and outlooks even when it is believed that their judgments are mistaken".[21] Beauchamp and Childress then apply this principle to three areas - informed consent, refusal of treatment and autonomous suicide - and there is no suggestion that "ordinary judgment" in any of these areas alters in any way the principle which they first enunciate. A similar pattern is followed in the chapters on beneficence and non-maleficence.[22]

In the fourth edition, and in other recent writing, Beauchamp and Childress have substantially reworked their discussion of the nature of moral theory and the relationship between moral theory and experience. Whereas the first edition unapologetically offers a moral theory for biomedicine, the fourth edition places its combination of "principle-based, common-morality ethics" and a "coherence model of justification" within an abundance of bioethical approaches, theories and perspectives.[23] The defining characteristic of principlist approaches is now softer than previously. Instead of principlist approaches requiring us to apply principles to cases in a hierarchical fashion, Beauchamp and Childress opt for the view that principlist

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[20] Beauchamp & Childress, *Principles* (1st edn)..., 56-96.
[21] Beauchamp & Childress, *Principles* (1st edn)..., 58.
[22] The chapter on "Justice" is arranged somewhat differently, but the underlying approach of applying theory *to* situations still obtains.
[23] Beauchamp & Childress, *Principles* (4th edn)..., 101. Chapter 2 on "Types of ethical theories" now discusses seven theoretical perspectives, in addition to their own "principle-based, common-morality"

approaches merely place general moral norms at the centre in bioethics, in a non-absolute way.[24] Principlist theories have a structure which, "at the most general level...consists in a plurality of non-absolute principles of obligation".[25]

The issue of the relationship between principles and cases (in fourth edition terminology), or principles and ordinary judgments (in first edition terminology), becomes a central one for the fourth edition of *Principles of Biomedical Ethics*, covered over 27 pages in the first chapter. Beauchamp and Childress now suggest that there are three roles that principles might take in moral decision-making. *Deductivism* involves the application of a principle or rule to a case that falls under that rule. In deductivist approaches, principles are statements of absolute moral obligations and the movement is top-down, from theory to action.[26] *Inductivist* approaches, by contrast, move 'bottom-up' from cases to generalise norms and rules for behaviour, drawing on the specific context and incorporating the use of analogy. Inductivism tends to generate relatively weak norms and rules-of-thumb.[27] Beauchamp and Childress' preference in the fourth edition is for neither of these two approaches; instead, they advocate a *coherentist* model.[28]

Before discussing the coherentist model in more detail, a little needs to be said about the deductivist approach. The model Beauchamp and Childress present of deductivism in the fourth edition, with its four tiers – (1) particular judgments at the bottom, (2) rules and (3) principles in an intermediate position, and (4) ethical theory at

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theory. Beauchamp & Childress, *Principles* (4th edn)..., 44-119.
[24] Childress, Principles-oriented bioethics ..., 73.
[25] De Grazia D. 1992 Moving forward in bioethical theory: Theories, cases, and specified principlism. *Journal of Medicine and Philosophy* 17: 518.
[26] See Beauchamp & Childress, *Principles* (4th edn)...,13ff and Childress, Principles-oriented bioethics ..., 77-80.
[27] See Beauchamp & Childress, *Principles* (4th edn)..., 17ff and Childress, Principles-oriented bioethics ..., 77-80. DeGrazia, Moving forward in bioethical theory..., uses a similar schema, but assigns the label casuistry to his inductivist approach, whereas Beauchamp & Childress see casuistry as one version of inductivism. I take up the challenge that casuistry offers to principlism later in the chapter.
[28] Beauchamp & Childress, *Principles* (4th edn)..., 20ff.

the top - is almost identical to the hierarchical model they espoused in the first edition.[29] Now, however, the model is found wanting, because they suggest it does not capture how moral reasoning works in complicated cases. In all but the most simple cases, Beauchamp and Childress believe there is a dialectic between particular judgments and rules or principles, and particular judgments also involve balancing and specifying norms for concrete situations. Deductivism creates an infinite regress, for it is forever searching for justification. The search is doubly hopeless because there is no single theory at the top of the hierarchy, but rather a number on offer.

Beauchamp and Childress now favour the coherentist approach, which they suggest is “a matter of the mutual support of many considerations, of everything fitting together into one coherent whole”.[30] In this definition, they depend a great deal on Rawls' ‘reflective equilibrium'.[31] Beauchamp and Childress now argue that moral argument should begin with considered judgments which we “match, prune and adjust”, in the light of case evidence and our theoretical premises. Based on this process, action guides are developed which can be tested to assess whether they yield coherent results. The continual process of reflection and adjustment yields a set of theoretical generalisations that are subject to revision and therefore always incomplete. For Beauchamp and Childress, principles are always non-universal and “dialectically adaptable”.[32]

Following Richardson and DeGrazia[33], Beauchamp and Childress suggest that there are at least three ways of conceiving of the relationship between principles and cases. Principles can *override* cases. Beauchamp and Childress state that there are

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[29] Beauchamp & Childress, *Principles* (4th edn)..., 14-17. There is one small change: the earlier version of the hierarchy had "theories" at the top; the most recent version has "theory".
[30] Beauchamp & Childress, *Principles* (4th edn)..., 23.
[31] Rawls J. 1972/86 *A Theory of Justice.* Oxford University Press.
[32] Levi BH. 1996 Four approaches to doing ethics. *Journal of Medicine and Philosophy* 21:15. Levi's description of principlism is an excellent summary of their position in the fourth edition of *Principles of Biomedical Ethics.*
[33] Richardson HS. 1990 Specifying norms as a way to resolve concrete ethical problems. *Philosophy and*

some norms which are "virtually absolute", such as prohibitions on torture and cruelty, and these norms can be applied straightforwardly to cases. However, situations in which these norms apply are rare.[34] Far more commonly, principles can be related to cases by *specification* of the principle, which involves "substantive development of the meaning and scope of norms", so that principles move from being abstract and general statements to being tailored to the demands of specific situations.[35] Under specification, principles are understood "less as norms that are applied...and more as guidelines that are *interpreted and made specific* for policy and clinical decision making".[36] Specification allows us to establish whether a certain action will indeed be covered by a particular principle. It offers a way to deal with conflict between principles, by developing and defining principles in ways that do not bring them into conflict with each other. Beauchamp and Childress recognise that specification has difficulties, because it will not always do away with conflict between principles.

Given that moral conflict is often inevitable, Beauchamp and Childress have a third model for the relationship between principles and cases. This model involves *balancing*. "Whereas specification entails a substantive development of the meaning and scope of norms, balancing consists of deliberation and judgment about the relative weights of norms."[37] Actual obligations to act in certain ways are determined by balancing and weighing all norms against each other, using good reasons to explain why a certain norm take priority over others.[38] Against the criticism that a balancing model

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Public Affairs 19:279-310, and DeGrazia, Moving forward in bioethical theory...

[34] Beauchamp & Childress, *Principles* (4th edn)..., 32-33. The use of overriding principles in extra-ordinary situations is the one instance in which Beauchamp and Childress consider that deductivism actually works. See Childress, Principles-oriented bioethics..., 81.

[35] Beauchamp & Childress, *Principles* (4th edn)..., 32, and DeGrazia, Moving forward in bioethical theory..., 525. See also Gillon, *Philosophical Medical Ethics...* and Gillon R. 1994 Preface: Medical ethics and the four principles. In Gillon R. (ed.) *Principles of Health Care Ethics.* John Wiley and Sons, xxi-xxxi. Gillon pays considerable attention to the scope of application of the principles.

[36] Beauchamp, Principlism and its alleged competitors..., 184.

[37] Beauchamp & Childress, *Principles* (4th edn)..., 32.

[38] Beauchamp and Childress invoke WD Ross' distinction between *prima facie* obligations and actual obligations. A *prima facie* obligation "is binding unless overridden or outweighed by competing moral obligations". (Beauchamp & Childress, *Principles* (4th edn)..., 33) The qualifier "*prima facie*"seems unnecessary in the context of a discussion about balancing and weighing principles. If principles or norms can be balanced against each other, they can not be absolute principles.

is too intuitive, Beauchamp and Childress have a list of conditions that fill out the meaning of 'good reasons'. The conditions include: the likelihood that infringing a principle will achieve the end desired; the absence of other morally acceptable alternatives; and the need to minimise the harm from infringing the principle. Beauchamp and Childress regard these conditions as non-controversial, but think they are often overlooked in moral deliberation.[39]

As in the first edition, the coherentism advocated in the first two chapters of *Principles of Biomedical Ethics IV* seems not to find its way into the central chapters of the book.[40] The core chapters of the fourth edition of *Principles of Biomedical Ethics* do try to give some indication of how the coherentist model works in practice, but it is far from complete. For example, chapter three on "respect for autonomy" begins with a theoretical discussion of the concept of autonomy as self-governance, and then suggests that any theory of autonomy must be within the grasp of "normal choosers".[41] Normal choosers act with varying degrees of understanding and subject to degrees of controlling influences over their actions, and the principle of respect for autonomy must be able to accommodate this variability.[42] Despite this attempt to introduce ordinary judgments into the specification of autonomy, the discussion that follows - of competence, informed consent and surrogate decision-making - still looks rather like the application of a 'principle' to a group of issues. The same situation obtains in the chapters on nonmaleficence and beneficence. For instance, Beauchamp and Childress explicate the principle of nonmaleficence, and then consider a number of areas in which it may be

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[39] The conditions look remarkably similar to the 'decision questions' featured in a number of the earlier texts on medical and nursing ethics. See, for example, Benjamin M & Curtis J. 1981 *Ethics in Nursing.* Oxford University Press, 11-21; Yezzi R. 1980 *Medical Ethics: Thinking about Unavoidable Questions.* Holt, Rinehart & Winston, 37-47; and Curtin L & Flaherty MJ. 1982 *Nursing Ethics: Theories and Pragmatics.* Robert J Brady Co., 57-63.
[40] In a round-about way, Beauchamp and Childress acknowledge this themselves in the preface to the fourth edition, in which they point the reader to "far-reaching changes in Chapters 1, 2 and 8...Despite these changes, the book retains its previous chapter structure and characteristic perspectives on major issues." (vii)
[41] Beauchamp & Childress, *Principles* (4th edn)..., 122-3.
[42] How intentionality figures in this account is discussed below, when the individualist orientation of principlism is considered.

relevant: the distinctions between optional and obligatory treatments, and between killing and letting die; assistance in dying; and decision-making for incompetent patients. Again, it seems that Beauchamp and Childress' coherentism (or dialecticism, as it is termed in the first edition) is stronger in theory than in practice.

In summary, principlism, as articulated in *Principles of Biomedical Ethics*, has changed since the first edition was published in 1979. In their theoretical chapters, Beauchamp and Childress have moved from a top-down deductivist approach to a coherentist theory of moral deliberation, which makes far more of the dialectical relationship between theory and practice. However, the change in theoretical orientation over the four editions has not been systematically applied throughout their work, so that what results in the fourth edition is an internally inconsistent picture of principlism.

This section has focused on principlism in isolation. In reality, of course, bioethicists, like Kuhn's scientists, work in a dialogic community in which ideas and theories are introduced, debated, modified, maintained and/or discarded. From a history of ideas perspective, the argument I have presented about the development in Beauchamp and Childress' work raises at least two questions. First, what factors have helped to shape the way that principlism has changed? Second, how has the change in Beauchamp and Childress' principlism, and its internal inconsistency, influenced other work in bioethics? The sections that follow address these questions.

2.2.2 The 'traditionalist' response to principlism

Beauchamp and Childress' principlism has been heavily criticised since the late 1980s. The criticisms come from a wide range of perspectives – from traditional moral theory, casuistry, virtue theory, feminism, through to social science. Moreover, there is considerable agreement amongst these critics about *what* is wrong with principlism, notwithstanding the divergence of views about *why* it is wrong and about what to replace it with. In this section, I consider the response to principlism offered by "more

traditional moral theorists".[43] The traditionalist critique of principlism has clearly had an impact on the development of Beauchamp and Childress' work, encouraging them to articulate more clearly their understanding of how principles relate to each other, and how they apply to cases. Other critics also take up the traditionalists' criticisms and their influence has been different. I will follow those arguments through in later sections of this chapter; I begin the discussion here because much of the principlism debate has been conducted around the issues the traditionalists raise.

Many critics make much of the purported deductivism of principlism.[44] They present Beauchamp and Childress' work as exclusively deductivist and top-down in approach.[45] For example, Green takes issue with Beauchamp and Childress over their use of 'applied ethics'. He suggests that we use the term 'applied' to talk about things like 'applied mathematics' and there we take it to mean the application of previously established methods or principles to a practical area. Either 'applied ethics' means the "more or less rote application of allegedly 'accepted' principles and concepts" or the term is a misdescription.[46] Green thinks that Beauchamp and Childress' work is an excellent illustration of rote application.

The traditionalists' charge that principlism is deductivist is well-founded when one recognises that they are writing from around 1990, and working with the first, second or, occasionally, the third edition of *Principles of Biomedical Ethics.* These critics have a weaker and less developed model of theory and justification in bioethics to

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[43] Levi, Four approaches to doing ethics…, 15. I borrow Levi's term "traditional moral theorists" to refer to critics who approach principlism from the perspective of mainstream moral philosophy. Here I include: Green RM. 1990 Method in bioethics: A troubled assessment. *Journal of Medicine and Philosophy* 15: 179-197; Clouser & Gert, A critique of principlism…; Holmes RL. 1990 The limited relevance of analytical philosophy. *Journal of Medicine and Philosophy* 15: 144-159. Green, Clouser and Gert are elsewhere labelled "deductivist". Since Green, Gert and Clouser themselves reject this label, it is not appropriate to use it. See Green RM, Gert B & Clouser KD. 1993 The method of public morality versus the method of principlism. *Journal of Medicine and Philosophy* 18:477-89.

[44] The traditional moral theorists are not alone in this. Critics from both within and outside traditional moral theory decry the deductivism in *Principles of Biomedical Ethics.*

[45] DeGrazia also notes this tendency in Moving forward in bioethical theory…

[46] Green, Method in bioethics…, 186.

attack than those who have the fourth edition to consider. As discussed above, the first edition openly adopts a top-down approach, and refers to a dialectical relationship between principles and ordinary judgment in a single paragraph. In the second edition, a second paragraph is added; in the third, the notion that dialecticism involves both drawing theory from cases, and applying theory to cases, is developed over one and a half pages. Only in the fourth edition is the coherentism taken up in any greater detail, and in all editions the core chapters of the book treat the principles, issues and cases they discuss in a way which supports the assertion that Beauchamp and Childress work deductively.

Beauchamp and Childress vehemently deny the charge of deductivism, even when it is aimed at earlier editions of *Principles of Biomedical Ethics*.[47] They do acknowledge that their understanding of the relationship between principles and cases and between principles themselves has developed over time.

> Even though elements of all three models [of the relationship between principles and cases] appear in PBE [Principles of Biomedical Ethics], we were not as clear as we might have been in our theoretical statements or our practical applications...
> Beauchamp and I have not always stated our (current) view of the relation between principles and cases clearly.[48]

Nevertheless, Beauchamp and Childress suggest that earlier versions of their work are not so far removed from later versions so as to make criticisms of the former irrelevant. For example, Childress comments in parentheses on the statement above that:

> "I include the qualifier 'current' because our position may have become clearer to us as we worked on it over time, but I would argue that even the first edition of *PBE* in 1979 was richer on this point than is sometimes recognised".

He goes on to argue that:

> In particular...problems in interpreting our principlism could easily arise because of our continued use of the metaphor of 'application,' along with such metaphors as hierarchical tiers, foundation, basis, and ground, and the use of diagrams that sketch the relations between theories, principles, rules, and particular judgments in ways that seem to deny or diminish the certitude in casuistical judgments other than by way of application of general principles and rules.[49]

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[47] See Beauchamp, Principlism and its alleged competitors..., and Childress, Principles-oriented bioethics... Other defenders of principlism also assert that the label is unwarrented. See DeGrazia, Moving forward in bioethical theory..., and Lustig BA. 1992 The method of 'principlism': A critique of the critique. *Journal of Medicine and Philosophy* 17: 487-510.
[48] Childress, Principles-oriented bioethics..., 82, 87.
[49] Childress, Principles-oriented bioethics..., 87.

There seems to me little evidence in *Principles of Biomedical Ethics* to support Childress' apologetic assertion that he and Beauchamp could have been clearer about the relationship between principles and cases, but that they did, even in these early editions, avoid a straightforward deductivism. The one paragraph reference to the dialectical nature of moral reasoning in the first edition clearly does not constitute a 'rich' treatment of the relationships between principles and ordinary judgment. In addition, Beauchamp and Childress do use a deductivist approach in the bioethical work that they do in the core chapters of *Principles of Biomedical Ethics*, and it is an approach which meshes perfectly with the hierarchical language they use in the opening chapters of the earlier editions. That hierarchical language has disappeared in the fourth edition, but the deductivist method of moral analysis remains in the central chapters.

The traditionalist critique of principlism has more to offer than mere name-calling. Critics such as Clouser and Gert begin their assessment of *Principles of Biomedical Ethics* with the accusation of deductivism, but they quickly get beyond it to the nub of their difficulties with principlism.[50] They hone in on the indeterminacy of the principles and the lack of clarity about the relationship between them. Clouser and Gert argue that Beauchamp and Childress' principles are not principles at all, in any meaningful sense of the word. In other areas of philosophy, and in common language, a principle is a summary or short hand form for a complete unified theory. For example, the utilitarian principle requires one to act so as to maximise overall welfare, and the specification of the principle covers all that is required for a complete moral theory: issues of what welfare means, or how to go about the maximising welfare. Clouser and Gert suggest that Beauchamp and Childress' principles are only 'chapter headings' which allow us to have elaborate discussions of concepts that are sometimes only superficially related to

[50] Clouser & Gert, A critique of principlism…; Clouser KD. 1995 Common morality as an alternative to principlism. *Kennedy Institute of Ethics Journal* 5:219-236. These criticisms were intially directed at the first three editions, but Clouser holds to the same position in the 1995 paper published after the fourth edition of *Principles of Biomedical Ethics*. See below for some speculative comments on the ways in

each other. The principles function mostly as reminders of morally relevant considerations to include in the analysis of any ethical problem. They do no more than ask us to "'Think about justice' or 'Think about helping people'".[51] Applying the principles means merely thinking about the problem from a number of points of view.

The tendency in principlism to encourage 'having a go' at a problem from a number of angles is a symptom of what Clouser and Gert call the "anthology" approach to bioethics. A myriad of theories, principles, and rules are offered, the strengths and flaws of each are pointed out, and the hapless problem-solver is left to choose the one(s) that best match his or her intuitions.[52] At its worst, this method of decision making is merely a form of after-the-event justification.

Clouser and Gert's critique is similar to that offered by other traditional moral theorists. Green and Holmes share with Clouser and Gert a stronger conception of moral theory than that espoused by Beauchamp and Childress, arguing that principlism "does not encourage people to look deeper to the roots of the principles being promoted".[53] To do that we need a more unified and substantial moral theory, which they think can clarify how principles relate to each other and how they determine action.[54] Green, Clouser and Gert's alternative is a theory of moral justification which involves a "public system of rules and ideals that all impartial rational persons would put forward as a public guide to everyone's conduct".[55]

The traditionalists' critique has clearly left its marks on the fourth edition of

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which the traditionalist criticism may be moving.

[51] Clouser, Common morality..., 223.

[52] Clouser, Common morality..., 224

[53] Levi, Four approaches to doing ethics..., 15. See also Holmes, The limited relevance of analytical philosophy...; Green, Gert & Clouser, The method of public morality...; and Green, Method in bioethics...

[54] Green, Gert & Clouser, The method of public morality... Holmes' alternative is different: he despairs of any useful role for moral philosophy in practical decision making.

[55] Green, Gert & Clouser, The method of public morality..., 481.

Principles of Biomedical Ethics. Beauchamp and Childress are concerned in the fourth edition, as they were not before, to clarify the nature and scope of their principles, and to explain how they understand principles to relate to each other. They have responded to their critics with a lengthy discussion of these issues, and their other recently published papers address the same issues.[56] The attempt at specification of principles is a response to the criticism that the principles are too indeterminate, and the introduction of the notion of balancing is an attempt to show just how the principles relate to each other. However, although *Principles of Biomedical Ethics* takes up these issues in a formal methodological sense in the opening chapters, the chapters that really do the work of showing how principles relate to each other and to cases do not seem to bear the same imprint. One might speculate as to whether we are due next for an overhaul of the chapters of *Principles of Biomedical Ethics* devoted to autonomy, non-maleficence, beneficence and justice. Such an overhaul might lead to a clearer articulation of how the specification of principles actually works in practice. It is less likely to show successfully how principles are balanced with each other, simply because using a chapter structure built around the four principles as distinct entities will severely limit the writers' ability to make those principles relate to each other.

One of the aims of this chapter is to show how these bioethicists work in a dialogic community. The preceding material shows how that dialogic community has functioned to subtly shift the orientation of Beauchamp and Childress' principlism toward a concern for the specification and balancing of principles. Obviously, there have been other influences on their work, some of which are discussed below. Before concluding this section, however, I want to suggest that the influence has not been only one way. There is, at least, a suggestion that the traditionalists are sensitive to the need for compromise and accommodation as well.

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[56] See, for example, Childress, Principles-oriented bioethics... and Beauchamp, Principlism and its alleged competitors...

One of Clouser and Gert's initial criticisms of *Principles of Biomedical Ethics* was that it seemed to have invited a tiresome and mechanical application of principles. Clouser and Gert were acutely aware of this:

> Throughout the land, arising from the throngs of converts to bioethics awareness, there can be heard a mantra '...beneficence...autonomy...justice...' Brandishing these several principles, adherents to the principles approach go forth to confront the quandaries of biomedical ethics.[57]

More recently, Clouser has suggested that it is not Beauchamp and Childress' conception of principles which is at fault here, but the uses to which it is put by others less skilled in moral deliberation.[58] He is prepared to assert that:

> If [Beauchamp and Childress' book] were the only book on principlism and none of the popular incorporation of their approach existed, we would never have written our critiques.[59]

Clouser thinks Beauchamp and Childress' articulation of the principles is written with "depth, understanding, sensitivity, and care about the issues of bioethics". It is only when in the hands of principlism's devotees that things start to go wrong.

Clouser's accommodating view of principlism suggests, as Beauchamp and Childress' developing theory does, a dialogic community in which people have to get on together. One way to get along together is to revise one's own work in the light of one's critics, and this is Beauchamp and Childress' way of dealing with the traditionalist critique. Another possibility is to scapegoat some nameless writers, and this is path Clouser chooses. There is, in fact, little evidence in Clouser and Gert's critique that they really take this accommodation seriously. If they did, their critique would focus on the "hundreds of articles"[60] that claim the principles as their foundation. As it stands, the critique directs all its energy at *Principles of Biomedical Ethics* itself, rather than at these other papers. And there is a sting in the tail of Clouser's comments. Although, in one statement, he praises Beauchamp and Childress' principlism, in the next he suggests that:

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[57] Clouser & Gert, A critique of principlism..., 219.
[58] Although Clouser is sole author in this paper, he makes it clear that his views are shared by his colleagues, Gert and Culver.
[59] Clouser, Common morality..., 222.
[60] Clouser, Common morality..., 222.

> ...we suspect that it is the nature of the principles and the reasoning that goes with them that enables, and perhaps encourages, various writers to go wrong.[61]

Despite his generous comments about Beauchamp and Childress' work, Clouser stills thinks there is something fundamentally wrong with their approach.

2.3 THE CHANGING CHARACTER OF CASUISTRY

Casuistry is a case-based approach to the resolution of moral problems. Even within a statement as simple as this, though, there are immediately a number of complexities. First, the casuistic approach encompasses several different models.[62] I will focus on the model which Jonsen and Toulmin develop, since their names are most closely linked with the re-emergence of casuistry in the modern era. Second, as with principlism, casuistry has not been a moral theory that, once delineated, is set in stone. In this section I will argue that Jonsen and Toulmin's description of casuistry has changed: in *The Abuse of Casuistry*, casuistry is an approach to moral reasoning grounded in an historical account of the moral practice of a group of individuals; in Jonsen's later work, it has become more a method of moral analysis. Because of these changes, 'later' modern casuistry begins to impose an order on the process of reasoning not apparent in 'earlier' modern casuistry. In addition, *The Abuse of Casuistry* contains at least two interpretations of the relationship between principles and cases. Jonsen adopts the weaker of these in later work when he is commenting on the similarities and differences between principlism and casuistry. This allows for an accommodation between the two approaches that might be more difficult to maintain if the stronger interpretation were adopted.

2.3.1 Casuistry as methodology

The sentinel work for an account of modern casuistry is Jonsen and Toulmin's *The Abuse of Casuistry*, a thickly-textured history of casuistry that aims to demonstrate

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[61] Clouser, Common morality..., 222.

[62] Wildes contrasts the approach taken by Jonsen and Toulmin with that of Baruch Brody in Wildes KW. 1993 The priesthood of bioethics and the return of casuistry. *Journal of Medicine and Philosophy* 18:34.

the relevance of casuistry for modern times.[63] Jonsen and Toulmin begin this work by suggesting that there are two, quite distinct, ways to discuss ethical issues. The first frames issues in terms of principles, rules and generalities, whereas the second focuses on the particularities of specific cases. In the former, a universal major premise provides the starting point for argumentation that leads deductively to a conclusion. Jonsen and Toulmin liken this mode of reasoning to that which occurs in classical geometry, and it is very similar to the deductivism that Beauchamp and Childress use. The case-based approach is closer to practical reasoning, and it "draw[s] on the outcomes of previous experience, carrying over the procedures used to resolve earlier problems and reapplying them in new problematic situations".[64] Although *The Abuse of Casuistry* is an account of the history of casuistry, Jonsen and Toulmin's central thesis relates to the present:

> Practical moral reasoning today still fits the patterns of topical (or 'rhetorical') argumentation better than it does those of formal (or 'geometrical') demonstration.[65]

The classical casuists who dominate *The Abuse of Casuistry* were prolific writers, but they did not leave behind any explicit accounts of their methodology.[66] The best we can do, say Jonsen and Toulmin, is to infer the method from their practice. That method involves six "steps" consistently taken but seldom reflected on.[67] First, casuists reasoned by analogy with "paradigm cases", in which the proposed solution was one on which all authors could agree. Second, they relied on the moral "maxims" that seemed embedded within cases. These maxims were well-known but rarely defended explicitly, and they acted as a linchpin for much casuistic argument. For example, in cases based

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[63] Jonsen AR & Toulmin S. 1988 *The Abuse of Casuistry. A History of Moral Reasoning*. University of California Press. Some of the key aspects of Jonsen and Toulmin's views on contemporary casuistry appeared in print before *The Abuse of Casuistry* was published. See, for example, Jonsen AR. 1986 Casuistry and clinical ethics. *Theoretical Medicine* 7:65-74; and Toulmin S. 1981 The tyranny of principles. *Hastings Center Report* 11: 31-39. Since then, Jonsen has written particularly on the methodological aspects of casuistry. See, for example, Jonsen AR. 1995 Casuistry. in Reich WT. (ed.) *Encyclopedia of Bioethics.* (2nd edn) Simon and Schuster Macmillan, 344-350; Jonsen AR. 1991 Casuistry as methodology in clinical ethics. *Theoretical Medicine* 12:295-307; and Jonsen AR. 1995 Casuistry: An alternative or complement to principles? *Kennedy Institute of Ethics Journal* 5:237-251.

[64] Jonsen & Toulmin, *The Abuse of Casuistry*..., 35.

[65] Jonsen & Toulmin, *The Abuse of Casuistry*..., 326.

[66] Jonsen & Toulmin, *The Abuse of Casuistry*..., 251.

[67] Jonsen & Toulmin, *The Abuse of Casuistry*..., 250 - 265 is an account of these steps. This paragraph

around the eighth commandment, the relevant maxims were often drawn from scripture and included statements like "the mouth that lies kills the soul". Third, the casuist moved out from paradigm cases by adding complicating detail. There was a traditional list of circumstances that were invoked: "who, what, where, when, why, how and by what means". Fourth, the conclusions for cases, beyond the paradigm cases, were rarely certain; instead, they were phrased as more or less probable. Fifth, the casuists adopted a cumulative approach to moral reasoning, in which the strength of an argument depended less on its internal logic than on the "accumulation of many and varied supporting reasons". Finally, the casuists always concluded the discussion of each case with a "resolution", although these resolutions were invariably couched in the language of probability. On this basis of this account, Jonsen and Toulmin venture a definition of casuistry:

> the analysis of moral issues, using procedures of reasoning based on paradigms and analogies, leading to the formulation of expert opinions about the existence and stringency of particular moral obligations, framed in terms of rules or maxims that are general but not universal or invariable, since they hold good with certainty only in the typical conditions of the agent and circumstances of action.[68]

The term 'steps' in Jonsen and Toulmin's account of the casuistic method is something of a misnomer, if it is taken to mean a set of procedures that are followed in order to achieve a satisfactory outcome.[69] In *The Abuse of Casuistry*, however, there is little evidence that the casuists' method was a series of ordered steps. If anything, the examples of casuistic analysis in *The Abuse of Casuistry* imply an eclectic process, in the sense that the casuists moved backward and forward between paradigm cases, maxims and the problem case, with the details of the case unravelling, the maxims thrown in and paradigm cases moving in and out of the picture, as the casuists debated their problems. Jonsen and Toulmin's 'steps' are better described as 'tools of the trade' that the casuists picked up, used, and put down as the circumstances of the case demanded.

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draws particularly on this chapter.

[68] Jonsen & Toulmin, *The Abuse of Casuistry*..., 257.

[69] The closest analogy is to cooking. The steps in a recipe need to be followed in the right order if the novice cook is to have a reasonable finished product.

Although *The Abuse of Casuistry* as history focuses on how casuists in the Middle Ages and the renaissance resolved moral problems, Jonsen and Toulmin conclude that practical moral reasoning today is a variant of medieval and renaissance casuistry, resembling these earlier counterparts in several ways.[70] "Similar type cases ('paradigms') serve as final objects of reference in moral arguments, creating initial 'presumptions' that carry conclusive weight, absent 'exceptional' circumstances." The casuist's task is to decide which paradigm cases are relevant to the problem under scrutiny. As with medieval and renaissance casuistry, there are significant difficulties if paradigm cases fit only partially or if the applicable paradigm cases point in different directions. Today, as then, casuists deal with these difficulties by concentrating on the substantive aspects of practical reasoning - by understanding with subtlety and detail "in what kinds of circumstances and to what types of cases" rules, maxims and principles are relevant.[71] To resolve perplexing moral problems, the casuist turns to the detail of the case, not to the meaning of an abstract principle, rule or maxim.

Jonsen's short paper on "Casuistry and clinical ethics", published two years before *The Abuse of Casuistry*, also commented on the method of contemporary casuistry. Jonsen noted that the classical casuists were rhetoricians who did not apply principles to cases in any carefully deductive or inferential manner. Their "system" was not that of philosophy, but rather that of rhetoric, and their tools were the tools of rhetoric.[72] Jonsen suggested that two of these tools, in particular, are important for modern casuistry. The first of these was the paradigm or analogy noted above. Secondly, rhetoricians relied on "topics" to define debate and create the structure for argument. Both of these 'tools' receive considerable attention, primarily in an historical context, in *The Abuse of Casuistry*.

[70] Jonsen & Toulmin, *The Abuse of Casuistry*..., 304-332.
[71] Jonsen & Toulmin, *The Abuse of Casuistry*..., 259.
[72] Jonsen, Casuistry and clinical ethics..., 68-70.

Jonsen's later work explicitly takes up the question of the methodology of casuistry, and gives it a considerably more ordered appearance than seemed apparent in his earlier writing or in *The Abuse of Casuistry.* In his review article for the *Encyclopedia of Bioethics*, Jonsen questions the use of the term 'methodology' for casuistry, for he thinks it may be too formal a word for casuistry's way of dealing with moral problems.[73] Nonetheless, he goes on there, and elsewhere, to describe the characteristic features of casuist methodology, by filling out some of the terms that he has previously mentioned and putting them in some kind of step-by-step order.[74] The actual steps vary between papers: in some papers, the first step in casuistic analysis is the identification of paradigm cases; in others, it is the identification of the topic. In all papers, however, the notion of ordering is apparent. The account below is that which offers the most complex interpretation of the casuist method.[75]

Throughout Jonsen's discussion of the method of casuistry, the notion of rhetorical analysis is central. Rhetoric is:

> ...the art of making a persuasive argument in favour of the just, the good, and the right...the art of encouraging citizens to decide rightly about civic matters and courts to decide fairly about legal ones. Finally, rhetoric [is] the art of reasoning with contingent facts and drawing plausible conclusions.[76]

Rhetoric starts with 'topics' - those invariant features that constitute the framework of an activity. In political science, Jonsen suggests the topics might begin with the form of government, the locus of authority, and common welfare. The topics that Jonsen recommends for clinical ethics are medical indicators, patient preferences, quality of life and contextual features (such as allocation of resources).[77] The casuist's first task is to site his case within the appropriate topic.

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[73] Jonsen, Casuistry...
[74] Jonsen, Casuistry...; Jonsen, Casuistry as methodology in clinical ethics; and Jonsen, Casuistry: An alternative or complement...
[75] See Jonsen, Casuistry: An alternative or complement...
[76] Jonsen, Casuistry: An alternative or complement..., 241.
[77] He refers the reader to Jonsen AR, Siegler M & Winslade W. 1992 *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine.* (3rd edn) Macmillan. As a teacher using this book, I

From topics the casuist moves to a thorough description and evaluation of the circumstances or particulars of the case. The case is constructed in terms of time, place, person, actions and affairs.[78] These details stand around the core of the case, which is a maxim, rule or value that defines the case as a certain 'type'. The maxim is, in a sense, a "cut-down" version of those principles that are relevant to the topic under consideration. For example, the principle of autonomy cut-down for use in a particular case might become "persons have a right to take their own risks".[79] The maxim is important in that it establishes the base from which one moves to compare the case under scrutiny with other cases.

The third step in casuistic analysis is the comparison of cases. In comparing the case with other cases, one seeks to identify 'paradigm' cases. A 'paradigm case' is now:

> A case in which the circumstances were clear, the relevant maxim unambiguous and the rebuttals weak, in the minds of almost any observer. The claim that this action is wrong (or right) is widely persuasive. There is little need to present arguments for the rightness (or wrongness) of the case and it is very hard to argue against its rightness (or wrongness).[80]

The casuist looks for paradigm cases that bear some sort of family resemblance to the case under investigation. Both Jonsen's early work and *The Abuse of Casuistry* note that the classical casuists "read each others' works assiduously and commented on others' ideas incessantly", generating in turn a form of continuous self-correction.[81] Their paradigm cases were public cases with a long history of debate, discussion and correction. Jonsen's attempts to 'modernise' the method of casuistry lead him to cite Karen Ann Quinlan, Baby Doe of Bloomington, and "Debbie" (discussed in the pages of the *Journal of the American Medical Association*) as paradigm cases for the contemporary casuist. He thinks that, as for the classical casuists, these cases have generated a body of discussion and criticism, an awareness of general agreement and points of difference and, most importantly, some consensus about 'the right thing to do'.

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did not interpret the content of *Clinical Ethics*... as a set of rhetorical topics.

[78] Jonsen, Casuistry as methodology..., 298.

[79] Jonsen, Casuistry: An alternative or complement..., 244.

[80] Jonsen, Casuistry as methodology..., 301.

[81] Jonsen, Casuistry and clinical ethics...,70.

What is startling about Jonsen's 'later' attempts to describe the method of casuistry is the order that is imposed on what appears in *The Abuse of Casuistry* to be a much more fluid and circular process. Each element in Jonsen's later description of casuistic method - topic, case particularity, and paradigm - is there in *The Abuse of Casuistry*, but not presented in a fashion which invites the reader take them one step at a time. The later versions of casuistic methodology appear much closer to the recipe approach to moral analysis.

In Jonsen's later casuistry, the cumulative nature of casuistic reasoning also receives little attention. Jonsen appears more concerned to describe casuistry as a method through which the novice moral reasoner can proceed step-by-step. The accumulation of evidence, in a piecemeal but additive fashion, is not easy to fit into a step-wise model of moral reasoning.

2.3.2 Principles and cases in casuistry

Jonsen and Toulmin note toward the end of *The Abuse of Casuistry* that there are two ways one might interpret their definition of casuistry for the relationship between principles and cases. The weaker version suggests only that casuistry is an essential accompaniment to any moral theory based around the application of principles to cases. In this version, the principles, or maxims as they appear in casuistry, are applied to cases and casuistry simply supplies the way of getting from the principles to the cases. Jonsen and Toulmin reject this version of casuistry for a stronger claim - namely, "that *moral knowledge is essentially particular*, so that sound resolutions of moral problems must always be rooted in a concrete understanding of specific cases and circumstances".[82]

[82] Jonsen & Toulmin, *The Abuse of Casuistry...*, 331. Arras argues that Jonsen and Toulmin convey in their writings both a weak and strong sense of casuistry. (Arras JD. 1991 Getting down to cases: The revival of casuistry in bioethics. *Journal of Medicine and Philosophy* 16: 30-31.) I think his judgment holds for Jonsen's later writing, but Jonsen and Toulmin are clear in *The Abuse of Casuistry* that they reject the weaker version. Their comments about weak *versus* strong casuistry are clearly informed by views Arras presented in an earlier oral paper quoted in *The Abuse of Casuistry...*, 331.

Although *The Abuse of Casuistry* formally rejects the weaker version of casuistry, in later work Jonsen seems to vacillate between the strong and weak versions. For example, he begins his *Encyclopedia of Bioethics* article with the statement that contemporary casuistry is a "method of analyzing and resolving instances of moral perplexity by interpreting general moral rules in the light of particular circumstances".[83] This is a relatively weak interpretation of the method of casuistry. On the other hand, Jonsen continues to invoke the metaphor of the courts in his descriptions of the method of casuistry, and the legal metaphor prescribes a rather stronger role for cases and a weaker one for principles and theory. Just as casuists have paradigm cases, so Jonsen sees that the law has 'landmark' cases that are used repeatedly to derive new judgments. In the same way that legal precepts develop out of common law, so principles arise out of cases. These legal precepts are not set in stone; rather, they are open-textured and subject to change in the light of new cases.[84]

Jonsen's equivocation about the 'strength' of casuistry in his later writing provides the context for his comments on the relationship between cases and principles. In 'Casuistry: An alternative or complement to principles?' he suggests two models for the relationship between principlism and cases.[85] First, casuistry is an alternative to principlism in so far as the two approaches are engaged in different scholarly activities. The casuist does not really need principles for most of his or her moral reasoning, because the every-day work of practical reasoning takes place at the level of case comparison.[86] Second, casuistry is a complement, rather than an alternative, to principles, because "no sound casuistry can dispense with principles". Ordinary moral

[83] Jonsen, Casuistry...

[84] Toulmin, by contrast, tends to maintain a strong version of casuistry. He thinks that casuistry *reverses* the relationship between theory and cases. Toulmin S. 1994 Casuistry and clinical ethics. In DuBose ER, Hamel R & O'Connell LJ. (eds.) *A Matter of Principles? Ferment in US Bioethics.* Trinity Press International, 310-318. One might speculate on who was writing what in *The Abuse of Casuistry*, but there is not enough evidence here to push the argument any further.

[85] Jonsen, Casuistry: An alternative or complement..., 246-250.

[86] This argument is not entirely convincing on the basis that all comparison is value-laden.

judgments by case-comparison methods have maxims embedded within them and principles are more general versions of maxims. The complementarity works itself out in two ways: "the circumstances of cases suggest the relevance of principles" and "circumstances reveal the suitability and fittingness of a particular specification of a principle".

In keeping with the broad theme of this chapter, that bioethicists have worked in a dialogic community as normal scientists, the next task is to consider how principlism and casuistry have influenced each other. Before doing so, I want to look briefly at how writers, other than Jonsen and Toulmin, have developed the thesis of *The Abuse of Casuistry* in their own discussion of the relationship between principles and cases, and between principlism and casuistry.

Casuistry takes up the traditional moral theorists' point that the principlism is too abstract and indeterminate. In hard cases, the principlist has no strategy to adjudicate between principles; he or she is forced back on "inarticulate and intuitive 'balancing' of competing moral principles".[87] In addition, the application of principles to cases (or the specification of principles for cases) requires interpretation that can not be referred back to the principle itself. Principlism will not tell us which of two competing interpretations of a principle we should accept.

Scholars with a casuistic bent also suggest that the problem with principlism is really a problem of priorities.[88] By according prime of place to particular judgments, and developing maxims out of those judgments, casuistry is able to avoid much of the conflict that a more theoretically driven approach cannot. In a sense, casuistry avoids the dilemma of competing principles by reversing the relationship between theory and

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[87] Tomlinson T. 1994 Casuistry in medical ethics: rehabilitated or repeat offender? *Theoretical Medicine* 15: 6.
[88] Arras, Getting down to cases..., 34-36.

practice. In addition, casuistry relies heavily on the casuist's skill in rhetorical argument to assess which maxim arising from which paradigm case is to rule in a particular situation.

Linked to the charge that principlism is abstract and indeterminate is a third point: the accusation that principlism excludes a large part of moral experience. The principlist frames ethical analysis with principles, using them to define what counts as relevant to analysis, to direct discussion, and to "characterize and resolve conflict".[89] In this sense, all principlist approaches are 'top-down' and, by their very nature, exclusionary. For example, in Beauchamp and Childress' case, if a consideration cannot be subsumed under the headings of beneficence, autonomy, non-maleficence or justice, it tends to be ignored in discussion. And to "create a system of ethical analysis that depends upon (by definition) exclusionary principles is to inappropriately exclude certain aspects of our lives from ethical considerations".[90] Casuistry avoids this problem by being 'bottom-up' – it incorporates the details of experience ethical analysis. Casuistry attends to the richness of moral experience, and forces the presentation of lengthy, richly detailed cases.

Granted these additional comments on the relationship between principlism and casuistry, two summary points can be made on the basis of the previous two sections. First, over time Jonsen's casuistry appears to move toward a methodological focus. Second, his later work displays a vacillation between the weak and strong versions of casuistry that is not apparent in *The Abuse of Casuistry*.

2.3.3 Casuistry and principlism

Casuistry has clearly had an impact on the nature and development of principlism, particularly in the way it has contributed to the movement in *Principles of Biomedical*

[89] Levi, Four approaches to doing ethics…, 19.
[90] Levi, Four approaches to doing ethics…, 19.

Ethics away from a deductivist understanding of moral reasoning to a coherentist one (at least in theory). The notion of 'reflective equilibrium', which Beauchamp and Childress borrow from Rawls, is rather similar to the casuists' to-and-fro movement between the particularity of cases and the maxims embedded in paradigms.

In other ways, also, casuistry has left its mark in principlism. The language of Beauchamp and Childress' first edition used 'ordinary judgments' to refer to everyday problems and decisions; by the fourth edition of *Principles of Biomedical Ethics*, 'ordinary judgements' become 'cases'. In addition, the cases Beauchamp and Childress describe are longer, more detailed and more richly textured.

On casuistry's side, the impact has been two-fold. First, Jonsen's increasing focus on a methodology that is step-wise and ordered looks rather like Beauchamp and Childress' method in intent, if not in content. The first edition of *Principles of Biomedical Ethics*, against the prevailing literature on problems in bioethics, was concerned to provide a framework for moral argument. Its rules, principles, and theories offered a process through which one could proceed to arrive at good conclusions to moral problems. Jonsen's later interpretation of the casuist method looks rather similar. As with Beauchamp and Childress' method, it offers a step-wise process that the moral reasoner can use to arrive at sound judgments.

Jonsen's later vacillation between strong and weak versions of casuistry has also opened the door for accommodation and rapprochement between casuistry and principlism. There seems to be a developing recognition that weak casuistry and coherentist principlism are not so far apart. The question of whether cases or principles are to have priority is perhaps not a very important one, when it comes to dealing with actual moral problems. If there is a difference between the coherentist principlism of Beauchamp and Childress – with its considered judgments adjusted in the light of case evidence and theoretical premises – and the weaker 'later' casuistry of Jonsen - with its

maxims and rules developed out of particular cases – then that difference is, at most, a matter of emphasis.

Beauchamp takes Jonsen's notion of maxims as "cut-down versions" of principles and suggests that, turned on its head, they are rather like the "built-up" specification of principles. "Like us, Jonsen sees an intimate connection between principles and what we call progressive specification to rules (maxims, etc.) in order to meet the demands of particular contexts."[91] Beauchamp and Childress think:

> Casuists and principlists should be able to agree that when they reflect on cases and policies, they rarely, if ever, have in hand either (1) principles that were formulated without reference to experience with cases or (2) paradigm cases that have not become paradigmatic *because* of a prior commitment to general norms. When philosophers now speak, as they often do, about 'the top' (principles, theories) and 'the bottom' (cases, individual judgments) in moral philosophy, it is doubtful that these poles can be either a starting point or a resting point without some form of cross-fertilization and mutual development...[92]

Jonsen, in similar vein, suggests that:

> Moral philosophers and casuists can also *compliment* each other when they find that the structure of principles that frame a moral problem and the interior design that highlights the concrete features of that problem in a specific instance fit together in ways that allow persons to reach a conclusion about a moral question. They, like the architect and interior designer who create a pleasing and functional edifice, have worked well together and are, as Beauchamp suggests, 'good friends [rather] than hostile rivals'.[93]

Beauchamp's conclusion in a recent issue of the *Kennedy Institute of Ethics Journal* devoted to principlism, echoed by Jonsen in another paper in the issue, makes the same point:

> It is hard to understand, then, how casuistry is a rival paradigm to principlism, although it has been so received in contemporary bioethics. Moreover, I believe the methodology for bioethics that Childress and I have defended – a method of coherence, specification, and balancing – need not deviate from the methods and standards proposed by Jonsen. If so, principlism and casuistry seem more like allies than enemies.[94]

This friendly accommodation turns, of course, on Jonsen's weak version of casuistry and Beauchamp and Childress' coherentist principlism. The earlier versions of both perspectives could not have provided the climate for such conciliatory remarks.

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[91] Beauchamp, Principlism and its alleged competitors..., 191.
[92] Beauchamp, Principlism and its alleged competitors..., 192-3.
[93] Jonsen, Casuistry: An alternative or complement to principles..., 250.
[94] Beauchamp, Principlism and its alleged competitors..., 193..

2.4 THE CONTRIBUTION OF VIRTUE THEORY

2.4.1 Virtue theory in bioethics

Like casuistry, virtue theory has a long and venerable history.[95] Also like casuistry, virtue theory fell from favour in the modern period, but it has undergone something of a renaissance in the last 20 years, in a form based on the Classical-Medieval conception of virtue.[96] According to Pellegrino, the concept of virtue "is the most ancient, durable, and ubiquitous concept in the history of ethical theory."[97] This is so because the specific focus of virtue theory raises basic questions about the character and intentions of persons and their role in the moral life.

It is more difficult to discern changes in the contributions of modern virtuists because, as a challenge to the dominance of principlism, virtue theory is a relative latecomer. This section contents itself with a summary of the major characteristics of virtue theory, in the form that it appears in contemporary bioethics,[98] and comments in speculative way on the contribution that virtue theory has made to principlist perspectives in bioethics. Beauchamp and Childress' early work adopts a strong principle-oriented definition of virtue theory, whereas the most recent edition of *Principles of Biomedical Ethics* displays a more equivocal stance on the nature of the virtues. The equivocation in Beauchamp and Childress' work appears to lay the groundwork for some accommodating comments, from both virtuists and principlists, about the relative merits of their theories.

Virtues (and vices) are closely linked to notions of character and disposition. All of these concepts concern "habitual patterns of moral behaviour that make possible the

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[95] The reader is referred to Pellegrino ED. 1995 Toward a virtue-based normative ethics for the health professions. *Kennedy Institute of Ethics Journal* 5: 253-260 and Pellegrino ED & Thomasma DC. 1993 *The Virtues in Medical Practice*. Oxford University Press, chapter 1, for a brief history of the concept of virtue.

[96] Pellegrino, Toward a virtue-based normative ethics for the health professions..., 255.

[97] Pellegrino, Toward a virtue-based normative ethics for the health professions..., 254.

[98] This is not meant to be an exhaustive summary of virtue theory. I have focused on the work of Pellegrino and Thomasma, Drane and May as prominent and influential examples of virtue theory in

claim of 'knowing the way some people are''".[99] We are entering the terrain of character and the virtues when we describe someone as 'a cynic' or 'a Pollyanna', for these labels convey our expectation that the person will respond, in most circumstances, with an attitude of cynicism or extreme optimism.

Virtues are more, though, than just a disposition to behave in a certain way. If that were the case, then cynicism would be a virtue. Pellegrino delineates the idea of virtue:

> (1) as excellence in traits of character, (2) as a trait oriented to ends and purposes...(3) as an excellence of reason not emotion, (4) as centred on practical judgment, and (5) as learned by practice.[100]

First, a virtue is oriented toward excellence and goodness. The form of excellence that emerges in a virtuous person is beautifully illustrated by a story Drane retells about a American academic who rescues a drunken soldier from a bar and sends him home in a taxi, taking care to ensure that he is not exploited.[101] Drane suggests that we could dissect this tale in terms of rules, principles and duties; however, this would not convey what is essentially right about the academic's actions. To communicate that rightness, we need to attend to the moral excellence of this Samaritan's character.

The notion of moral excellence begs the questions: excellence in what? to what end? Pellegrino's answer, after Aristotle, emphasises the way in which the virtues are oriented toward the ends and purposes of human activity. Such an orientation requires some agreement about the nature of those ends and purposes, a notoriously difficult undertaking in our post-modern, pluralistic society.[102] Pellegrino argues that we may not

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contemporary bioethics.

[99] Drane JF. 1994 Character and the moral life. In Dubose ER, Hamel RP & O'Connell LJ. (eds.) *A Matter of Principles? Ferment in U.S. Bioethics.* Trinity Press International, 292.

[100] Pellegrino, Toward a virtue-based normative ethics for the health professions..., 256.

[101] Drane, Character and the moral life..., 284-286.

[102] MacIntyre A. 1984 *After Virtue.* (2nd edn) University of Notre Dame Press. It is also an undertaking that the principlists have been content to avoid. Beauchamp and Childress' intention to present an account of how to go about moral deliberation, rather than a treatment of particular moral issues, allows *Principles of Biomedical Ethics*, in the main, to avoid questions of ends and purposes. The four

be able to reach a shared understanding of what is desirable in human purposes and ends at a general societal level, but we can hope for consensus within the community of health care professionals, and so the list of virtues he develops is a subset of a larger concern. In health care, he thinks we are likely to be able to reach agreement that the purpose of professional activity is healing. Those dispositions – ways of being – that enhance the healing capacities of the professions are the virtues of medicine, nursing and the like. I return to the issue of the nature of the professional virtues later in this section.

Whatever the exact nature of the virtues, they share, according to Pellegrino, an emphasis on character traits "under rational control".[103] By this he means that the virtues are not our unconscious and immediate responses to situations, our knee-jerk emotional reactions when we are confronted with choices and decisions. Rather, they involve a thoughtful consideration of options, which is both assisted and constrained by a predictable disposition to choose in certain ways.

The virtues may be traits under rational control, but this does not necessarily exclude the realm of emotion. Drane argues that one of the distinctive features of virtue theory is that it *does* involve emotion, since dispositions, attitudes, and character all have an emotional component.[104] At one level, the virtuous person does respond 'intuitively', 'naturally' or 'spontaneously' to situations that call for a moral judgment, guided by her emotional response to the situation. At another level, the virtues that make possible that spontaneous response are not 'intuitive'; they are not things "we find

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principles are much closer to items on a list to take into account when doing biomedical ethics than they are to ends in themselves.

[103] Pellegrino, Toward a virtue-based normative ethics for the health professions…, 257.

[104] Drane, Character and the moral life…, 292-5. For an example of the role of emotional responses in moral deliberation, see Veatch RM. 1985 Against virtue – a deontological critique of virtue theory in medical ethics. In Shelp EE. (ed.) *Virtue and Medicine*. D Reidel Publishing Company, 329-345. Veatch's example is of a clinician who is highly skilled and technically competent, but ultimately concerned only for herself. See also Putman DA. 1988 Virtue and the practice of modern medicine. *Journal of Medicine and Philosophy* 13: 433-443, for a critique of Veatch's position.

ourselves with, but something we construct over a lifetime".[105] The virtues are acquired human qualities, learnt and practised in what we do and how we think about our actions.[106] Virtue theory is able to occupy a special place in contemporary bioethics because it harnesses the emotions by bringing the character traits they mirror "under rational control".

The notion of the virtues as acquired human qualities also points to the close two-way relationship between character development and the social and cultural environment.[107] The way in which character is formed is obviously influenced by the social settings in which people live: medical students who learn the skills of doctoring in impersonal hospital bureaucracies take from those bureaucracies values which contribute, for ill or good, to their own character formation.[108] Just as importantly, our characters contribute to social values and the moral life of institutions. This is obvious, for example, when we meet individuals whose honesty and integrity have exercised a significant influence on the ethos of their work place.

It is probably the prominence that virtue theory gives to the relationship between character and environment that accounts for the explicitly religious element in much virtue theory. The theological connection is very much to the fore in May's and Drane's writing. Virtue theory encourages reflection on how we come to be the people we are and to have the moral preferences we have. It is not surprising, given this emphasis, that the question of the role of beliefs and belief systems in character formation should surface in virtue theory.

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[105] Drane, Character and the moral life..., 295.
[106] This is the first of two characteristics of MacIntyre's definition of a virtue (MacIntyre, *After Virtue...*). The notion of the virtues as acquired rather than inherited occurs also in: May W. 1994 The virtues in a professional setting. in Fulford KWM, Gillett GR, Soskice JM. (eds.) *Medicine and Moral Reasoning.* Cambridge University Press, 75-90; Drane, Character and the moral life..., 284-309; and in Pellegrino & Thomasma, *The Virtues in Medical Practice....* Pellegrino and Thomasma tackle the question of the acquisition of virtue in part by considering whether medical virtues can be taught in chapter 14.
[107] Drane, Character and the moral life..., 295-7.
[108] See, for example, Becker HS. 1961 *Boys in White: Student Culture in Medical School.* University of Chicago Press; Merton RK. 1957 *The Student Physician.* Harvard University Press; and Fox RC. 1979

The final element of Pellegrino's definition of virtue points us to virtue theory's emphasis on the practical nature of judgment. Pellegrino conveys two aspects of the virtues with this point. First, the virtues offer guidance as to how we should live; they are practical in the sense that they respond to, and are modified by, concrete decisions and actions in our everyday lives.[109] The virtues make no sense if construed as abstract ideals, unrelated to the exigencies of the moral life. Second, an important aspect of virtue theory is its emphasis on practical wisdom or prudence, the "capacity, in a given set of circumstances, to discern what moral choice or course of action is most conducive to the good...".[110] Practical wisdom allows the virtuous person not only to deliberate well when making decisions, but also to know how to act wisely. The doctor exercising the virtue of prudence knows that being honest with patients is important, but just as important is how he tells a patient a test result. Practical wisdom moderates bad news with careful use of words, intonation and touch.[111]

A further element of virtue theory is implied by the way that the virtues have been defined above. Virtue theory points us to the importance of relationships in moral theory. Being a good mother is more than knowing the 'rules' of good mothering and applying them consistently. A good mother will have a settled disposition of response that recognises the uniqueness of each child and works to build a mother-child relationship that responds to that uniqueness. Similarly a good doctor has developed a certain way of being a doctor that includes a sensitivity to people's needs and "an ease with human relatedness".[112] The practical wisdom that is part and parcel of virtue theory embodies a familiarity with what is needed to sustain good relationships.

Essays in Medical Sociology: Journeys into the Field. John Wiley and Sons.

[109] This emphasis is similar to casuistry's focus on case-based reasoning.

[110] Pellegrino & Thomasma, *The Virtues in Medical Practice...*, 84. Chapter 7 considers prudence as a virtue. See also May, The virtues in a professional setting..., 85.

[111] Komesaroff P. 1996 Medicine and the ethical conditions of modernity. In Daly J. (ed.) *Ethical Intersections: Heath Research, Methods and Research Responsibility.* Allen and Unwin, 34-48, describes these aspects of the doctor-patient interaction as the microethics of a consultation.

[112] Drane, Character and the moral life..., 287.

This last element introduces the relationship between the virtues and particular roles. There is a lively debate around the notion of whether there are such things as role-specific virtues. I have already mentioned Pellegrino's view that we should be able to agree on the virtues for medicine if we can agree that the goal of medicine is healing. Pellegrino and Thomasma's work, outside of their text on virtue, has continued to focus on the goals and purposes of doctoring as a link to virtuist medical practice. Veatch, however, argues that we have no hope of deciding on what the virtues for medicine might be, because we can not agree on what makes a good medical practitioner.[113] According to Veatch, there can be no single set of virtues for any profession, since there are a large number of conceptions of each profession, grounded in different systems of belief and value. I think both Veatch and Pellegrino and Thomasma overstate their cases. We are less disparate a society than Veatch imagines; even though people of different beliefs will seek different things from their doctors, most of us, most of the time, will look for doctors who are concerned to provide healing. And while healing is certainly one of the goals of medicine, perhaps the most important, it is probably not the only goal, as Pellegrino and Thomasma do recognise. Unless the definition of healing includes care and minimisation of suffering, we would want to include these, at least, in our goals for medicine.

The criticisms of both Veatch's and Pellegrino's views do not undercut the need for discussion about what it is that we would look for in a good doctor. Most virtue theorists provide, however tentatively, a catalogue of the virtues required for medicine. The lists vary but they tend to contain some or all of the following: fidelity to trust, compassion, prudence, courage, humility, integrity, temperance, and hopefulness. Some of the virtues have their parallels in rules and principles: benevolence, non-malevolence,

[113] Veatch RM (1991) denies that there are such things as role-specific virtues in: Is trust of professionals a coherent concept? In Pellegrino ED, Veatch RM & Langan JP. (eds.) *Ethics, Trust and the Professions: Philosophical and Cultural Aspects.* Georgetown University Press, 159-173. See also the following for critiques of Veatch: Putman, Virtue and the practice of modern medicine…; Pellegrino & Thomasma,

justice, and respectfulness.[114]

In addition to medical virtues, there are also medical vices. Drane catalogues these most explicitly, but other authors also refer to them, generally by way of contrast with the virtues. Drane frames his discussion of the medical vices in terms of commitments. Medical vices accompany the wrong kinds of ultimate commitments: to money, for the doctor committed ultimately to money will cease to care for a patient when there is no economic benefit; to power, which is antithetical to empowering patients and to working in a team; to science, for when science alone can provide no biological remedies the "scientific" doctor loses interest; or to self, for "truth and commitment to truth rarely coincide with love of self and commitment to self-enhancement".[115]

2.4.2 Virtue theory's critique of medicine and bioethics

Virtue theory casts its net more widely than other moral approaches discussed so far. Virtue theorists complain not only about the deficiencies in other approaches to bioethics, but about the problems with the medical enterprise itself. Pellegrino argues that current deficiencies in medical morality are a product of deficiencies in character and virtue.[116] He suggests that this connection has always existed, but the current crop of morally questionable practices in medicine – refusing to treat patients with HIV, turning away the poor, complying with early discharge rules when it is medically inappropriate, medical entrepeneurialism - demonstrate the pre-occupation with self-

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The Virtues in Medical Practice...

[114] The changing understanding in principlism of how principles and virtues relate to each other is taken up below.

[115] Drane, Character and the moral life..., 298-300. For an Australian example of the ethical problems associated with financial commitments, see Hicks N, Reynolds C & Braunack-Mayer AJ. 1996 *Ethical Issues Associated with Sources of Funding for Divisions of General Practice.* Prepared for the Divisions Strategy Group Ethics Committee, General Practice Branch, Department of Human Services and Health, Canberra.

[116] Pellegrino ED. 1989 Character, virtue and self-interest in the ethics of the professions. *Journal of Contemporary Health Law and Policy* 5: 53-73.

interest in contemporary medicine and the parlous state of the virtues in medicine.[117]

May picks up a different aspect of current medical practice, to argue that we need an emphasis on virtue because of the specialisation and bureaucratisation of medicine.[118] These factors have meant that we now see very little of what an individual practitioner does, where once the doctor's work was more open to scrutiny. May does not develop this argument, but he may be thinking of the contrast between, say, the practice of a specialist vascular surgeon working in a large city and that of a general practitioner based in a small country town. An efficient grapevine ensured that the country doctor's successes and failures were more widely known than those of the vascular surgeon are. In addition, the country doctor could be the sole receiver of blame and praise which can now be dispersed widely in an institution. A focus on virtue can help protect us against the self-interested physician, who, in a smaller world, would have been scrutinised carefully by a watchful community.[119]

Implicit in these comments about contemporary medicine is also a critique of principlism's response to medicine. The critique that virtue theory offers of principlism shares some similarities with that offered by 'strong' versions of casuistry. Virtue theorists maintain that principle-oriented bioethics is too abstract and too removed from day-to-day decisions; its legalism stifles compassion and creativity; and the principlist's approach offers no strategy to adjudicate between competing principles.[120] These are all complaints that I have discussed from the perspective of the casuists' critique, so I will not restate them here.

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[117] Pellegrino's catalogue of dubious practices reflects the organisation of the United States health care system. Yet, a similar list that would share some elements with Pellegrino's list could be constructed for Australian medicine. See Chapter Five of this thesis for a discussion of the organisational context of general practice in Australia.

[118] May, The virtues in a professional setting..., 76.

[119] Veatch maintains the exact opposite in: Against virtue – a deontological critique on virtue theory in medical ethics. He argues that in the era of "stranger medicine" rules are preferable to a reliance on virtue. His view is countered successfully by Pellegrino and Thomasma, *The Virtues in Medical Practice...*, 14.

[120] See Pellegrino & Thomasma, *The Virtues in Medical Practice...*, chapter 2 and Pellegrino, Toward a

Virtue theorists also add a slightly different complaint. They argue that bioethics, and they include here both principlism and casuistry, has been preoccupied with cases, dilemmas and quandaries.[121] On this view, the moral life is merely a series of moral crises, and the chief task of the moral agent is adjudication of competing rights and obligations, leading to the resolution of dilemmas.

Virtue theory's response to the pre-occupation with quandary ethics is to point out that the moral life is continuous; we do not cease to be moral people just because there is no moral crisis to spur us to action. Even when we face moral dilemmas and quandaries, our settled dispositions to respond in certain ways play an important role in how we act. Virtue theory can and does play a role in quandary ethics: the practical nature of the virtues, the capacity of the moral agent to resolve conflict between competing principles with the aid of practical wisdom, and the way in which virtue theory can rehabilitate compassion are all important to the resolution of moral problems.

Pellegrino and Thomasma acknowledge that a number of the different methods of moral analysis developed in response to the perceived deficiencies of principlist bioethics, including casuistry, are similar to virtue theory in so far as they "place more emphasis on persons, agents, and circumstances that principles do".[122] There is a sense, though, in which virtue theory, more that these other alternatives, makes most explicit the connection between our actions and our inner states of being. Although character and intentions never entirely disappear from whatever angle the moral debate is conducted, virtue theory does more than any other theory to incorporate them into moral deliberation.

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virtue-based normative ethics for the health professions..., 266.

[121] May, The virtues in a professional setting..., 75-6. See also Whitbeck C. 1992 The trouble with dilemmas: rethinking applied ethics. *Professional Ethics* 1: 119-142. The issue of what makes a moral problem or dilemma is considered in Chapter Six.

[122] Pellegrino & Thomasma, *The Virtues in Medical Practice...*, 19.

2.4.3 Virtue theory and principlism

How has the distinctive perspective of virtue theory influenced principlism? One way to consider this question is to examine the way in which Beauchamp and Childress' treatment of the relationship between virtues and principles in *Principles of Biomedical Ethics* has changed between the first and fourth editions.[123] There are at least two ways one can conceive of this relationship.[124] First, there is a principle-oriented definition of virtue, which emphasises the primacy of judgment and action, influenced by principles, over the role of virtues and character in the moral life. Principle-based theories of morality do not ignore virtues altogether, but they subordinate them to principles. They sort the virtues in terms of the things we do, the decisions we make, and the problems we solve. There is, however, a stronger version of virtue theory, which emphasises the primacy of the virtues over principles. This virtue-oriented theory of virtue reverses the principlists' subordination of virtues to principles, and asks us to think first about how we will *be*, about the character and strengths we will have and develop, as the definer of what we will *do*.[125]

The strong version of virtue theory, with its focus on the primacy of the virtues, has little in common with deductivist versions of principlism. Nonetheless, recent writing by Beauchamp and Childress and by Pellegrino about the relationship between virtues and principles is conciliatory, suggesting that both camps have found ways to accommodate each others' views. An important factor in this rapprochement has been the movement in Beauchamp and Childress' writing from a clearly principles-oriented definition of the virtues to a more equivocating position somewhere between the principle- and virtue-oriented definitions.

[123] In both editions, virtues and character are considered in chapter 8. In the first edition, this chapter is titled "Ideals, virtues and integrity"; in the fourth edition, it is "Virtues and ideals in professional life". There is also a brief treatment of character ethics at 62-69.
[124] The distinction between principle- and virtue-oriented theories of virtue is taken from May, The virtues in a professional setting...
[125] See also Pellegrino & Thomasma, *The Virtues in Medical Practice...*, chapter 2.

In the first edition of *Principles of Biomedical Ethics*, Beauchamp and Childress' definition of the virtues is clearly a principle-based one and they work with a very narrow understanding of the relationship between principles and virtues. They recognise that the moral realm encompasses judgments about moral goodness and badness, traits of character, dispositions, motives and behaviour, as well as judgments about acts.[126] The question 'what should I be?' has a place in moral deliberation along-side 'what ought I to do?' Yet, Beauchamp and Childress do not agree, in their first edition, with those who "try to drive a wedge between an ethics of duty and an ethics of virtue or between acts and agents" or those "who try to make the ethics of virtue primary", for they think that no discussion of morality is complete without treatment of the rightness or wrongness of acts.[127]

Despite some general language about the importance of both virtues and principles, or character and action, the first edition of *Principles of Biomedical Ethics* in its treatment of the virtues makes being very much less important than doing. For example, Beauchamp and Childress seem almost unable to look beyond their four principles for virtues. For them, the virtues correspond to the duties and ideals in a rule-base theory of morality, just as vices correspond to wrong acts. The most important virtues in medicine correlate with:

> "the major principles and rules of ethics as applied to medical practice. These include, but are not limited to, veracity, benevolence (including nonmalevolence), respect for persons (particularly their autonomy), and justice".[128]

There is little room in this interpretation of the virtues of medicine for the virtuists' emphasis on character, moral development, environment and emotion.

The realm of the virtues is a larger one in the fourth edition of *Principles of*

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[126] Beauchamp & Childress, *Principles,* (1st edn)..., 233.
[127] Beauchamp & Childress, *Principles* (1st edn)..., 234.
[128] Beauchamp & Childress, *Principles,* (1st edn)..., 235-6.

Biomedical Ethics. In the opening pages of the chapter on the virtues in professional life, Beauchamp and Childress appear to have a clearer picture of how principles and virtues might relate to each other, and they have included more virtues within their net. Beauchamp and Childress begin by stating that the focus on rules and principles in moral deliberation must be complemented by an interest in character and virtue because "principles require judgment, which in turn depends on character, moral discernment, and a person's sense of responsibility and accountability".[129] The virtues for health professionals derive from health care relationships, which are themselves grounded in the public expectations attached to these roles. Now, Beauchamp and Childress choose four virtues for analysis – compassion, discernment, trustworthiness and integrity – noting that they have treated other key virtues in earlier chapters in the context of discussion of rules and duties.

The broader conception of the virtues in the fourth edition is not necessarily accompanied by a softening of the line on how principles and virtues relate. Beauchamp and Childress assume that their examination of the four principles in earlier chapters conveys all that is needed for the examination of the related virtues. Thus they continue to blur the distinction between character and action. Even their treatment of other virtues is still in line with a principle-oriented definition of virtue. For example, they discuss the virtue of discernment, which is "the ability to make judgments and reach decisions without being unduly influenced by extraneous considerations, fears, or personal attachments."[130] By contrast, virtue theorists understand discernment rather differently. For them, discernment involves the ability to understand, evaluate, and incorporate *into* one's judgment extraneous considerations, fears and personal attachments. Beauchamp and Childress also have a high regard for the role of principles in discernment. For them, discernment "involves understanding both *that* and *how* principles and rules are relevant in a variety of circumstances". Discernment is the

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[129] Beauchamp & Childress, *Principles*, (4th edn)...463.
[130] Beauchamp & Childress, *Principles* (4th edn)..., 468-9.

capacity to know how and when particular principles should be invoked; "understanding that one's actions should be in conformity with a balance of principles itself exhibits a complex form of discernment". Beauchamp and Childress' examination of the virtue of discernment seems little more than a restatement of the specification and balancing of principles.

In summary, the rise of contemporary virtue theory to prominence between the first and fourth editions of *Principles of Biomedical Ethics* has left some marks on Beauchamp and Childress' work. The fourth edition contains a more nuanced discussion of the nature of the virtues and their role in professional life. It also expands the number of virtues that are regarded as central to moral deliberation in health care. However, the 'bioethical work' that Beauchamp and Childress do with virtues, in both the first and fourth editions, is heavily biased towards a principle-oriented interpretation of the virtues.

The equivocation in *Principles of Biomedical Ethics* on how virtues and principles should relate provides the foundation for conciliatory remarks between the virtuist and principlist camps. Recent writing by Beauchamp and Childress and Pellegrino suggests that the differences of opinion between virtuists and principlists can be avoided by ignoring the question of whether principles or virtues are to take priority, and focusing instead on the complementarity of their approaches. Beauchamp and Childress suggest that "a moral philosophy is simply more complete if the virtues are integrated with principles" and that virtue theory and principlism can then be seen as "partners rather than competitors".[131] In return, Pellegrino claims that a moral theory based on the virtues can not stand alone.[132] Rather, virtue theory offers a perspective on the moral life that must be balanced by other perspectives, particularly those that emphasise actions and principles. Pellegrino's conclusion is that:

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[131] Beauchamp, Principlism and its alleged competitors..., 195.

[132] Pellegrino & Thomasma, *The Virtues in Medical Practice...*

> Today's challenge is not how to demonstrate the superiority of one normative theory over the other, but rather to relate each to the other in a matrix that does justice to each and assigns to each its proper normative force.[133]

The strong version of virtue theory and the deductivist version of principlism could not support such statements. Beauchamp and Childress and Pellegrino seem to choose the weaker versions of their theories when in dialogue, allowing these weak versions to do the daily work of consolidating a unified theory for bioethics. However, this accommodation appears relatively fragile, built on generous interpretations of each others' work.

2.5 INDIVIDUALISM AND BIOETHICS

2.5.1 The individualist paradigm

The principlists', casuists' and virtue theorists' development of theory in their work is an example of normal science activity. The scientist working within a paradigm seeks to account for conflicting evidence and interpretations in the context of familiar theories. Evidence is drawn into and accommodated within a theory in ways that do not threaten the theory's interpretation of the nature of reality. When confronted with novelties and anomalies, scientists articulate and modify their theories to eliminate apparent conflict. Normal science does not "aim at novelties of fact or theory"; when it is successful, it finds none or, at least, disposes of potentially troubling ones.[134]

As in normal science, so too in bioethics. The previous sections discussed the ways in which principlists, casuists, and virtue theorists have been able to interpret each others' work in ways that are supportive, rather than destructive, and compromising, rather than rigid. They have been able to do this by focusing on some aspects of their own and each others' work, and de-emphasising other aspects. In the main, this selective emphasis has involved fashioning weaker understandings of their theoretical positions, and using these weak versions in dialogue with each other.

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[133] Pellegrino, Towards a virtue-based normative ethics for the health professions, 273.
[134] See Kuhn, *The Structure of Scientific Revolutions...*, 52ff.

None of this theory modification would be possible if principlists, casuists and virtue theorists did not share a great deal of common ground. Scholars in bioethics, as in normal science, can only accommodate alternative views and agree that some issues matter more or less than others because, in a fundamental sense, they see the world in the same way. The paradigm that provides the lens through which they view moral phenomena must be a shared one. For principlists, casuists and virtue theorists, that paradigm is individualism, the belief that the primary unit of analysis in moral life is the individual.

Individualism shapes activity in bioethics at a number of levels. At the level of professional interaction between colleagues, it ensures that participants in a controversy or contributors to a debate treat each other's views with politeness, and often with respect: 'you are entitled to your view, just as I am entitled to mine'. At another level, the individualist paradigm shapes what gets discussed and debated in bioethics, the forms debate and discussion take, and the solutions that are proposed. This section focuses on this deeper level of analysis, beginning with a brief examination of the nature of individualism and the individualist paradigm in bioethics, and followed by a discussion of the ways in which the individualist paradigm shapes activity in each of principlism, casuistry and virtue theory.

The concept of individualism is a complex one. Lukes shows that most uses of the term combine a number of different meanings, or "unit-ideas", and he describes ten of these.[135] Not all of Lukes' unit-ideas are relevant for this discussion, but four of them, taken together, communicate the meanings implied when bioethics is described as individualist. First, individualism conveys the notion of self-direction or autonomy, "according to which the individual subjects the norms with which he is confronted to

[135] Lukes S. 1973 Types of Individualism. In Wiener PP. (ed.) *Dictionary of the History of Ideas. Studies of Selected Pivotal Ideas.* Charles Scribners' Sons, 594-604.

critical evaluation and reaches practical decisions as the result of independent and rational reflection".[136] Linked to this is a second unit-idea, that of privacy, which focuses on the idea of a private existence within the public world, a sphere in which the rational and deliberating individual can think and act as he or she chooses. A third unit-idea, "methodological individualism", relates to the concept that all social phenomena can be explained solely in terms of facts about individuals. The final unit-idea, "ethical individualism", parallels methodological individualism, arguing that the individual is the source, creator and arbiter of moral values and principles.

Freidson develops these concepts of individualism in his discussion of the difference between sociology of and sociology in medicine.[137] His ideas are relevant here, because the criticism of the relationship between sociology and medicine can also be applied to the relationship between bioethics and medicine. Freidson argues that the sociology in medicine approach is flawed because it is inherently individualistic. It takes its lead from the approach of medicine itself, which is also individualistic in character, for medicine is pre-occupied with patients as discrete, individual organisms.[138] Medicine is not alone in this; it reflects a "common-sense individualism" - a societal preoccupation with choice, rather than constraint; with individuals, rather than groups; with actors, rather than environment.[139] Problems are analysed by focusing on individual motives, values and knowledge, rather than by reference to the way in which the world in structured and organised. In like fashion, the individualist paradigm assumes that the solutions to the world's problems lie in changing those values, motives and knowledge, by devising programs that strive to improve individuals' health, education and psychological well-being.

[136] Lukes, Types of individualism..., 598.
[137] Freidson E. 1970 *Professional Dominance.* Atherton Press. See the introduction for a brief discussion of the distinction between sociology of and in medicine.
[138] Freidson, *Professional Dominance...*, 60ff.
[139] Freidson's "societal individualism" reflects the pre-occupations of mid-twentieth century Northern America, a point he does not make quite clear in *Professional Dominance.* This point is discussed below.

Freidson suggests that there are two flawed assumptions with this approach. The first is the assumption that "the human world is made up of individuals [and so] there is no such thing as a relatively stable, structured, social environment that constrains, limits, and channels an individual's behaviour regardless of his personal qualities".[140] Second, common-sense individualism assumes that "the individual's characteristics are definitely formed at some point of time into a stable and fixed bundle of knowledge, motives, and values, and that therefore he will act, from that time of formation and subsequently, more or less the same way no matter what the environment he acts in may be."[141]

Just as individualism has left its mark on medical sociology, so also it has influenced bioethics. Bioethics has been preoccupied with individual choice; with the interests of individuals, rather than those of groups; with decisions and actions by agents, rather than with the environment in which decisions get taken and actions are carried out. In the same way that medical concerns steered the orientation of medical sociology, so the close relationship between bioethics and medicine has fostered the focus on individuals in bioethical work. When bioethics does take an interest in communities and relationships, it tends to focus on the private relationships between individuals, for example doctors and patients, or parents and children, rather than on the social structures which shape those relationships. For the bioethicist, moral problems are solved by cognition - by individuals thinking rationally, coherently and logically about their moral problems and acting on the basis of their cognitions - rather than by changing social structures. The bioethicist seeks to change behaviour by changing values, motives and knowledge, a route that invokes ethics education, rather than political activity.

Jennings' account of the bioethical perspective in neonatal intensive care provides

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[140] Freidson, *Professional Dominance...*, 64.
[141] Freidson, *Professional Dominance...*, 65.

an excellent example of the individualist orientation of bioethics.[142] Jennings notes that the bioethical literature on neonatal intensive care has dealt primarily with a small number of themes: the principles and guidelines that determine life-and-death decisions; the role of surrogate decision-makers, particularly parents; and the importance of an infant-centred standard for treatment decisions. These issues are notable for two reasons. First, they focus attention on only a small group of individuals - primarily parents and neonatal intensive care staff - and they bracket out a myriad of other individuals, and the institutions and organisational structures in which they operate. Second, they seem to imply that the only ethical issues of importance in neonatal intensive care units relate to decision-making and decision-making is, here, the province of individuals. The bioethicist's 'solution' to ethical problems in neonatal intensive care is to improve the quality of decision-making, by using rational persuasion and debate to make values and reasons explicit.

Jennings contrasts the bioethical approach with studies that take a sociological approach. These studies reveal a different perspective on the ethical complexities of neonatal intensive care.[143] These studies show that decisions in neonatal intensive care units are not made by individuals, but by consensus; that parents are generally excluded from the decision-making process; and that the 'decision' not to treat is frequently a default one that cuts in when all treatment options have been tried and found wanting.

One explanation for the differing perspectives of bioethics and sociology is that bioethicists are interested in what ought to be and sociologists in how things are.[144] This

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[142] Jennings B. 1990 Ethics and ethnography in neonatal intensive care. In Weisz G. (ed.) *Socila Science Perspectives on Medical Ethics.* Kulwer Academic Publishers, 261-272.

[143] Jennings uses the term "ethnography" rather than sociology, and he appears to treat ethnography as the empirical arm of a social science perspective. At least one of the works that Jennings alludes to (Anspach R. 1993 *Deciding Who Lives: Fateful Choice in the Intensive Care Nursery.* University of California Press) explicitly denies the ethnography label. I use the term 'sociological perspective' because I think it is broader and more inclusive, and there seems to me little difference between what I mean and what Jennings describes as an ethnographic perspective.

[144] David Armstrong and Charlotte Humphrey appear to take this view in Armstrong D & Humphrey C. 1994 Health care, sociology and medical ethics. In Gillon R. (ed) *Principles of Health Care Ethics.* John

explanation is overly simplistic, for many sociologists are concerned to change and improve the things they study. Likewise, many bioethicists do conduct 'fieldwork' of a sort, by reflecting on their own experience, working in clinical settings and engaging in dialogue with clinicians and patients. Jennings suggests that the differences can be explained better by attending to ways in which the two disciplines 'see' the moral world differently.[145] Put in Kuhnian language, sociologists and bioethicists operate in different paradigms. How the individualist paradigm has shaped activity in principlism, casuistry and virtue theory is explored below.

2.5.2 Individualism in principlism, casuistry and virtue theory

The paradigm of individualism emphasises the rationality, cognition and agency of human actors. This emphasis resonates with the focus in *principlism* on a rigorous and deductivist model of decision making. Human beings, in this model, are valued principally for their ability to reason; in a sense, they are abstractions, without particularising attributes. Little, a feminist critic, writes of the principlist version of traditional moral theory that it:

> ...tends to concentrate on moral questions that adjudicate relations beyond equal and self-sufficient strangers, to stress impartiality, to acknowledge obligations beyond duties of non-interference only when they are incurred by voluntary contract, to emphasize a search for algorithmic moral principles or 'policies' that one could apply to any situation to derive right action.[146]

Principlism's emphasis on human beings as rational decision-making entities goes hand-in-hand with its disregard for other aspects of the moral life. Fox suggests that principlism in Northern American bioethics has contributed to a narrowing of moral outlook:

> It downplays communal values and qualities of the heart, like caring, kindness, compassion, generosity, service, altruism, sacrifice, and love. These values involve recognizing and responding to close and distant others in a self-transcending way - to 'neighbors' and 'strangers', members of future generations in distant lands, as well as 'sisters' and 'brothers' who inhabit this

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Wiley and Sons, 855-860.

[145] Notwithstanding their earlier comments, Armstrong and Humphrey imply something similar: "the very questions asked by ethicists and sociologists about health care provision (as well as other things) are different in the form of the questions, the assumptions which lie behind them, and what are to count as acceptable answers." Armstrong & Humphrey, Health care, sociology and medical ethics…, 859.

[146] Little MO. 1996 Why a feminist approach to bioethics? *Kennedy Institute of Ethics Journal* 6:14.

time and this familiar place.[147]

Principlists find it hard to deal with relationships, particularly when the relationships derive most of their meaning from the domestic or private spheres. The feminist critique of principlism has particular force here for an 'ethics for strangers' makes no sense in the domestic and private spheres which, for many women, are their primary domains. Principlist ethics is unable to account for the partiality, dependencies and unchosen obligations that comprise the moral lives of many women.[148]

Because the individualist paradigm makes facts about individuals the most significant ones in the moral life, respect for autonomy has been the paramount principle for principlism. Anspach's description of bioethics attests to the dominance of autonomy:

> [Bioethics is] dominated by an image of an individual autonomous moral agent who reaches decisions apart from social constraints. This model portrays physicians as able to contemplate complex moral problems free from competing demands on their time, untroubled by patients with perplexing prognoses, and unconcerned with the threat of medical malpractice suits, legal reprisal, and consequences to their own careers.[149]

In a similar way, patients are assumed to be autonomous agents who seek out professional help judiciously, provide doctors with a full and truthful account of their problems, ask meaningful questions, understand what they are told and make rational decisions about the best treatment options for them.[150] The fascination with autonomy diverts attention from issues related to responsibility for the community and society. Fox and Levi both note that this preoccupation with autonomy has meant that bioethics, in its principlist form, has studiously ignored questions of social justice as they relate to the poor, the disadvantaged, and the victims of social prejudice and discrimination.[151]

An excellent example of how individualism plays itself out in principlism can be

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[147] Fox, The entry of U.S. bioethics into the 1990s..., 53.
[148] Little, Why a feminist approach to bioethics?...14.
[149] Anspach, *Deciding Who Lives...*, 35.
[150] Chambliss DF. 1993 Is bioethics irrelevant? *Contemporary Sociology* 22: 649-652.
[151] Fox, The entry of U.S. bioethics into the 1990s..., 50; and Levi, Four approaches to doing ethics...

seen in the way Beauchamp and Childress seek, in the fourth edition of *Principles of Biomedical Ethics*, to define the boundaries of autonomous decisions. As noted earlier, they believe that any theory of autonomy must accommodate the variability amongst normal choosers in understanding and controlling influences. Nonetheless, normal choosers must intentionally choose their acts.[152] This, for Beauchamp and Childress, is an all or nothing matter. When they take up the issue of intentionality later in *Principles of Biomedical Ethics*, their account focuses on concepts of volition, deliberateness, willing, reasoning and planning. For them, intentionality and, by inference, autonomy have to do with the capacity of individuals to will or intend their actions. There is no discussion, at all, of the ways in which our intentions are socially shaped, of how our own choices and choosing reflect our cultural values, upbringing, institutional and bureaucratic frameworks, and political systems.

The individualist paradigm has structured activity within casuistry, but in a more indirect way. Casuistry, through its use of paradigm cases, works mainly with current and past experiences, and it is therefore socially conservative. It "takes 'what is' as given and treats it as the starting point of moral reasoning".[153] It also ignores the fact that a case can be presented in ways that accord different weights and meanings to different types of evidence. So, casuistry tends explore, explain and interpret the moral life as a (very large) set of individual experiences without questioning the ways in which those experiences are packaged.

To question the 'packaging' of moral problems, casuists would need to examine the same issues that principlists neglect - cultural values, institutional values, political

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[152] Beauchamp & Childress. *Principles* (4th edn)..., 122-3.

[153] Kuczewski MG. 1994 Casuistry and its communitarian critics. *Kennedy Institute of Ethics Journal* 4: 101. See also Kopelman LM. Case method and casuistry: the problem of bias. *Theoretical Medicine* 15: 25-28, for a similar criticism of casuistry. Similar points can be made with respect to the ways in which case comparisons work in casuistry: different people seize on different things in comparing cases; the cases for comparison can be chosen selectively; and even the order in which cases are presented can influence outcomes.

presuppositions.[154] Casuistry is ill equipped to do this, because it focuses on particular experiences of individuals, and it presupposes that what ought to be valued in the moral life can be captured within a reasoning process that oriented toward the particular. The conservatism pushes casuistry to adopt uncritically the values of the culture that provides its cases; in the situation of contemporary bioethics, that culture is individualist and it makes the individual the sole arbiter of moral authority.[155] Casuistry has no in-built mechanism for challenging these dominant social meanings and it tends, therefore, to mirror the individualism of the society it finds itself in.

Arras provides an excellent example of how casuistry's social conservatism might structure what gets onto the moral agenda. A casuist, faced with the problem of heart transplants, might turn for paradigm cases to the other 'high-tech' therapies already available to people in medical need. If heart transplants were shown to be medically efficacious, these other therapies would provide all the paradigm support needed to approve them. The casuist's focus on local and "proximate moral precedents" would not provide the leverage to question whether we did indeed want to be the sort of society which supported heart transplant technology over other forms of health care. Casuistry's dependence on analogous reasoning would not invoke a set of important global questions about what sort of society we might want to have and who we might want to be.[156]

There is a second way in which the individualist paradigm has shaped casuistry. Earlier in the chapter I discussed the emphasis in recent casuistry on methodology. Beauchamp and Childress' *Principles of Biomedical Ethics* has been a conspicuous example of the recipe approach to moral deliberation, and Jonsen's recent attempts to

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[154] Casuistry can take a broader approach and much of *The Abuse of Casuistry* tends toward a wider view. However, when applied to the resolution of contemporary moral problems, casuistry tends to neglect the impact of institutional and social forces.
[155] Kuczewski, Casuistry and its communitarian critics..., discusses this issue at some length.
[156] Arras, Getting down to cases..., 46-7.

articulate the 'method' of casuistry seem to suggest a similar recipe for casuistical reasoning. In the individualist paradigm, methodological recipes are appealing: they support the notion that moral problems are solved by good cognitive practices - by individuals thinking rationally and logically about their moral problems and acting on the basis of their cognitions. The more closely the individual's reasoning processes resemble the stated method, the better the reasoning, and the stronger the likelihood that the decisions made will be sound. As Freidson noted for sociology, the individualist solution to social problems is education. Similarly, in bioethics, the individualist solution to faulty morality is education, and an accent on education is fully compatible with the methodological concern to 'get the reasoning right'.

The individualist paradigm has shaped casuistry mainly via its status as the dominant ideology of contemporary northern American culture. In a similar way, it has influenced *virtue theory*. A good deal of writing in virtue theory is devoted to analysis of relationships between doctors and patients, and that analysis takes place in a culture that treats the doctor-patient relationship as a contract between individuals. Virtue theorists have followed this lead and tended to ignore social and organisational factors in favour of the micro-ethics of the interaction between doctor and patient. There seems little recognition within virtue theory that those in the best position to define what is good in medicine - the doctors - are also those who wield the most power. A disproportionate amount of attention has been devoted to articulating virtues for physicians, and relatively little to virtues for patients, health administrators, or politicians, yet these other parties are as significant in the health system as doctors.

These comments notwithstanding, the match between individualism and virtue theory is less complete than between individualism and principlism or casuistry, in at least two ways. Virtue theory, more than principlism or casuistry, has the capacity to look beyond itself. More clearly than these other perspectives, it has mounted a critique of medical practice. In both cases, virtue theory's independence derives from its

recognition of the close two-way relationship between character development and the social and cultural environment and its concern to explore how virtuous practices can be nurtured over a lifespan.

Virtue theory's complaint that bioethics, in both its principlist and casuist versions, is excessively pre-occupied with cases, dilemmas and quandaries is, in some ways, a critique of the individualist paradigm. The virtuist suggests that principlism and casuistry can not see the moral wood for the individual trees. The individualist paradigm encourages us to focus on discrete problems that require solutions. Lurching from moral crisis to crisis allows little time to contemplate some of the issues that contribute significantly to those crises - issues related to the values our culture nurtures and sustains. Virtue theory attempts, at times, to begin a critique of that culture.

2.6 CONCLUSION

In summary, the individualist paradigm has shaped the ways that principlism, casuistry and, to a lesser extent, virtue theory formulate moral problems and methodologies. In each case, it has focused bioethical attention on the individual. This orientation has created a common space in which principlism, casuistry and virtue theory can dialogue, and has supported the accommodation and apparent convergence between the three perspectives.

The examination above of the individualist paradigm and its impact on bioethics has concentrated on the way that paradigm shapes the theoretical orientation of bioethics. This thesis is a thesis about the practice of ethics, and I will conclude this chapter with some comments on how individualism shapes empirical work in bioethics. The focus is, again, on how a few key writers in bioethics define and use empirical work in their writing. In the next chapter I will explore the nature of empirical work in ethics in general practice.

An oft quoted criticism of bioethics is that its forms, language and style bear little relationship to the ways in which ordinary people describe and talk about moral problems. Although, for the most part, the moral theorists discussed above do not address this criticism in a formal way, they do take interest in the empirical correlates of their work. Most assert, in some way, that the theory they espouse does match real life moral decision-making. However, the evidence that they bring in favour of their assertions is often limited, reflecting personal experiences or those of their colleagues.

Green, Clouser and Gert, for example, claim that their own moral theory offers a close fit with real life moral decision-making.[157] To develop their theory, they take "ordinary morality" as a starting point, recognising that:

> ...ordinary morality, as practiced, has some confusions, contradictions, and ambiguities that must be worked out, interpreted in the light of customs and beliefs, and otherwise reconciled.[158]

The job of moral theory, for Green, Clouser and Gert, is to tidy up ordinary moral reasoning, to turn the confusion of every day moral activity into a systematic theory.

> Our own account of morality, which has evolved over the last 30 years, begins with everyday intuitions about moral right and wrong. We see that there is a system of moral decision making at work, and we understand the work of moral theory to be the systematic description and justification of the actual practice of morality. To justify that practice is to show that it constitutes a public system that all persons who are rational and impartial can endorse. The general moral rules that are embedded in actual practices are also embedded in features of human nature, namely, the desire to avoid specifiable harms, unless one has an adequate reason not to.[159]

Clouser, Gert and Green's position is that their moral theory is no more than the systematic account of the moral reasoning of thoughful people. However, there is little evidence in their work to support this assertion. The few examples of "ordinary morality" they provide are decontextualised, presented simply as rules and ideals (for example, 'do not cheat') on which, they assume, we all agree. Even if Green, Clouser and Gert could be sure that 'ordinary people' do agree with these rules, they would still have to show that these ordinary people do use moral rules are they suggest they do. It

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[157] Green, Clouser & Gert, The method of public morality..., 481.
[158] Clouser, Common morality..., 228.
[159] Clouser, Common morality..., 235.

may be that ordinary morality is like this, but Green, Clouser and Gert provide us with no empirical evidence.

One might speculate that Green, Clouser and Gert's views about 'ordinary morality' mirror more closely than anything else their *own* moral reflections and deliberations. This would be compatible with the dominance of the individualist paradigm in their work, for that paradigm grants priority to the individual as the source, creator and arbiter of moral reasoning. Within a world-view that puts individuality on a pedestal, the notion that a bioethicist's, perhaps accurate, view of his own processes of moral deliberation approximates those of 'ordinary people' is a plausible one.

Jonsen and Toulmin also suggest that their theory of morality mirrors ordinary moral judgment but, unlike Green, Clouser and Gert, they offer an extended empirical example of moral reasoning at work. Jonsen and Toulmin begin *The Abuse of Casuistry* with a statement of "the problem": the tyranny of principles in public (and private) discourse about moral problems.[160] They contextualise that problem with a set of 'cases', itself hardly surprising for a text on casuistry. The nature of the cases is illustrative of Jonsen and Toulmin's attitude toward empirical evidence in bioethics. They choose: a public debate about the legalisation of abortion; the "true story" of a young handicapped woman whose dealings with an inflexible social security system contributed to her suicide; a sociological analysis of the moral and intellectual positions by activists on each side of the abortion debate; and, most importantly, an autobiographical account of their work on the United States National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research that spawned the *Belmont Report*.[161] The first two stories illustrate, for Jonsen and Toulmin,

[160] Jonsen & Toulmin, *The Abuse of Casuistry...*, chapter 1.
[161] National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. 1978 *Ethical Guidelines for the Protection of Human Subjects of Research*. DHEW Publication No. (OS) 78-00. Department of Health, Education, and Welfare. See Jonsen and Toulmin, *The Abuse of Casuistry...*, 16-19. Most introductions to contemporary casuistry relate the Jonsen and Toulmin version of the background to the *Belmont Report.*

that principle-oriented approaches to moral problems are ubiquitous but unhelpful; the third is "fascinating and helpful" but, because it attended to activists, limited in its generalisability. Instead, Jonsen and Toulmin think we need an account of how "people in the middle might argue the case".[162]

Jonsen and Toulmin's recollection of the work of the Commission is central to their argument that casuistic reasoning is to be preferred over deductivist principlist approaches. They suggest that their account of their own work on the Commission gave them both a "striking first-hand experience of what 'the new casuistry' holds in store for moral reflection and discussion, and compelled us to think about its methods".[163] They believed the day-to-day activity of the Commission exemplified casuistry at work, for they found that the commissioners and their consultants could agree on what recommendations to make, even though they did not agree on why they thought they should make them.

> So long as the debate stayed on the level of particular judgments, the eleven commissioners saw things in much the same way. The moment it soared to the level of 'principles,' they went their separate ways.[164]

Jonsen and Toulmin imply that their experience on the Commission provided evidence that people really do reason as casuists, rather than as principlists. Although they do not draw the conclusion explicitly, one might infer that they think their experience was an example of how people "in the middle" argue about moral problems, one that they believe can contribute to an accurate account of moral reasoning.

Beauchamp and Childress have their own memories of the workings of the same National Commission that imply a different construction of moral reasoning.[165] Beauchamp recalls that:

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[162] Jonsen & Toulmin, *The Abuse of Casuistry...*, 5.
[163] Jonsen & Toulmin, *The Abuse of Casuistry...*, 16.
[164] Jonsen & Toulmin, *The Abuse of Casuistry...*, 18.
[165] See, for example, Childress, Principles-oriented bioethics..., 85-6 and Beauchamp, Principlism and its alleged competitors..., 192-3.

> It is a little known fact, but a fact nonetheless, that the final comprehensive drafting of *The Belmont Report*...was done by three people in a small room at NIH: Al Jonsen, Stephen Toulmin, and me. Toulmin and Jonsen made significant and commendable contributions to the polishing of the statement of *principles* in that report. I do not recall any objection that the strategy of using principles should be anything other than central to the Commission's statement of its ethical framework, especially in the attempt to justify its reasoning about cases. They did, as one would expect, mention that the Commission was engaged in casuistry, but they understood the Commission's casuistry to be consistent with and supported by its invocations of moral principles.[166]

Childress makes similar comments about the way that the Commission developed its principles. He acknowledges that Jonsen and Toulmin's interpretation of the Commission's processes may be plausible. Just as plausible, for him, is the interpretation that:

> ...these general principles were already embedded in the Commission's agreements about problem areas, such as research involving children, and that the *Belmont Report* simply articulated these principles with greater clarity.[167]

It is hardly surprising that Jonsen and Toulmin, and Beauchamp and Childress should remember the work of the National Commission differently. The fact that their recollections are different is less important here than the assumption, made by all four scholars, that the work of that Commission provides an example of ordinary moral reasoning or, to use Jonsen and Toulmin's phrase, reasoning of people "in the middle". However, if it is to be construed as evidence of how people "in the middle" argue, then it is a rather peculiar form of evidence, for it is based on the experience of a quite select group of people, with considerable experience between them in medical science, psychology, philosophy, law, theology and the "public interest".[168] In addition, the commissioners and their consultants were arguing about moral problems that people "in the middle" rarely have to consider. Furthermore, the account we hear of the moral deliberation of this select group is filtered through the experiences and perceptions of Jonsen, Toulmin and Beauchamp themselves. They do not tell us what the other commissioners thought they were doing, only what they observed them doing.

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[166] Beauchamp, Principlism and its alleged competitors..., 192-3.

[167] Childress, Principles-oriented bioethics..., 85. See also Beauchamp and Childress' more general commnets about moral reasoning in *Principles of Biomedical Ethics* (4th edn)..., 36:"Ross' distinction between prima facie and actual obligations, as well as his model of balancing, are also attractive in that they conform closely with our experience as moral agents."

[168] Jonsen & Toulmin, *The Abuse of Casuistry*..., 17.

Beauchamp and Childress, and Jonsen and Toulmin, just as much as Green, Clouser and Gert, appear to fall into the trap of assuming that examples of their own moral activity provide all the empirical evidence we need to state that 'ordinary moral reasoning takes this or that form'.[169] And, as with Green, Clouser and Gert, that assumption reflects the dominance of the individualist paradigm in bioethics.

This excursus into the way that the bioethicists discussed in this chapter understand empirical evidence clearly reflects only a very small sample of empirical work in bioethics. The next chapter explores a larger example of that work: empirical work in ethics in general practice.

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[169] To be fair to Jonsen and Toulmin, their account of the history of casuistical reasoning does not fall into the same trap. They provide many examples of the historical casuists' reasoning, and draw their conclusions about the general forms of that reasoning from those examples. Nonetheless, their defence of modern casuistry does not display the same careful and analytical approach.

3 EMPIRICAL STUDIES OF ETHICS IN GENERAL PRACTICE

3.1 INTRODUCTION

This chapter explores empirical work in ethics, taking general practice as its example. In general practice, empirical research about the way in which ethical problems are treated appears in three forms: as surveys of general practitioners' experience of and attitudes to ethical problems in their work, as case reports of ethical dilemmas in general practice, and as sociological studies of general practice.[1] Each of these forms of empirical research offers a partial portrait of ethics in general practice, but none, in isolation, can tell the full story. Quantitative surveys that canvass opinions on ethical problems indicate that a broad range of views about ethics can be found amongst general practitioners. However, these surveys provide little guidance on why general practitioners think and act as they do when faced with ethical problems. Case studies report examples of ethical problems in general practice and they move beyond mere description of ethical problems to document the ways in which the general practitioner authors resolve their dilemmas. Although these reports, more than any other form of empirical research, indicate the uniqueness of ethical problems in general practice, case studies are always isolated instances of ethics in action, never systematic collections of data. In addition, through the ways in which cases are selected for analysis, they presume agreement about the nature and description of 'cases' in general practice. The methodologies used in sociological approaches supply rich and detailed studies of general practice and they do not fall prey to the problems associated with presuming agreement about the content of the moral agenda. However, their interest in the problems of general practice writ large is too unfocused to inform us adequately about how ethics is practised in general practice.

[1] This chapter draws primarily on international work. Clearly, there are differences between general practice, as practised in Australia, and general practice (in the United Kingdom), family practice and family medicine (in Northern America). (The social, organisational and financial context of general practice in Australia is discussed in Chapter Five.) However, the ethical problems that general practitioners/family physicians recount in each of these countries seem very similar. For examples of ethical dilemmas that Australian general practitioners report, see A Doctor's Dilemma: assorted articles on ethical issues in general practice. *Australian Family Physician* 1994; 23:1028-1092, and *Ethics in the Consulting Room.* 2 videos prepared by the Royal Australian College of General Practitioners.

Threaded through this account of empirical studies of ethics is a discussion of the ways in which moral theory and empirical work intermingle in general practice. What forms of moral reasoning dominate these studies? Put in the Kuhnian language of Chapter Two, what paradigms shape this empirical work? My answer to these questions, developed below, is that quantitative surveys and case studies fashion from mainstream bioethics and general practice the lens through which they view moral problems in general practice. Sociological studies, not surprisingly, use a different lens, the context offered by sociology's focus on the relationship between individual and society. Even the sociological studies, however, to some degree take general practice's definition of itself as a starting point, although they also look outside the general practice model to explain their findings. Furthermore, since they are not concerned explicitly with ethical deliberation and decisions, sociological studies of general practice have relatively little to say about the relationship between moral theory and their empirical findings.

3.2 QUANTITATIVE SURVEYS OF ETHICS IN GENERAL PRACTICE

There have been relatively few surveys of ethics in general practice. Rogers' systematic review of empirical research into ethics in general practice draws on a search of medical databases between 1980 and 1995 and of sociological databases between 1974 and 1995. From over 1000 citations identified by these search methods, she finds only nine published papers which meet her inclusion criteria of: being written in English; being based in general practice, family practice or primary medical care; using more than one research subject; and containing an empirical study which included in its aims the description or evaluation of ethical issues. Rogers excludes studies on single issues and on students' understanding of ethical issues.[2] There are a number of similarities and differences between Rogers' paper and the analysis presented in this chapter. Rogers' paper is a thorough review of the aims, methods and findings of empirical studies in the survey tradition, and it includes a brief discussion of the

[2] Rogers W. 1997 A systematic review of empirical research into ethics in general practice. *British*

relationship between theory and empirical work. My discussion of similar papers (and, in some cases, the same papers) is briefer, and focuses more on how theory and practice relate. Rogers' review is restricted to surveys on general practice ethics; I have broadened the scope of empirical work to include case reports and sociological studies. Notwithstanding these differences, the two analyses concur on many issues.

Both the studies identified in Rogers' review and those discussed below typically use a structured interview or mailed questionnaire to assess general practitioners' response to ethical issues. For example, Lako *et al* presented 272 general practitioners with 10 cases involving confidentiality and asked them how they would respond to requests for disclosure of information.[3] It is unclear whether questions were open-ended or closed. Mabeck mailed questionnaires to 1679 general practitioners in Denmark and France in 1980 and 1984 and to 848 lay people in Denmark in 1980; response rates ranged from 49 to 82%.[4] A number of "typical situations" involving confidentiality in general practice were presented and respondents were asked, using closed questions, under what circumstances and to whom it was right for general practitioners to divulge information. Christie *et al* mailed questionnaires to general practitioners in three countries and asked how they would handle the ethical problems posed in six sample cases from general practice and what reasons were relevant to their decisions.[5] 1301 Canadian, 1187 British and 1272 United States general practitioners received questionnaires. Dunn and Shaw also used a postal questionnaire of 500 general practitioners to assess their attitudes to several ethical issues: abortion, euthanasia, criteria for brain death, contraception and artificial insemination.[6]

Journal of General Practice 47: 733-7.

[3] Lako CJ *et al.* 1990 Handling of confidentiality in general practice: A survey among general practitioners in the Netherlands. *Family Practice* 7: 34-38.

[4] Mabeck CE. 1985 Confidentiality in general practice. *Family Practice* 2: 199-204.

[5] Christie RJ, Hoffmaster CB & Stewart MA. 1987 Ethical decision making by Canadian family physicians. *Canadian Medical Association Journal* 137: 891-897; Christie RJ, Freer C, Hoffmaster CB & Stewart MA. 1989 Ethical decision making by British general practitioners. *Journal of the Royal College of British General Practitioners* 39: 448-451; Hoffmaster CB, Stewart MA & Christie RJ. 1991 Ethical decision making by family doctors in Canada, Britain and the United States. *Social Science and Medicine* 33: 647-653; Hoffmaster CB, Stewart MA & Christie RJ. 1992 A survey method for investigating ethical decision making in family practice. *Family Medicine* 24: 433-8.

[6] Dunn JWM & Shaw RW. 1983 Medical ethics: A survey of general practitioners' attitudes. *Journal of the Royal College of General Practitioners* 33: 763-767.

As a group, studies of this nature provide a sketch of what large numbers of general practitioners say they would do when confronted with specified ethical problems. Not surprisingly, there is a wide range of views expressed. For example, Dunn and Shaw report a clear acceptance by general practitioners of artificial insemination by husband, some contraceptive practices, withholding of life support for a severely disabled infant, and criteria for brain death, yet there are a wide variety of opinions on abortion and euthanasia.[7] Christie *et al* similarly report a wide range of views on the ethical problems concerned with "how much information to divulge to patients, how extensively a physician should be involved in the lifestyles of patients and how to deal with a possible family problem".[8] Lako *et al* find no unanimity amongst their sample of general practitioners with regard to maintaining confidentiality.[9]

The studies offer little explanation as to why such a range of views is expressed beyond brief discussions of the relationships between ethical decision making and demographic variables. Lako *et al* find that general practitioners who are younger, female or practising in group practices and those who involved patients in decision-making are less likely to disclose information to third parties.[10] The Christie and Hoffmaster studies suggest that age, sex, certification in family medicine and church attendance are related in a variety of ways to the ethical choices general practitioners make and the reasons for those choices. The only consistent pattern, however, is between ethical decision making and certification in family medicine. Physicians who were certified were more likely to choose "patient-control courses of action" for four of the six cases and this appears to be associated with tolerance and sensitivity to patient involvement in care.[11]

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[7] Dunn & Shaw, Medical ethics...
[8] Christie *et al*, Ethical decision making by Canadian family physicians...; Christie *et al*, Ethical decision making by British general practitioners...; Hoffmaster *et al*, Ethical decision making by family doctors... ; and Hoffmaster *et al*, A survey method...
[9] Lako *et al*, Handling of confidentiality in general practice...
[10] Lako *et al*, Handling of confidentiality in general practice...
[11] See, for example, Christie *et al*, Ethical decision making by Canadian family physicians..., 894-6.

The surveys are also silent on the question of why general practitioners choose as they do when faced with ethical dilemmas. When linked to the diversity of views expressed, this raises questions on a number of fronts. First, how do we make sense of apparently inconsistent findings? Dunn and Shaw's study, for instance, does not explore why most general practitioners in their study supported withholding life support from a severely disabled infant, but opposed euthanasia. Second, what do the wide range of views expressed in these studies reflect? Do they indicate a similarly wide range of ethical approaches, idiosyncratic understandings of issues, or an apparently poor fit between the solution chosen and the processes of moral reasoning used to reach it? Christie and Hoffmaster's papers are the only ones that begin to address the relationship between general practitioners' attitudes and their ethical approaches. Their work shows that the general practitioners in their sample appear to make case by case decisions and take little account of the relationships between cases. In particular, general practitioners do not consistently choose either patient-control or doctor-control options when explaining their decisions. According to Christie and Hoffmaster, in many cases their respondents' views on one problem are irreconcilable with their views on other problems. Christie and Hoffmaster suggest that large-scale surveys, such as theirs, are probably not able to interpret the relationship between attitudes and ethical decisions. They advocate "qualitative studies involving long interviews with physicians from a variety of communities". They think such studies are better able to get doctors to reflect on the processes of ethical decision making in ways which:

> illuminate how the particular details of moral problems and contextual factors, such as the environments in which they practice, influence how these problems are perceived, structured and resolved.[12]

Christie and Hoffmaster's comments imply for their own work what is obvious in other studies: work of this kind is generally undertheorised. In other words, while quantitative surveys describe neatly what general practitioners think, they rarely explore why they think it. One of the reasons why the surveys are silent on 'why' questions is because they presume agreement about what ethical dilemmas in general practice are.

[12] Hoffmaster *et al*, A survey method..., 438.

This is a typical characteristic of normal science activity: the paradigm defines what counts as a problem, allowing the normal scientist to get on with his or her work.

Two paradigms are apparent in these surveys of ethics in general practice. First, there is a 'mainstream bioethics paradigm'. Dunn and Shaw, for example, offer the general practitioners in their survey a list of moral dilemmas - abortion, euthanasia, criteria for brain death, contraception and artificial insemination – that looks very like the dilemmas routinely described and analysed in mainstream bioethics texts. They appear to take for granted that the moral problems they choose to present to general practitioners are indeed those which count most in general practice. Lako, in similar fashion, seems to presume that dilemmas concerning confidentiality (also central to mainstream bioethics) just exist out there in general practice, awaiting discovery. This presumption about ethical dilemmas in general practice relates both to what dilemmas make it onto the bioethical agenda (the identification of dilemmas) and to how these dilemmas are specified (what counts as an adequate description of an ethical dilemma).[13] On both counts, mainstream bioethics seems to provide the ethical glasses these authors don to view general practice.

Even Christie and Hoffmaster (whose considerably more sophisticated approach to the identification of dilemmas in general practice is discussed below) seem to presume that mainstream bioethics can provide the paradigm which defines ethical problems in general practice. They also assume that mainstream bioethics, specifically in its principlist form, can provide guidance for empirical work in ethics. Their vignettes reflect, in part, what they describe, quoting Siegler, as the dominant concern in bioethics over twenty years: "the proper relationship between paternalism and autonomy in medical practice and clinical investigation".[14] They note that their cases

[13] This is no different to the presumption that the casuist makes when identifying and defining a case for analysis. The point applies equally to another form of empirical research in ethics, the case study, and I shall take up the issues that arise from it again when that form is considered below. See Arras JD. 1991 Getting down to cases: The revival of casuistry in bioethics. *Journal of Medicine and Philosophy* 16:29-51 for a development of this criticism. See also Chapter Two for further discussion of this issue.
[14] Siegler M. 1985 Book Review of Childress J. Who Should Decide? Paternalism in Health Care. *Perspectives in Biology & Medicine* 28:452, quoted in Hoffmaster *et al*, A survey method..., 434.

were written, in part:

> to reflect the tension between the two values – respect for patient autonomy and concern for patient welfare – that engender the problem of medical paternalism.[15]

One might speculate that there is more than a casual link between the principlist orientation of some of these surveys and the positivist assumptions that guide much quantitative research. Quantitative research, of which these surveys are examples, usually assumes a positivist paradigm in which hypotheses are tested and the findings deemed to reflect universal truths.[16] Principlism, particularly in its deductivist form, also has a tendency to assume that abstract moral principles are 'out there', waiting to be taken down off the shelf and applied to whatever ethical dilemmas arise.

A second paradigm - the 'general practice paradigm' - also shapes the form of these surveys of general practice ethics and that of related theoretical work. The 'general practice paradigm' in its Australia context is discussed in detail in Chapter Five in terms of two models of general practice – an altruistic professional model and a business model. At this point I want only to flag that assumptions about what general practice is and does shape the way ethical problems are defined and presented.

In several papers reporting quantitative surveys the dilemmas presented to respondents appear to develop out of discussion with or through educational programs for general practitioners. Christie and Hoffmaster, for example, began the construction of their questionnaire with cases collected from family physicians, including doctors enrolled in the authors' seminars on ethical issues in family medicine. Open-ended questionnaires, using the cases, were sent to family physicians who provided detailed information on the issues the cases raised, the information they would need to make a decision, the preferable course of action, and the factors they would take into account when deciding what to do. These responses provided the basis for close-ended

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[15] Hoffmaster *et al*, A survey method..., 434.
[16] See Rogers, A systematic review... for a similar point and Guba EG & Lincoln YS. 1994 Competing paradigms in qualitative research. in Denzin NK & Lincoln YS. (eds.) *Handbook of Qualitative Research.* Sage Publications, 105-177. The question of research strategy in this thesis is taken up in detail in Chapter Four.

questions concerning six cases. The authors also used an "international panel of ethicists and family physicians" to rank the response choices offered in the questionnaire and to rate the reasons for courses of action. Finally, Christie and Hoffmaster piloted their survey with 55 part-time faculty members in the Department of Family Medicine at the University of Western Ontario.[17]

Hoffmaster and Christie's ethical dilemmas were grounded in their experience of working with family physicians in Canada, suggesting that they, at least, are sensitive to the fact that the ethical problems bioethicists identify are not necessarily the ones general practitioners encounter. Even so, basing one's vignettes on the experiences of general practitioners carries its own assumptions about the nature and specification of the ethical dilemmas. For example, Christie and Hoffmaster used their survey instrument not only in Canada, but also in the United States and the United Kingdom, evidently without repeating in those countries the exercise through which they had generated the questionnaire. They seem to presume that the ethical problems generated by family physicians working in Canada would be the same as those of family physicians working in Britain or the United States. However, general practitioners in each of these countries work in quite different social, organisational and financial circumstances and, accordingly, are subject to quite different pressures. It is, at least, possible that such different circumstances might give rise to different moral problems for the general practitioners concerned.

The 'general practice' paradigm has also shaped Christie and Hoffmaster's theoretical account of ethics in general practice, published in book form as *Ethical Issues in Family Medicine*.[18] That account begins with a definition of family practice and extracts from it a typology of the good family physician. This typology and the definition of family practice in which it is grounded are tested against a series of cases. *Ethical Issues in Family Medicine* is thus, according to Christie and Hoffmaster's own

[17] Hoffmaster *et al*, A survey method..., 434-6.
[18] Christie RJ & Hoffmaster CB. 1986 *Ethical Issues in Family Medicine*. Oxford University Press.

definition, an example of casuistry in practice. They advocate that we:

> ...examine moral conflicts as they arise in concrete cases, unconstrained by either the ideology of benign medical paternalism or the ideology of liberal individualism...Our method is inductive rather than deductive. We prefer a 'bottom-up' approach - one that begins with the scrutiny of cases and works up to principles – because we believe it is more fruitful. It is difficult to resolve conflicts between values and other considerations when they are presented abstractly. Ethical disputes are better understood in the context of cases and their alternative resolutions. Examining possible solutions to cases is, in fact, a way of testing moral positions.[19]

Notwithstanding this description of their work, the order of chapters in *Ethical Issues in Family Medicine* undercuts Christie and Hoffmaster's belief that they take a "'bottom-up' approach". An examination of that order suggests that Christie and Hoffmaster's interpretation of the definition of family practice drives the moral theory they develop, rather than cases driving the development of theory and the understanding of the definition of family practice. *Ethical Issues in Family Medicine* begins with a discussion of the definition of family medicine and the patient-physician relationship, and moves from there to consideration of patient welfare and autonomy and an analysis of the notion of the family as patient. The first part of the book concludes by bringing together the critique of principles-based ethics and the discussion of the definition of family practice to forge an "ethics of family medicine".[20] In the second part Christie and Hoffmaster address a number of issues of concern to family practitioners, in "an attempt to illustrate, clarify, and test our ethics of family medicine".[21] Elsewhere, Hoffmaster *et al* have suggested that the strategy presented in *Ethical Issues in Family Medicine* was to:

> formulate a definition of family practice, extract the notion of a good physician implicit in that definition, and then test this notion (along with the definition of family practice that generates it) using cases.[22]

Regardless of whether a definition of family practice or particular cases has priority, Christie and Hoffmaster's methodology and the theory they develop is consistent for the most part, with their approach to empirical studies in general practice ethics. In both theoretical and empirical work, they are concerned to reflect the

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[19] Christie & Hoffmaster, *Ethical Issues in Family Medicine...*, xii, xvi.
[20] Christie & Hoffmaster, *Ethical Issues in Family Medicine...*, chapter six.
[21] Christie & Hoffmaster, *Ethical Issues in Family Medicine...*, xiv.
[22] See, for example, Hoffmaster *et al*, A survey method..., 434.

experience of general practitioners.

Granted these criticisms about the paradigmatic bases of the quantitative surveys discussed above, there is still much of value in these studies. They provide a population perspective on ethics in general practice that can not be had by theorising alone. Howard Brody, in a commentary on an early study by Christie *et al*, argues that such empirical surveys can serve as a "valuable corrective to the pronouncements of ethics experts whose views are largely restricted to the classroom and teaching hospital".[23] Baruch Brody makes essentially the same point in his comments on the role of empirical research in bioethics, but also states the obverse: empirical research is valuable because it lays actual practice open to ethical scrutiny.[24] Both Brodys imply that the cross-fertilisation between theoretical and empirical research that they favour is not yet well established.

Christie and Hoffmaster's work apart, the isolation of theory from empirical work seems particularly apparent in most of the surveys discussed above. There is little, if any, analysis which attempts to relate theoretical approaches to practice and vice versa. For example, in Mabeck's study of general practitioners' views on confidentiality, the justification for confidentiality, and some factors which influence the general practitioner's decision whether to disclose information, are presented in the introduction, but these points do not appear to influence strongly the design of the survey.[25] Christie and Hoffmaster do recognise the limits imposed by large-scale quantitative studies, and note that their results "suggest several factors that influence the moral decision making of doctors, but not how and why these factors operate or what other factors might be relevant".[26]

One implication of the lack of cross-fertilisation between theory and practice in

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[23] Brody H. 1983 Empirical studies of ethics in family medicine. *Journal of Family Practice* 16:1061.
[24] Brody B. 1990 Quality of scholarship in bioethics. *Journal of Medicine and Philosophy* 15:162.
[25] Mabeck, Confidentiality in general practice…
[26] Hoffmaster *et al*, Ethical decision making by family doctors…, 653.

these empirical studies in general practice is that the study of general practitioners' own theories of ethics or processes of reasoning about ethical problems has been neglected as an area where theory and practice might meet. With the exception of Lako and Christie and Hoffmaster, the surveys give little indication of what influences the decisions general practitioners make and why they decide as they do. Even Christie and Hoffmaster's surveys provide scant information about how and why general practitioners make ethical decisions. The methodology required for these large surveys just can not be used for detailed studies of complex matters like how and why general practitioners choose as they do. Knowing more about the 'how' and 'why' of ethical problem solving in general practice might help us to understand better what drives their practical decision-making and then to understand the practice itself better. It should also strengthen the critique that practice and theory offer each other and allow new possibilities for the task of assessing the fit between theory and practice (something advocated by both Brodys).

3.3 CASE REPORTS

The 'case report' or 'case study' is the second type of empirical research on ethics in general practice. It is, as Baruch Brody suggests, a special type of empirical research.[27] In many examples of case studies from general practice, the general practice setting plays no significant role, but my focus here is on those cases in the general practice setting and/or the involvement of a general practitioner is singled out for attention. In this group, there are both 'thickly' and 'thinly' described cases.[28] 'Thick' cases provide rich and full descriptions of the detail of cases, but do so at the risk of invading the privacy of individuals who constitute the case. 'Thin' cases, in their concern to protect privacy, offer little detail and lose the charm of realism.[29] Both types help to fill out the content of ethics in general practice, and each has its shortcomings. The focus here is on how they contribute to our empirical knowledge of ethics in

[27] Brody, Quality of scholarship..., 162.
[28] See Davis DS. 1991 Rich cases. The ethics of thick description. *Hastings Center Report* 21:12-17 for a discussion of 'thick' and 'thin' in bioethics scholarship.
[29] Brody, Quality of scholarship..., 164.

general practice.

Thin case reports provide brief descriptions of ethical problems. The following are a sampling drawn from two important texts on ethics in general practice by Christie and Hoffmaster and Smith and Churchill. Christie and Hoffmaster's *Ethical Issues in Family Medicine* makes considerable use of short case studies; two are reproduced here.

> Case 3-1
> One of the reasons Dr. T decided to put his office records on computer eighteen months ago was his worry that he might miss problems that needed recurrent supervision. He established a program that provides him with monthly information about patients who need recall or follow-up.
> On reviewing the list of patients for the month of May, Dr. T discovers that Mrs. H is due for a repeat of her Pap smear. The Pap smear done one year ago was reported as showing metaplasia, and a repeat smear in twelve months was recommended by the cytopathologist. On checking with his receptionist, Dr. T notes with concern that Mrs H. has not made arrangements for a repeat of her Pap smear, even though the follow-up appointment is now a month overdue.
>
> Case 8-1
> Mr. N is an eighteen-year-old who suffers from bronchial asthma. He has been in hospital four times in the last six months for his asthma. It is difficult to control despite the use of potent medications including cortisone. Dr. G, his family physician, is concerned about the long-term effect of these medications.
> Despite the best of efforts of Dr. G, Mr. N continues to smoke two to three packets of cigarettes per day because "all my friends do and I don't want to be different". There is no question in Dr. G's mind that the asthma is being significantly worsened by the smoking.[30]

Smith and Churchill make similar use of case reports in *Professional Ethics and Primary Care Medicine.*

> Mr. and Mrs. C were patients in Dr. K's family practice. In the course of annual physical examination, customary blood serology revealed that Mrs C. was positive for gonorrhea. Mr. C's serology was negative. Dr. K was troubled about how to manage this situation: Mrs. C had not intended to reveal an extramarital affair to Dr. K, and would not have done so voluntarily and verbally; Mr C. was also Dr. K's patient and should be protected from the infection. Dr. K believed that he could not, however, violate the confidential relationship between himself and Mrs. C by informing Mr. C. Dr. K considered several alternatives, among which were drugs resistant to the gonococcus bacterium for Mr. C and fabricating reasons why Mr. and Mrs. C should abstain from sexual intercourse during the infectious period.[31]

An important role for cases like these is to provide fodder for a theoretical point, or to ground a conclusion. They are not so valuable as windows onto how ethics is done in general practice, because the information they provide is scant, and too much is left to the imagination. Thick cases describe far better what the practice of ethics in general practice is really like. Higgs, a general practitioner in London at the time,

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[30] Christie & Hoffmaster, *Ethical Issues in Family Medicine...*, 32-33, 121.
[31] Smith HI & Churchill LR. 1986 Professional Ethics and Primary Care Medicine: Beyond Dilemmas and Decorum. Duke University Press, 72-3.

prepared the following thick case, for the Journal of Medical Ethics.[32] The case revolves around Mrs Jasper, admitted to hospital by her general practitioner after an apparent heart attack. After a long silence from the Jaspers, the general practitioner was visited by Mr Jasper, who reported that Mrs Jasper was about to have an operation to investigate a shadow on her lung. Three weeks later, Mr Jasper returned with the news that his wife had cancer and "'it was only a matter of time'". The surgeon, on Mr Jasper's request, had told Mrs Jasper that he had found a fungal infection and removed it. Mrs Jasper made a good recovery from her operation and returned home. Despite repeated requests from the general practitioner, Mr Jasper and his daughter remained adamant that Mrs Jasper should not be told the cause of her illness or her prognosis. This situation continued for six months, during which time Mrs Jasper became more fretful and depressed, and did not recover her strength. Yet, she still maintained that she expected things to improve. Mr Jasper drank and smoked more than usual. One day, Mrs Jasper asked her general practitioner outright: "'What is wrong with me? Have I got cancer?'" Tears and hugs greeted the doctor's affirmation. The atmosphere in the home was relaxed afer that. All three spoke openly about the horror and pain of the last six months, although Mrs Jasper did not ask about the future. The next day Mrs Jasper gathered her friends and relatives around her, and they spent a pleasant evening together. The following day, she died peacefully. Her doctor was with her at the time.

The commentary by Higgs on this case is based around two questions: Why did Mrs Jasper die in this way? What are the rights and wrongs of the information she was given at first by the surgeon? Higgs focuses on the way in which Mrs Jasper's dying was obstructed, and the way in which that obstruction harmed her. He argues that:

> "[i]f these manoeuvres of deception or evasion create false plans, obstruct dying, and by contamination reduce the power of medicine for other patients through their mistrust of doctors to reassure and may well, it appears that the apparent balance of benefit and harm that most doctors have in mind when confronted with terminal illness must be altered".[33]

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[32] Higgs R. 1982 Truth at the last - a case of obstructed death? *Journal of Medical Ethics* 8:48-50. The account which follows is a summary.

[33] Higgs, Truth at the last..., 50. Eight years later, Dunbar offered another view of the same case. (Dunbar S. 1990 An obstructed death and medical ethics. *Journal of Medical Ethics* 16:83-87.) His analysis was very different, focusing far more on the application of the principles of veracity and respect

What do such case reports contribute to our empirical knowledge of ethics in general practice? Baruch Brody suggests that they point us to the way in which a wide variety of different questions interact in the one arena. They bring to our attention problems and perspectives that might be neglected otherwise.[34] Case studies present a snapshot of reasoning about an ethical problem, which privileges some data, discards other data as peripheral, identifies certain theoretical perspectives as relevant and shows how they relate to the problem, and displays ways to put these diverse elements together. Selection of material for the case description and analysis is at once instructive and troublesome. It is instructive because it can describe eloquently how ethics gets done in general practice. Yet, case studies, like empirical surveys of ethics in general practice, presume agreement about what 'ethical dilemmas in general practice' are. The general practice case study literature rarely asks questions about how cases are selected: about "what gets placed on the moral agenda, and why?", in Arras' words, and "what description of a case shall count as an adequate and sufficiently complex account of the issues, the participants and the context?"[35]

Arras' qualified response to his question about what makes it on to the bioethical agenda (which also goes some way toward answering the question about complexity) is helpful to understand how general practice cases are selected for ethical analysis. Arras suggests that problems make it onto the bioethical agenda because health practitioners and policy makers put them there. He notes, though, that the selection of problems is more complicated than this, reflecting also the social context in which the problems arise. The impact of that context is particularly apparent for the selection of general practice cases, as they reflect both a 'general practice paradigm' and a 'bioethics paradigm'.

General practice case studies have built into their description of cases an altruistic professional model of general practice and the general practitioner, revealed in terms of

for autonomy to the case, yet also paying attention to the distance between theory and practice.
[34] Brody, Quality of scholarship..., 164.
[35] Arras, Getting down to cases..., 38-9.

a number of features.[36] The case reports focus on the general practitioner's relationships with the patient and his or her family. Dr. K, in the example from Smith and Churchill, is concerned both for his relationship with his patients and for their relationship with each other. Higgs' case emphasises two other characteristics of general practice case studies: the role that family members have in decision-making and the way in which ethical problems develop and change over time. General practice case reports may also stress the general practitioner's role in health promotion, for example, as Case 8.1 from *Ethical Issues in Family Medicine* suggests.

General practitioner authors themselves recognise that a professional model of general practice underpins their case reports. Christie and Hoffmaster take as one of their goals in *Ethical Issues in Family Medicine* "to assess, on moral grounds, the definition of family medicine"[37] and they begin this task with a critique of the definition of family medicine. Similarly, Smith and Churchill begin their text on general practice ethics with definitions of ethics, moral problems and primary care. They use their definition of primary care to formulate a model of professional ethics and of the relationship between doctor and patient that is not grounded in physician authority. Primary care, for them, is:

> ...a type of health care which encompasses first-contact care and assumes ongoing responsibility for the patient in both health maintenance and therapy of illness; it is personal care involving a unique interaction and communication and includes the overall co-ordination of care of the patient's health problems with the appropriate use of consultants and community resources.[38]

In both Smith and Churchill's and Christie and Hoffmaster's work their definitions of general practice underpin and support case reports.

Paradoxically, in addition to drawing on the profession's self-definition to define what counts as a case, some general practice case studies also select for moral analysis problems which have been central to mainstream, hospital-oriented bioethics. For example, end-of-life issues (as in Higgs' case) are presented as general practice case

[36] The contrast between this model of general practice and a business model is discussed in Chapter Five.
[37] Christie & Hoffmaster, *Ethical Issues in Family Medicine...*, xii.
[38] Smith & Churchill, *Professional Ethics and Primary Care Medicine...*, 18.

studies, even though many people face death in hospitals, away from their home and their general practitioner.[39] What Arras notes of health professionals generally seems also to hold for some general practice case reports: they are "bound to conventional ways of thinking", which may define ethical problems unquestioningly with the language and concepts of mainstream bioethics.[40]

Case studies tend also to be preoccupied with the particularities of the situation - the personalities and characteristics of individuals, the family situation, the details of medical and social histories - at the expense of broader background considerations.[41] In the case of general practice, institutional structures and the historical, social and cultural factors that have contributed much to the way in which this doctor and this patient interact are rarely mentioned. Yet, these factors are important to a complete understanding of the moral problem.[42]

Returning to the question 'what is it that case studies contribute to our knowledge of ethics in general practice?', these studies indicate that ethical problems in general practice are, at least sometimes, different from those in other health care settings. They point us to at least four differences. First, long-standing relationships are much more common in general practice, and these relationships can be important to the resolution of moral problems. Second, families may participate in events in their own right, both as patients themselves, and as concerned relatives with whom the general practitioner deals on a regular basis. In hospital settings, families are more likely to be classified only as surrogates of the patient. Third, in general practice, there may be time to 'wait and see' how things develop, whereas hospital medicine rarely allows this luxury. Finally, general practitioners often incorporate into their work strategies to prevent ill health in patients, not just the cure of illness or amelioration of suffering. All of these differences suggest that there is a congruence here between the definition of general

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[39] This is probably more common in the US than in the UK.
[40] Arras, Getting down to cases...
[41] Hoffmaster B. 1992 Can ethnography save the life of medical ethics? *Social Science and Medicine* 35:1421-1431, fn39.
[42] The ways in which these factors shape general practice and the interaction between doctor and patient

practice and the way in which ethical problems are labelled and described, which is hardly surprising if the dominant paradigm is one which shapes both the way in which general practice is defined and the ethical problems it is able to address.

Recognising this congruence helps us to understand the practice of ethics in general practice better, but the congruence also constrains our understanding. We are forced to accept a pre-packaged representation of general practice ethics. Is there a way to view ethical problems in general practice other than through glasses that take for granted the definition of a problem as 'ethical'? On one level, the answer is clearly no for, as Kuhn notes, it is impossible to conceive of scientific activity that operates outside of a paradigm. In the same way, it is impossible to regard a problem as ethical without some notion of what 'ethical' means. On another level, though, a different set of glasses may enable us to view ethics in general practice in a different way. One solution therefore may be to turn to scholarship which is not explicitly concerned with ethics or ethical dilemmas, but which still pertains to general practice. Much empirical work that could be thought relevant to ethics in general practice is contained in research that is not explicitly labelled 'empirical studies of ethics in general practice' or 'case reports'. A rich source of data on the description and analysis of issues in general practice that have ethical implications is contained within studies which can loosely be described as 'sociological accounts of general practice'.

3.4 SOCIOLOGICAL ACCOUNTS OF GENERAL PRACTICE

A large number of empirical sociological studies of general practice have been conducted. The term 'sociological' is used here in the sense that it is introduced in Chapter One, to mean the study of the relationship between individuals and society in a manner that explores the ways in which social structures influence decisions, actions and ways of living. This sociological paradigm, as discussed in Chapter Two, stands in contrast to the individualist orientation of bioethics. Although the studies reported in this section all share, at the most general level, a sociological world view, they use a

in Australia is discussed in detail in Chapter Five.

diversity of approaches and focus on a wide range of topics. The overview below is not a comprehensive survey. The emphasis is on a few book-length and shorter studies that are indicative of the broad range of approaches in this field.[43]

The starting point for these ethnographic studies is Cartwright's large 1967 survey in Britain, by mailed questionnaire and interview, of general practitioners and their patients, undertaken at a time when the future of general practice in Britain was widely regarded to be under threat.[44] By 1977, when a follow-up survey was undertaken, the future of general practice seemed assured, and the focus generally had shifted to what sort of future could be envisaged.[45] In both studies, Cartwright aimed to describe the care given by general practitioners and the attitudes of patients and doctors to this care. The studies focused on the setting for the delivery of care in general practice, the nature and frequency of doctor-patient interactions, relationships between general practitioners and other health professionals and between general practitioners and hospitals, and the demography of patients in the survey. Most of Cartwright's 1967 findings still held in 1977: most people had a general practitioner they had known for a number of years, who was accessible, who cared for other members of the family and most people appreciated this care.[46] Any changes had been few and small, apart from three that Cartwright thought significant. Cartwright described "deteriorations" in two areas: general practitioners appeared less willing to give support to patients with family problems and to accept this as part of their job, and there were declines in home visits and consequent patient dissatisfaction. Third, Cartwright suggested that "improvements" had occurred in patients' willingness to criticise and question the authority of their doctors. [47]

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[43] The studies reported below are predominantly British. This selection is justified, given the extent to which Australian general practitioners during the 1970s and 80s saw British general practice as a valid model (or as having values consonant with) their own work.
[44] Cartwright A. 1967 *Patients and Their Doctors. A Study of General Practice.* London: Routledge & Kegan Paul.
[45] Cartwright A & Anderson R. 1981 *General Practice Revisited. A Second Study of Doctors and Their Patients.* London: Tavistock Publications. See Hart JT. 1988 *A New Kind of Doctor: The General Practitioner's Part in the Health of the Community.* Merlin Press, particularly chapter 4, for a history and critique of the changing role of the general practitioner.
[46] Cartwright & Anderson, *General Practice Revisited...,* 180.
[47] Cartwright & Anderson, *General Practice Revisited...,* 184-7.

McKeganey notes that, at the time of Cartwright's first study, sociologists were not able to directly observe the encounters general practitioners and patients were describing to them.[48] By 1975, when Stimson and Webb's *Going to See the Doctor* was published, a wider range of methods was possible, which Stimson and Webb used in their study.[49] They used interviews with patients and doctors, direct observation of consultations, group discussions and written material to study how general practitioners and patients treat the consultation as a social encounter. Basing their fieldwork around two practices in South Wales and involving five doctors and their patients, Stimson and Webb focused on topics such as the social processes leading to the consultation, the face-to-face interaction between doctor and patient, the factors influencing compliance by patients with doctors' recommendations and the way in which context limits patient control. They argued that both patients and doctors use a range of strategies to exert control over each other and asserted that patients are not merely passive absorbers of information; they are able to employ a wide range of strategies that influence their relationships with doctors.

Jefferys and Sachs' study of general practice accompanied the introduction of Health Centres to the National Health Service in Britain in the early 1970s. Both government and the profession were concerned with the likely impact of the introduction of Health Centres on patients, doctors and other health professionals, and on the organisation and delivery of general practice care. This study was conducted over twelve years in five general practices in London. The research team collected information about patients from doctors' records, from interviewing them and from taped recordings of consultations. They compiled information about doctors through interviews, observations, short questionnaires on specific topics and attendance at staff meetings. From this mass of information, Jefferys and Sachs elected to focus on the

[48] McKeganey N. 1989 On the analysis of medical work: general practitioners, opiate abusing patients and medical sociology. *Sociology of Health and Illness* 11:26.
[49] Stimson G & Webb B. 1975 *Going to See the Doctor: The Consultation Process in General Practice.* Routledge & Kegan Paul.

general practitioners, and to "tell the story with them as the centrepiece".[50] Accordingly, their account of general practice focuses on the relationships between general practitioners and other occupational groups linked to them by work arrangements, and between general practitioners and patients, seen through the eyes of both the doctors and the patients.

Jefferys and Sachs suggest that the activities of the general practitioners in their study were indicative of those of other general practitioners across the country at the time. General practitioners had been successful in securing their position in the health care hierarchy by orchestrating an increase in the status of general practice. Central to the general practitioners' success was the way in which they had set themselves up at the centre of a multi-occupational work setting. In addition, they had fostered closer working relationships with their hospital colleagues, while at the same time emphasising the differences between general practice and hospital medicine. Finally, they had set about gaining the allegiance of their patients, by locating themselves with their patients in a stand against science, technology and bureaucratic relationships.[51]

In addition to these book length studies, there have been many shorter sociological accounts of aspects of general practice. They cover a wide range of topics from a number of methodological and theoretical perspectives. Like the longer studies, they are concerned principally with the doctor-patient relationship and they offer a range of perspectives on that relationship. I mention only a few, selected to give an indication of the breadth of the field. For example, Heath used examples from general practitioner-patient interactions to explore the "co-ordination of verbal and non-verbal

[50] Jefferys M & Sachs H. 1983 *Rethinking General Practice: Dilemmas in Primary Medical Care* Tavistock Publications.

[51] The Balint movement also contributed to this allegiance, by emphasising the individual doctor-patient encounter and the hidden needs behind the problems with which patients presented. See Balint M. 1957 *The Doctor, His Patient and the Illness.* Pitman, and also Hart, *A New Kind of Doctor...*, 87-9 and 97-9 and Toon P. 1994 *What is Good General Practice? A Philosophical Study of the Concept of High Quality Medical Care.* Royal College of General Practitioners, Occasional Paper 65, for a discussion of the contribution and legacy of Balintism. See also Chapter Five for comments on the importance of the Balint movement for Australian general practice.

behaviour by the doctor and patient".[52] He showed that patients time their speaking and use their bodies to secure and hold the attention of the doctor. He argued that "patients are not without resources when dealing with doctors and [they] have systematic ways of encouraging doctors to participate in and attend to the activities in which they are engaged".[53]

Horobin and McIntosh interviewed 50 general practitioners in rural and urban Scotland, focusing on their understanding of and attitudes toward their work.[54] Their paper dealt with the general practitioners' notions of risk, and the way in which it relates to time and routine. Their findings suggested that, for urban general practitioners, the pressures of workload led them to take risks with apparently 'routine' cases by adopting shortcuts in diagnosis and treatment. In rural practices, time was not experienced as a shortage, but there was poor access to expert opinion and technological and therapeutic innovations. Accordingly, general practitioners in rural areas related risk to unsupported work.

Boulton *et al* recorded 405 conversations between 16 general practitioners and their patients, focusing on the impact of social class on the interaction between doctor and patient.[55] The results of their study suggested that middle class patients sought more information and offered more opinions, but they were no more likely than working class patients to receive explanations. Working and middle class patients appeared to use a similar body of lay knowledge and explanatory models to make sense of their illness. These models were generally quasi-scientific in nature but, often, quite different from the general practitioner's thinking during the consultation.

Comaroff interviewed 51 doctors in South Wales concerning their views of their

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[52] Heath C. 1984 Participation in the medical consultation: the co-ordination of verbal and nonverbal behaviour between doctor and patient. *Sociology of Health and Illness* 6:311.
[53] Heath, Participation in the medical consultation..., 313-4.
[54] Horobin G & McIntosh J. 1983 Time, risk and routine in general practice. *Sociology of Health and Illness* 5: 312-331.
[55] Boulton M *et al.* 1986 Social class and the general practice consultation. *Sociology of Health and Illness* 8:324-350.

professional roles and of patient management.[56] In this paper she reported their views on how and why doctors communicate information about non-fatal illness with patients. Comaroff classified doctors' strategies as unelaborated, medium elaborated and highly elaborated, and suggested these strategies reflected that "the degree of complexity with which [the doctors] classified patients and the range of potential courses of action they recognised".[57]

Fisher and Groce's study used two interviews between residents and women in a general practice training program to argue that norms are both features of the clinical encounter and negotiated during interaction.[58] They showed how cultural assumptions about 'good' and 'bad' women were acted out in these interviews and how this influenced the resident's conduct and clinical care.

As noted above, all of these studies are concerned, in a general way, with how social structures and individuals and groups influence each other. Granted this general orientation, the studies do present a particular view of sociological work on general practice. Most obviously, they are all concerned, in one way or another, with the relationship between doctor and patient. McKeganey's summary conclusion for sociological studies of general practice holds for the studies cited here: they share a pre-occupation with the "social processes of power, domination and communication" in the encounter between doctor and patient.[59] There are reports on patient satisfaction, on the many ways in which doctors sustain social control, on the minutiae of communication in the consulting room, on how information is offered and received by both doctors and patients, on the influence of cultural norms and social class on communication and control, and on how patients assert independence. There is broad agreement that general practitioners are still the dominant partners in the doctor-patient relationship,

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[56] Comaroff J. 1976 Communicating information about non-fatal illness: the strategies of a group of general practitioners. *Sociological Quarterly* 4:269-290.
[57] Comaroff, Communicating information...,. 286.
[58] Fisher S & Groce SB. 1985 Doctor-patient negotiation of cultural assumptions. *Sociology of Health and Illness* 7:342-274.
[59] McKeganey, On the analysis of medical work...

but the extent of this domination is contested. That patients do act independently and use a range of strategies to manipulate or ignore their doctors is a theme common to a number of papers.[60]

The sociological studies offer three different perspectives on the relationships between doctors and patients in general practice. The first perspective focuses on the general practitioners' own understanding of their work and their relationships. For example, Jefferys and Sachs' decision to place general practitioners at the centre of their account inevitably meant that general practitioners' voices were heard most loudly. Comaroff, similarly, used general practitioners' own understandings of how and why they communicated information to patients to develop her explanatory model. Other studies view general practice primarily through the eyes of patients. Stimson and Webb, for example, used essays written by school children about 'going to see the doctor', interviews with patients and observations and recordings of 50 consultations to report patients' perceptions of the consultation, the doctor and their relationship with the doctor. Finally, there is the perspective that resolutely stands outside the encounter between doctor and patient to analyse it. For instance, Fisher and Groce measure the length and type of conversation in two encounters between doctor and patient.

Of course, to some extent, all of these studies present a mixture of perspectives. Jefferys and Sachs, while unashamedly focusing on the views and understandings of general practitioners, also appended to some chapters a "research team" view, which took issue with general practitioners' interpretations, presented findings from other sources, and placed the general practice view in a wider context. Stimson and Webb documented and analysed the lack of fit between the general practitioners' ideas about how their work was changing, patients' views, and their own audit of consultations.

Although these studies offer a range of perspectives on general practice, the general practitioners' viewpoint remains dominant, particularly in British studies. The

[60] See, for example, Stimson & Webb, *Going to See the Doctor...*

bias in these studies toward general practice's view of itself has ensured that we have a richly detailed and perceptive view of the profession. It has also meant, though, that, relative to other sociological accounts of medicine, little attention has been paid to the external and structural constraints on the practice of general practice.[61] This is a recurring problem for "micro" perspectives in sociology; their concern with the detail of interaction often leads them to ignore the structures that allow or inhibit that interaction.[62]

The particular concern in this thesis is what these sociological studies of general practice have to say about ethics in general practice. On initial observation, they offer not much at all. There are no papers on "An ethnography of general practitioners' ethical experiences" or chapters titled "Moral problems in general practice". These studies just do not take the description and analysis of ethical problems as their explicit topic. Nonetheless, they are concerned with topics which are problems for bioethics, and which are alluded in case studies and empirical surveys of ethics in general practice. For example, accounts of 'paternalistic' practices by general practitioners appear again and again in the sociological literature. Fisher and Groce described the "asymmetry" in the interaction between doctor and patient and saw it reflected in the consultations they analysed.[63] Stimson and Webb reported the ways in which doctors create and sustain control of the medical encounter, described the reasons doctors give for controlling patient's access to information and noted that patients were aware of their own lack of power but unable to do much about it.[64] The same topics of paternalism and control arose in Jefferys and Sachs' chapters on doctors and patients.

The examples above provide an excellent illustration of an issue that is central to bioethics - the practice of medical paternalism. However, the language and conceptual

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[61] See, for example, Freidson E. 1970 *Professional Dominance.* Atherton Press and Freidson E. 1975 *Doctoring Together: A Study of Professional Social Control.* Elsevier, for studies of the structural constraints on American medical practice.
[62] See Silverman D. 1985 *Qualitative Methodology and Sociology.* Gower, chapter four on macro and micro relations in sociological research.
[63] Fisher and Groce, Doctor-patient negotiation..., 345
[64] Stimson & Webb, *Going to See the Doctor...*, 62ff, 124ff

approach of bioethics is nowhere to be found. 'Respect for autonomy', 'patient welfare', and 'informed consent' simply never appear by name in these studies. A careful dissecting of the "conceptual and philosophical perplexities embedded" in general practice is not apparent either.[65] Just as Jennings found for the study of neonatal intensive care, so here it is apparent that sociologists and bioethicists do not speak the same language. The bioethics paradigm and the sociological paradigm seem incommensurate.

This does not mean that sociological accounts of general practice have little to offer the study of ethics in general practice. On the contrary, they are valuable for at least four reasons. First, they present a level of methodological sophistication that is not found in other empirical studies of general practice. For example, Cartwright, Stimson and Webb, and Jefferys and Sachs all used methodological triangulation to provide multiple views on the same subject.

Second, the typically detailed and intensive character of qualitative sociological work allows it to create the thick description of general practice which is missing from much other work, and particularly from the surveys reviewed at the beginning of this chapter. These methods seem to be particularly suitable when trying to record the richness and detail of general practitioners' ethical experiences. They are very sensitive to what general practitioners themselves think, how and why they make decisions and what actions then follow. Studies such as these can shed light on the reasons why general practitioners respond as they do to the surveys reported earlier. For example, Comaroff's study provides one explanatory model for why general practitioners regard paternalistic withholding of information as permissible or even required.[66]

Third, the sociological studies reviewed above may not supply a sophisticated or powerful analysis of the role of social structure in general practice, but they do

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[65] Jennings B. 1990 Ethics and ethnography in neonatal intensive care. in Weisz G. (ed.) *Social Science Perspectives on Medical Ethics*. Kluwer Academic Publishers, 262.
[66] Comaroff, Communicating information...

recognise the significance of that role. For example, Boulton *et al* showed that the patients' social class does influence how doctors provide information and how patients use that information.[67] Fisher and Groce similarly showed that doctors share a set of "social facts" about women which is part of their background knowledge and which influences the level of social control they exert over their patients.[68]

Finally, the sociological studies described above do not take for granted that they know what ethical problems in general practice really are. There is no pre-packaged representation of ethics in general practice that defines and constrains our view. Yet, the commentary above has shown that ethical considerations are central to many issues in general practice. The line between 'ethical' and 'other' problems is, at least, indistinct or perhaps even illusory. It may be that all problems in general practice are moral problems at their core or, at least, have a moral dimension.

3.5 CONCLUSION

This chapter has reviewed three forms of empirical research on ethics in general practice. Each offers, as suggested in the introduction, a partial portrait of the practice of ethics in general practice, influenced in significant ways by the paradigm that shapes the research. There appear to be no studies, however, which draw on the breadth of material conveyed in surveys, provide the depth of analysis of a 'rich' case study, and use the methodological approaches of sociological studies. When these three perspectives are brought together, they suggest an approach that enquires of general practitioners themselves: what do you see as the ethical problems in your work? Why are they so? How do you resolve them? The next chapter outlines the approach taken in this thesis to address these questions.

[67] Boulton *et al*, Social class and the general practice consultation...
[68] Fisher & Groce, Doctor-patient negotiation....

4 STUDY DESIGN AND CONDUCT

4.1 INTRODUCTION

In the nature of the matter, this thesis involved 'me' to a degree that is conventionally washed out of the written-up language of research. Therefore, it seems important to give a clear account of my approach to the work. Two threads are woven through this account of the conduct of my research. The first is a temporal thread, which describes what I did, when, where, and how. The sequence of events is ordered by time, from the beginnings of the research process in 1991, to its conclusion in 1998. The decisions I made and the justifications for those decisions do not always fit as neatly into the time sequence as they are portrayed here, although I have tried to provide an account of my decision making process which is true to what I thought at the time. However, to report every change of mind, new beginning, revision, and development in my understanding of what I was doing and thinking about my research would be laborious, for the reader and me. Instead, I have included examples which, I hope, convey enough of the process to give the reader a feel for the way in which I approached and carried out this piece of research.

There are similarities between this account of my research and the interviews I conducted with general practitioners. In both cases, the questions are basically the same: What did they/I do? When? Where? Who was involved? How did things turn out? What alternatives were possible? What reasons did they/I have for that decision? The purpose for telling the story, though, is rather different. The GPs[1] were telling me their stories because I wanted to understand how they thought; in this account, my intention is to provide the detail that another researcher would need if he or she wished to step into my shoes and undertake a similar piece of work.

[1] Hereafter, I use the term 'GPs' to denote only the general practitioners I interviewed. All other references are to 'general practitioners'.

There is another similarity between this account and the interviews I conducted. In both, I am concerned to explore why decisions were taken in certain ways. In my interviews with the GPs, this has led to an analysis focused on bioethical frameworks, general practice ideology, and the financial, organisational and structural factors that influence general practice work. In this account, my concern is with why *my* account of general practice ethics turns out as it does. In a sense, I am turning back on myself more of the questions I asked the GPs: why do they/I approach their/my work in the way they/I do? What factors have influenced the values they/I bring to their/my work? This similarity points to the second thread in this account of my research, concerned with my identity and role in the research process. What perspectives have I brought to this work? How have they influenced the research? This thread weaves across the first, presenting itself at many points in the temporal account of the research process.

In qualitative research this emphasis on the role of the researcher is not unique. Many authors note that the role of researchers in qualitative research is different from their role in quantitative research. In quantitative research, the researcher and researched are assumed to be separate. The researcher observes, measures, discusses and draws conclusions about an objective reality – the researched.[2] The best quantitative research, according to its textbooks, successfully 'controls for' any 'bias' that maybe introduced by the researcher's presence. In qualitative research there is no such divide between researcher and researched. "Objectivity" is replaced by "reflective subjectivity", whereby the researcher is always in the picture, seeing and influencing every aspect of the research process.[3] Qualitative researchers recognise that the decisions researchers make - about methodological strategies, about access and entry to field settings, about 'sampling' procedures, about establishing and maintaining rapport,

[2] Guba EG & Lincoln YS. 1994 Competing paradigms in qualitative research. in Denzin NK & Lincoln YS. (eds.) *Handbook of Qualitative Research.* Sage Publications, 105-177.
[3] Borkan JM. 1993. Conducting qualitative research in the practice setting. in Bass MJ *et al.* (eds.) *Conducting Research in the Practice Setting.* Sage Publications, 70. See also McCracken G. 1988 *The Long Interview.* Sage Publications, 18, on the researcher as "instrument" (18); Miller WL & Crabtree BF. 1992 Primary care research: A multimethod typology and qualitative roadmap. in Crabtree BF & Miller WL. (eds.) *Doing Qualitative Research.* Sage Publications, on semistructured interviews as "guided, concentrated, focused and open-ended communication events that are *co-created* by the investigator and interviewee(s)" (16 – emphasis added).

about what is observed, asked, recorded and coded – all contribute to what becomes the 'data'.[4] How that data is interpreted and reported is similarly a matter of deliberate choice.[5]

There are some excellent descriptions available of the ways in which qualitative researchers make decisions and achieve reflexivity in their fieldwork. For example, Anspach's study of life and death decision making in neonatal intensive care units includes a helpful appendix on her research methods. Treating research decisions as a problem in the sociology of knowledge, she discusses some of the decisions she made in the course of her research, focusing on "how the social organization of the intensive care nurseries [she] studied and [her] place in these organizations influenced the practical decisions [she] made as a participant-observer and shaped the character of the data [she] collected and the [findings] obtained".[6] My approach to my own research decisions follows something of the same path to that taken by Anspach. Like her, I am concerned to provide a narrative account of my research. In addition, like her, I attempt to offer an account of the influences on my research decisions. What follows is, therefore, an "analytical narrative".[7]

There are many good stories that might be told about general practice ethics on the basis of the research I conducted. One of the ways to establish the force of any one story, or, in other words, its validity, is to provide a clear account of the process of the research and the factors that influenced decisions and practice. This chapter is likewise part of the validation of my research.

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[4] Anspach R. 1993 *Deciding Who Lives: Fateful Choice in the Intensive Care Nursery.* University of California Press, 180-1.

[5] The issue of the role of the researcher in the research process is more complicated than I imply here. There are a range of views, linked to a multiplicity of theoretical approaches. See Miller and Crabtree, Primary care research… and Tesch R. 1990 *Qualitative Research: Analysis Types and Software Tools.* Falmer, for introductions to the huge variety of qualitative research approaches. I also found Silverman D. 1985 *Qualitative Methodology and Sociology.* Gower Publishing Company, extremely helpful in navigating my way through the maze of qualitative methods. I have deliberately avoided placing myself in a particular discipline or tradition, notwithstanding the comments I make in the first chapter of this thesis about the boundaries of this thesis. As I suggest there, this is a multi-disciplinary study of ethical decision-making by general practitioners which uses qualitative research methods.

[6] Anspach, *Deciding Who Lives…*, 178.

[7] Anspach, *Deciding Who Lives…*, 183.

4.2 BEGINNING THE RESEARCH

The empirical part of this thesis is based on data collected in semi-structured interviews with 15 general practitioners in South Australia during 1993.[8] I had three main objectives: first, to describe the ethical problems which general practitioners encounter in their work; second, to examine the practical and theoretical frameworks that general practitioners use in the resolution of ethical problems; and third, to explore the role of ethical principles and approaches.

Behind this bald statement of intent and method lie many decisions, influenced by many factors. First, there are issues related to the events that gave me my entrée into the world of general practice. Two years earlier, in 1991, a medical educator with the South Australian branch of the Royal Australian College of General Practitioners (RACGP) telephoned me, asking if I was interested in teaching a seminar in general practice ethics to trainee general practitioners undertaking the College's graduate training program. At that stage, I had already developed an interest both in how lay people made moral decisions and in the ethical issues associated with general practice. That preliminary phone call led, immediately, to my involvement in the RACGP teaching program and, eventually, to a joint application with the educator for a research grant to "evaluate a course in ethics for advanced trainees". The first part of that application concerned the development of an appropriate evaluation tool for ethics education in general practice, using interviews with a small number of experienced general practitioners to generate a set of dilemmas and inform course content. In addition, the interviews were to be structured and conducted in a way that allowed me to explore the research objectives stated above.

We decided that I would undertake these preliminary interviews while we were waiting for the grant to be processed, and we sought and gained approval for this

[8] There are several alternative terms for 'semi-structured' interviews in the literature that would serve as well as the ones I have chosen. Section 4.3.1 discusses what 'semi-structured' means in the context of my research.

through formal RACGP channels. By the time we learnt that the application was unsuccessful, I had completed most of the interviews. Even though the rest of the project did not proceed, the interviews I conducted were already a compromise (albeit a comfortable and intellectually acceptable one) between two purposes. The methodology I used for the interviews reflected both my research interests and the aims of the project grant.

The other reasons for my decision to explore ethical decision making by general practitioners using qualitative interviews were more formal methodological ones. As I suggested in Chapter Three, quantitative surveys and analysis of ethical decision making by general practitioners can give helpful insight into the range and order of magnitude of ethical dilemmas in general practice, but they offer little insight into how and why these decisions are made. Qualitative research approaches are necessary if the richness and detail of ethical decision making is to be explored.

In addition, I chose from the array of qualitative research strategies available the one that best suited my aims. My interest lay primarily in how general practitioners described and deliberated about the moral problems they encountered in their work. To borrow Miller and Crabtree's terms, I wanted to collect "stories and cognitive maps".[9] Talking to general practitioners was the obvious way to tap into their descriptions and deliberations, and this talk needed to be done in a way which allowed the GPs to explore their own interests and concerns. I deal with the ways in which I encouraged this exploration in section 4.3.1 below.

There are clearly some disadvantages to interviews. My research design did not give me access to what general practitioners actually do in the face of moral uncertainty. It is possible to imagine a research strategy that might yield better data about what general practitioners do about moral problems. For example, I could have chosen to undertake participant observation in doctors' surgeries, to select from the huge number

[9] Miller and Crabtree, Primary care research..., 17.

of consultations I observed those which the GPs identified as morally or ethically problematic for them, and to interview the GPs about those consultations. I gave some preliminary thought to this approach, but decided after a review of the problems associated with it that such a strategy simply would not work. First, the strategy assumed that the consultation is the setting for all ethical problems in general practice. There was evidence from the literature that at least some of the ethical problems with which general practitioners deal concern their colleagues rather more than they concern patients.[10] Using the consultation as a base would not have given me any better insight into these problems than would talking to the GPs about them. Second, the strategy would have been immensely time-consuming, and it would have yielded a considerable amount of data that was not relevant to the aims of the research. Third, it is quite likely that the most ethically interesting consultations would also be the ones that patients and doctors might prefer to conduct unobserved. Again, I would have been limited to talking about these problems with the GPs after the event. Finally, there were problems associated with gaining the informed consent of all participants in the research, an extremely difficult undertaking in general practice when patients move rapidly in and out of the clinic.[11]

In addition to these reasons for why other research strategies might not work, there are also several things in favour of using interviews in a general practice setting. First, general practitioners understand and are at ease with the interview as a method for collecting information. Although the semi-structured interview is unlike much of their own interviewing, the basic process of having a guided conversation with another individual is one with which they can identify.[12] Second, many general practitioners (perhaps unlike some of their specialist colleagues) can also appreciate, in a commonsense way, how content and style are related in a semi-structured interview, for

[10] See, for example, Christie RJ & Hoffmaster CB. 1986 *Ethical Issues in Family Medicine.* Oxford University Press, and, for Australian material, *Ethics in the Consulting Room.* 2 videos prepared by the Royal Australian College of General Practitioners.
[11] See also McKeganey N. 1989 On the Analysis of Medical Work: General Practitioners, Opiate Abusing Patients and Medical Sociology. *Sociology of Health and Illness* 11:24-40.
[12] Borkan, Conducting qualitative research in the practice setting..., 74.

they have some understanding of the role of "explanatory talk" – that explores "experiences, puzzlements, insights, and frustrations".[13] Finally, like many other professional people, general practitioners lead busy lives, and research approaches that need large amounts of their time, or that require them to step outside their usual settings, are less likely to be successful.[14] The decision to undertake interviews with general practitioners carries with it a commitment to slot into their lives at times and in places which suit them. If the researcher can be flexible, my experience in this study and others was that most general practitioners do not find a one to two hour interview onerous.

The reasons cited above for choosing semi-structured interviews are all essentially practical ones, influenced by the general practice setting. Choosing a method which will work in practice is, to say the least, sensible. Nonetheless, a critic might still assert that research strategies that provided data on what general practitioners actually did would have been better, the inference being that I should have tried harder to collect such data, perhaps by using participant observation. Such an assertion seems to me to imply that observational data are 'better' than data collected through interviews. In what sense might this be the case? Silverman has some helpful insights on this point. He suggests that the accusation that interviews are in some way inferior to observations rests on a view that interviews are merely the accounts of events that actors provide. He cautions against this view, arguing that, in being "smug about the status of naturally-occurring data", qualitative researchers risk assuming that what they see people doing is closer to the 'truth' than what people tell them about what they do. He reminds us that:

> ...there are no 'pure' data; all data are mediated by our practices of reasoning as well as those of participants. So to assume that 'naturally-occurring' data are unmediated data is, self-evidently, a fiction of the same kind as put about by survey researchers who argue that techniques and controls suffice to produce data that are not an artifact of the research setting.[15]

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[13] Miller and Crabtree, Primary care research..., 17.

[14] Bernard HR. 1988 *Research Methods in Cultural Anthropology.* Sage Publications, 205, notes that semi-structured interviews work well with people who are accustomed to using their time efficiently. This interview style allows researchers to indicate that they know what they want to get from the interview, but that the interviewees' responses are guiding the direction the interview takes.

[15] Silverman D. 1989 Six rules of qualitative research: a post-romantic argument. *Symbolic Interaction* 12:227. See also Silverman, *Qualitative Methodology and Sociology...*, 105-6. He also notes that there is a similar danger when interviews and naturally-occurring data are triangulated to compare findings from different settings. Here the researcher risks assuming that the point at which triangulated data intersect is the 'true' account of the phenomenon being studied.

The most meaningful interpretations of interview data arise when interviewees' stories are related reflexively to the conditions under which those stories are produced. People's accounts of themselves are valuable precisely because they "reflect members' artful methods in appealing to culturally-based knowledge of reality".[16] Interviews, then, do not doom the researcher to a *lesser* analysis and story; rather, they provide the raw material for a *different* analysis and story to that which might be gained by other methods.

Having made the decision to interview, I needed to determine who to interview, where, and when. These are all questions of sampling.[17] When I discussed this issue with a number of academic general practitioners, they suggested that 'the average general practitioner' might not be all that interested in discussing ethics, and that many would have difficulty with the questions I wished to ask. With this in mind, I chose "intensity case sampling", focusing on cases that were likely to be rich in information precisely because they were interested in ethical issues. It was important that the GPs I interviewed were both articulate and sensitive to their own environment. This would allow me to speak with general practitioners from whom I could be confident I would be able to learn a great deal.[18] However, I also realised that I needed to ensure that an interest in ethics did not carry with it unusual or atypical forms of general practice (for example, a practice that revolved almost exclusively around family therapy). My formal criteria, therefore, for involvement in the study were two: the general practitioners were interested in talking about moral problems in general practice; and they were in active, mainstream, general practice.

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[16] Silverman D. 1989 Telling convincing stories: A plea for cautious positivism in case-studies. in Glaser B & Moreno JD. (eds.) *The Qualitative Quantitative Distinction in the Social Sciences.* Kluwer Academic, 67.

[17] Some qualitative researchers object to the term 'sampling', arguing that it is grounded in positivist assumptions about the need to select a sample that is representative of the population from which the sample is drawn. Following Patton MQ. 1990 *Qualitative Evaluation and Research Methods.* (2nd edn) Sage Publications, 169, I take sampling in qualitative research to mean the purposeful selection of information-rich cases. See also Kuzel AJ. 1992 Sampling in qualitative inquiry. in Crabtree BF & Miller WL. (eds.) *Doing Qualitative Research.* Sage Publications, 33.

[18] Patton, *Qualitative Evaluation and Research Methods...*, 169. See also Gilchrist VJ. 1992 Key informant interviews. in Crabtree BF & Miller WL. (eds.) *Doing Qualitative Research.* Sage Publications, 75. Gilchrist suggests that good key informants need to be able to describe their culture

The general practitioners who took part in interviews were volunteers, recruited through the networks of the RACGP.[19] They were invited to express an interest to take part in an "Ethics in General Practice" study through the pages of the (then) Royal Australian College of General Practitioners-Family Medicine Program newsletter, which is mailed to about 1000 general practitioners in South Australia. The small advertisement in the newsletter commented that the wisdom and experience of general practitioners in dealing with ethical problems were rarely tapped. Here was an opportunity for general practitioners to help assess the value of teaching ethics to general practice trainees by agreeing to be interviewed to describe one or two ethical problems in their work, what they did about them and why. The general practitioners were invited to register their interest by returning a reply paid post card.[20]

Eighteen general practitioners returned a post card on which they had ticked either a willingness to take part in the study or an expression of interest. I contacted all general practitioners by telephone. I began each telephone conversation with a description of the research:

> ...The Ethics in General Practice Study aims to do a number of things. Most generally, we want to ensure that, in the long term, ethics is taught in Australian universities and general practice training programs in ways that are relevant to general practice. As a starting point, we want to build up a picture of the ethical problems that Australian general practitioners face, how they regard these problems, and what steps they take to resolve them. We will use the information collected in the interviews to improve teaching materials for advanced workshops for FMP trainees.[21]
> To do this we are asking about 20 GPs who have at least 5 years post-FMP experience, or equivalent to that, to be interviewed about their own experience of ethical or moral problems. If you agree to take part, I will talk with you for about an hour. During that time, I will ask you to describe in detail one or two ethical problems you have encountered in your work as a general practitioner. I will ask you to tell me why these problems were troublesome for you, what you decided to do about them, and how things turned out. I will also ask about why you made the decisions or acted as you did – what kind of things you thought about in working out what to do....

At this point I checked that they were still there, and still interested. After that the direction the conversations took varied. Often the GPs had comments about their own

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well; they may also be able to offer "insightful analysis and interpretation of events", but this is not essential.

[19] See Lofland JH &Lofland LH. 1984 *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis.* (2nd edn) Wadworth Publishing Company, 25, on the usefulness of "connections" when beginning qualitative research.

[20] See Appendix One for the initial invitation and the reply paid card.

[21] When these invitations were mailed and the interviews were conducted, the RACGP's training program for general practitioners was called the Family Medicine Program (FMP).

experiences, and questions about how, when and where I would interview them. In addition to answering the queries, I also covered a number of other issues, in varying order:

- Procedures for taping and transcribing the interview and storage of transcripts;
- Developing teaching materials with the interviews;
- An assurance that their responses would be anonymous, and that only I and the secretary involved in administration of the study would have access to identifying information.

The latter part of these conversations raised a number of ethical issues that I am not sure I dealt with particularly well. Some of the GPs were just not interested in knowing what would happen to the information they provided, how it would be used, and even whether their responses would be anonymous. Despite their indifference, I ploughed on and informed them of the details of the study. I became acutely aware of the parallels with the literature on informed consent and paternalism! Two GPs were not sure they could think of ethical problems, and asked me to clarify what "I wanted". In both cases, I gently refused to give them any guidelines, and repeated my request for ethical or moral problems they had experienced in their work.[22] Both suggested dilemmas at that point, and asked if these would be "all right".

Three of the GPs I spoke to did not continue on to be interviewed. One was a general practice trainee at the time, and she therefore did not meet one of the criteria I had set; the second felt he was too busy to take part, but he had expressed an interest because he was involved in the establishment of Divisions of General Practice and, in that forum, had taken part in discussions about the ethical issues associated with accepting money from pharmaceutical companies; and the third declined to take part when he learnt that it was a research project, rather than an "action-discussion group". The conversation with the last of these GPs was a difficult one; he seemed to want to

[22] See Bernard, *Research Methods in Cultural Anthropology...*, 206 on dealing with respondents who think they have nothing to contribute to a research project, for interview style.

talk mainly about his concerns about the RACGP and the training program. I had the feeling we were talking at cross-purposes.

I fixed a date, time and place to interview each of the GPs who agreed to take part in the study, and mailed them a leaflet which contained the material I had discussed with them over the telephone and a letter confirming the details of their participation.[23]

The most important methodological issue that arises out of this account of the first stages of my study concerns how my decisions about research methods contributed to my findings and conclusions. Clearly, the decisions I made along the way - to use the RACGP as a vehicle for my research; to conduct interviews; to word the invitation to participate in certain ways; to include particular issues in my telephone discussions - all had an impact on which GPs decided to take part, what they talked to me about, how and why. The general practitioners I interviewed all shared the ability to conceive of their work in a way that included the notion of a moral domain. They were probably more sensitive to moral issues and perhaps more adept at moral deliberation than the mythical average general practitioner. These factors suggested that, to some extent, I might be working with 'moral experts'. However, I had no real way of knowing whether this was the case. The GPs I interviewed might not have been more reflective about moral issues, but just more articulate or communicative.

As my research proceeded, evidence both for and against the 'moral experts' label mounted. When I came to interview the GPs, I asked each at the end of the interview why they had decided to get involved in the study. The breadth of responses – from being troubled about an issue, to wanting an opportunity to chat, to having a long standing interest in "doctor-doctor ethics", to no reason in particular - suggested that many things besides an interest in the moral realm or formal bioethics prompted their interest. In addition, I had been an undergraduate medical student in the same year as two of the GPs I interviewed, and I had the sense that those two GPs were motivated as

[23] See Appendix Two for copies of the leaflet and letter.

much by curiosity about me as anything else.[24] On the other side, when I worked on projects with general practitioners in Divisions of General Practice between 1994 and 1997, I was repeatedly struck by how diffident they were about my research.[25] I learnt that, with most general practitioners, talking about ethics in general practice was a surefire way to kill the conversation. The GPs I interviewed clearly did not respond that way.

What is at stake here is the question of the generalisation of research findings. Unlike quantitative research, in which generalisation hinges on the representativeness of the sample, in qualitative research generalisation beyond the scope of the study is a matter of logic.[26] What I was hoping for was the capacity to be able to say, "if it holds here, it will hold elsewhere", or "if it does not hold here, it will not hold elsewhere". I deal with this issue in the concluding chapter of the thesis.

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[24] Two pieces of evidence point in this direction. First, assuming that, by 1993, 25 of the 100 students in my year of medical school had qualified as general practitioners and were receiving the RACGP newsletter (which is likely an overestimation), then I interviewed 8% of the general practitioners in the pool from my own year in medicine. Overall, the 18 GPs who sent a reply constituted 1.8% of all GPs who received the newsletter. The imbalance is striking. Second, and more significantly, one of the two GPs and I talked for about half an hour at the end of his interview about what we had done since our undergraduate years, both professionally and personally. His parting words were "it was nice to see what happened to you". The other GP made a number of references during his interview to events that we both remembered from our undergraduate years.

[25] My 'other life' as a general practice researcher and support and evaluation officer for Divisions of General Practice provided many opportunities to observe and explore general practice in Australia in the period 1994 to 1997. I spoke with general practitioners regularly about service projects they were developing or conducting, I took part in meetings with divisional officers to discuss the needs and concerns of local general practitioners, and I attended national forums on the status and future of general practice. In addition, I carried out needs assessments for two Divisions of General Practice (Braunack-Mayer AJ & Hicks N. 1994 *Needs Assessment for the Adelaide Central and Eastern Division of General Practice.* General Practice Program, Department of Human Services and Health; Braunack-Mayer AJ & Marley J. 1995 *Yorke Peninsula Needs Assessment, for the Yorke Peninsula Division of General Practice.* General Practice Program, Department of Human Services and Health); undertook a consultancy on the ethical implications of funding sources for divisions (Hicks N, Reynolds C & Braunack-Mayer A. 1996 *Ethical Issues Associated with Sources of Funding for Divisions of General Practice.* Prepared for the Divisions Strategy Group Ethics Committee, General Practice Branch, Department of Human Services and Health, Canberra); and evaluated two divisional projects (Wittwer T, Braunack-Mayer AJ, Moss JR, Hepworth J, Worsley A. 1998 *Upskilling in Counselling for GPs. Final Report for the Adelaide Hills Division of General Practice.* General Practice Program, Department of Human Services and Health; Beilby J, Braunack-Mayer AJ, Moss JR & Miller E. 1997 *Evaluation of an Obstetric Shared Care Program.* General Practice Program, Department of Human Services and Health).

[26] See Patton, *Qualitative Evaluation and Research Methods...*, 175 and Silverman, Telling convincing stories...,72.

4.3 THE INTERVIEWS

4.3.1 The interview guide

A range of practical and theoretical issues clearly influenced the decisions I made about the broad research approach I took and who I chose to interview. At the same time as I was making these decisions, I was also addressing issues about the content, style and conduct of the interviews.

I chose to use semi-structured interviews – "guided, concentrated, focused, and open-ended communication events that are co-created by the investigator and interviewee(s) and occur outside the stream of everyday life".[27] I have chosen this label and definition from the plethora available because it conveys succinctly the key features of my own interviews. Semi-structured interviews share these features with a number of other interview types, for example, long interviews[28], sociological interviews[29], key informant interviews[30], and nonschedule standardised or focused interviews[31].

My interviews were open-ended conversations.[32] I began with a "grand tour question"[33] - "Please tell me about an ethical problem you have encountered in your work as a general practitioner" - since my intention was to define the focus of the interview without specifying the content.[34] They were also guided, concentrated and focused conversations. I wanted 'good stories', so the first prompts were designed to fill out the initial story - Who was involved? What information was known about them? Where? When? What was the context or setting? I was also interested in the decision-making process, so I included prompts concerning choice and action, outcomes, their reasons for the decisions they took, and how they would have responded had the

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[27] Miller & Crabtree, Primary care research..., 16.
[28] McCracken, *The Long Interview...*
[29] Denzin NK. 1970 *The Research Act.* Aldine Publishing Co., chapter 6.
[30] Gilchrist. Key informant interviews...
[31] Denzin, *The Research Act...*, 122.
[32] The final version of the interview guide is included at Appendix Three; the reader is referred there for the detail of questions asked.
[33] Gilchrist, Key informant interviews..., 81; McCracken, *The Long Interview...*, 34-5; Crabtree BJ & Miller WL. 1991 A qualitative approach to primary care research: the long interview. *Family Medicine* 23:147.
[34] Bernard, *Research Methods in Cultural Anthropology...*, 209.

situation been different. I included questions about why the problem they were describing was a problem, and specifically an ethical problem.[35] Behind all these questions sits the assumption that people are moral agents – persons who actively make choices about "the standpoint they take and the concerns they voice and keep silent".[36]

I piloted the interview guide in a number of ways. First, I conducted a mock interview with my academic supervisor, which a colleague observed. This interview uncovered some lack of clarity in my questioning in the latter part of the interview. The problem was not so much with the questions in my guide as with other issues I wanted to explore but had difficulty putting into words. These issues related particularly to getting the GPs to talk about influences that might be important for their moral decision-making and about their familiarity with concepts in bioethics. To deal with this issue, I decided to conduct some more pilot interviews. At this stage I needed people who were reflective about themselves, understood a little of what was involved in moral reasoning (but not too much) and also worked in a client-professional setting, so that they had stories to tell. I was undecided about whether they needed to be general practitioners.

At the time I was pondering how to deal with this issue, I had a conversation with a group of ministers of religion about my research. One of them jokingly suggested that I interview them; after all, they were generally reflective, understood something about how beliefs and values were formed and sustained, and worked with clients. In addition, most ministers working in parish settings were not experts in moral theology or philosophy, so their responses might not be that far removed from how general practitioners would address these issues. The offhand comment, on reflection, made

[35] See Brown LM *et al.* 1989 Reading for self and moral voice: A method for interpreting narratives of real-life moral conflict and choice. in Packer MJ & Addison RB. (eds.) *Entering the Circle: Hermeneutic Investigation in Psychology.* State University of New York Press, Table 1, 147. The interview questions used here are similar to mine, except that moral conflict and choice there presume decision-making in the face of uncertainty, which I did not want to assume.

[36] See Brown *et al,* Reading for self and moral voice…, 147.

considerable sense. Shortly after, I asked three ministers if they would be prepared to help me pilot my interviews.

These interviews were immensely helpful. We began with "ethical problems they had encountered in their work as parish pastors" and explored the nature of those problems. In the second part of the interviews we moved back and forth between questions and answers about the influences on their moral decision-making and commentary on whether my questions meant what I thought they did. We also dealt explicitly with framing these questions in non-directive ways. At the end of these interviews, I added a second set of questions to my interview guide. These questions focused first on particular beliefs and values that had already been identified in the interviews (for example, honesty), what those values meant for the GPs and how they thought they had come to hold them. In addition, I had a series of prompts to use if they did not mention factors that I thought might be important. These concerned the role of family, friends, colleagues, role models, education and professional development, and key experiences. I included questions designed to get them to reflect on how similar they thought they were to other doctors, with respect both to their management of their moral problems and their attitudes and beliefs.

I also found a way to address whether the GPs had encountered the formal language of ethics, and what they had made of it:

> One of the things we are trying to do in this study is to look at how well the formal theory and language of ethics fits with what we all think about when we make decisions about perplexing decisions like these. I'm going to give you, one by one, a list of terms that crop up in the medical ethics textbooks. Could you tell me what they mean to you and whether they play any role in your everyday work?

The terms were: rights, confidentiality, respect for autonomy, paternalism, beneficence, justice, informed consent, deontology, utilitarianism. The final question for the interview asked why the GPs had decided to get involved in the study.

Finally, I piloted the interview with a general practice colleague with whom I had not discussed my research in any detail. This interview went remarkably smoothly; in

particular, I felt that the questions I asked about values, beliefs and meaning worked well. I thought I was ready to talk to GPs.

4.3.2 Conducting the interviews

In this section, I will discuss methodological issues related to the conduct of the interviews, and comment on the ways in which my decisions and perspective influenced the research process. A description of the GPs and their characteristics is found at Chapter Six.

I interviewed the GPs between January and June 1993. The time span was lengthy, mainly because of my other work commitments and the travel associated with some of the interviews. (In total I travelled about 3,000km to interview 15 GPs, most of this to conduct three interviews.) Nine of GPs were interviewed in their surgeries, four in their homes and two at my work place. The average interview length was just over one hour, and they varied in length from 45 minutes to one hour and 45 minutes.

I began each interview by reviewing the information I had provided over the telephone and by letter about the purpose of the study, who was involved as researchers, the possible uses of information, and the means by which the GPs' privacy would be protected. Each GP signed a consent form.[37] I then embarked on the interview proper using the interview guide I had developed.

The interviews were taped, and I also took very brief notes. I found note taking difficult; it was hard to follow the conversation, participate appropriately, and write reasonable notes. In addition, the GPs seemed to expect that the presence of the tape recorder meant that I did not need to take notes. (They were wrong.) Mostly, I noted only the occasional comment, or jotted down words and phrases I wanted to come back to. After each interview, I spent about 15 minutes writing (usually sitting in the car),

[37] See Appendix Four for a copy of the Consent Form. At the time the interviews were conducted there was no requirement in my university for Institutional Ethics Committee approval for research projects that involved qualitative methods.

reflecting on the interview process, summarising the main points, and commenting on interesting aspects.

I encountered a number of difficulties in conducting the interviews. First, I had asked each GP to think of one or two problems he or she had met in practice, with a view to discussing these with me. In response to my opening question: "tell me about an ethical problem you've experienced in your work", seven GPs gave me an issue. For example, Dr Bright began: "I suppose the main ethical problems a lot of doctors face are those, let us say, before birth". This response was initially quite disconcerting, because my carefully constructed prompts no longer made sense. I managed to ask about situations in which that issue had been particularly troubling, but, the first time at least, my questions sounded gauche and ill conceived, to my ears.

Second, I learnt quickly that the interviews did not proceed smoothly from the top of the interview guide to the bottom. In some cases, it seemed to me that we jumped all over the place from the first minutes of the interview. Was there an internal logic in the way the GPs tackled the issues we discussed? Or, was it that my interview guide imposed an artificial order and logic on their talk?

Third, I found that some of the GPs had considerable difficulty with questions about influences that might have been important for their moral decision-making. These GPs had very little to say when I asked general, non-directive questions about how they thought they had come to be the kind of doctors they were. The pilot interviews with ministers, while helpful for clarifying and shaping the content of my interview guide, probably contributed to my sense of surprise at the GPs' difficulties. The ministers had had few problems with the open-ended question about influences. Yet, I was obviously not the first qualitative researcher to encounter this difficulty. Jefferys and Sachs noted similar problems in the interviews they conducted with general practitioners about difficulties and conflicts in their work:

> We often asked ourselves how many of us, in any walk of life, would be able or willing to expose our professional activities, warts and all, to the gaze of an outsider, however sympathetic or well-disposed.[38]

The GPs I interviewed did, however, respond quickly and with perception to more directive questions about education, family, professional experiences, role models, and significant life events.

Fourth, I met the classic qualitative researcher's dilemma: the best talk sometimes took place when the tape recorder was not running. Dr Johnson[39] spent half an hour at the end of his interview telling me why he was dissatisfied with general practice; Dr Kingsford asked as I was walking in the door whether I was interested in "doctor-patient" or "doctor-doctor" ethics; Dr Stamos explained at the end of his interview why he was doing law part-time, and getting out of general practice as soon as he could.

On two occasions, the tapes were of very poor quality. In the first case the interview took place next to a major rural road and Dr Alderson had a very soft voice. The second interview in some ways was a qualitative researcher's nightmare. It took place during a thunderstorm which made conversation difficult and the tape recorder burnt out during a power surge about half way through! Dr Williams had chosen to talk about her experience of assisting women to deal with unwanted pregnancies. During the interview she revealed that she was infertile herself, and this complicated the issue for her. I was 17 weeks pregnant at the time of the interview, and this fact was not lost on either of us. Taking notes in such an emotionally charged atmosphere was impossible. We both found the interview exhausting and I was not surprised when Dr Williams implied at its conclusion that she might not have agreed to be interviewed, had she realised she would need to think so deeply about herself and her feelings. I wrote to her after the interview, to let her know that the tape was only partially complete, and to open the door for her to renew contact with me if she wished to complete the interview,

[38] Jefferys M & Sachs H. 1983 *Rethinking General Practice: Dilemmas in Primary Medical Care.* Tavistock Publications, 14.
[39] The names aere obviously pseudonyms. Even this decision to use pseudonyms reflects my approach to and understanding of qualitative research. I wished with pseudonyms to convey the personal, engaged and active nature of my interaction with the GPs.

perhaps by jotting down some thoughts on paper. One week later, the baby I was carrying died. Dr Williams did not make contact. Taking into account her feelings about the subject matter and the interview, and my own situation, I felt unable to pursue the matter further.

I spent 15 minutes, as mentioned above, at the end of each interview reviewing the interview and my thoughts about it were invaluable for all that I had missed when the tape-recorder was not running, but my notes could not replace the transcribed texts. I have included these comments and experiences in the analytical process where possible, but they have not had the same impact on the analysis as the transcriptions have.

These difficulties all point in one way or another to the issue of who I was in these interviews and how I acted. It raises again the reflexive subjectivity of qualitative research and the need for the researcher to think about his or her identity in the research process, particularly in interaction with participants.[40] What did I bring, by way of style and perspective, to the interviews?

Qualitative researchers deal with the issue of the researcher's stance in a number of ways. McCracken, for example, notes that:

> The investigator cannot fulfil qualitative research objectives without using a broad range of his or her own experience, imagination and intellect in ways that are various and unpredictable.[41]

For him, the stance of "investigator-as-instrument" means that the researcher uses not only cognitive and practical skill to collect, analyse and interpret data, but that he or she also brings to bear "the whole of one's experiences and imagination".[42] He advises the researcher to convey a balance between the formality of professional curiosity and the informality of genuine interest in and benign acceptance of the respondent.[43] Denzin argues that the interview is a special form of face to face interaction, in which

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[40] Borkan, Conducting qualitative research in the practice setting..., 78.
[41] McCracken, *The Long Interview* ..., 18
[42] McCracken, *The Long Interview*..., 19.
[43] McCracken, *The Long Interview*..., 26.

interviewer and interviewee come together as strangers, interact for a short period of time and then separate again.[44] The interview is a conversation, but not one in the usual sense.[45] Denzin suggests a number of strategies to manage the potentially problematic nature of this conversation-that-is-not-a-conversation, including challenging interviewees' remarks and playing the novice.[46] The novice role is also explicitly advocated by Lofland and Lofland, who suggest that "[o]ne tried-and-true strategy for getting along in the field is to adopt a 'learner' or even 'incompetent' role". They note, however, that the learner role needs to be balanced by an indication of one's basic familiarity with the setting and persons one wishes to study.[47]

My style in the interviews was to try to adopt the stance of an interested novice, which was not all that difficult, since I was both fascinated by the topic and quite unfamiliar with the way in which general practitioners actually thought about moral problems. This meant that I asked questions that probably appeared naïve, for I was trying to get underneath their common-sense responses and assumptions. Yet, this statement of my approach to and role in the interviews represents a vast oversimplification of my identity. For, in many respects, I was not a novice; I brought to the interviews a wide range of skills and experience. Perhaps the most important aspect of my relative expertise was my experience as a teacher of ethics. This affected the interviews in two ways. First, sections of the interviews resembled a Socratic dialogue between tutor and student, in which I as researcher-tutor asked a series of non-directive questions to encourage the general practitioner-student to explore and question assumptions and conclusions. Second, I was interested in moral reasoning, and consciously or otherwise, the interviews were steered toward this area and, by implication, away from other areas.

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[44] Denzin, *The Research Act...*, 134.
[45] See also Bernard, *Research Methods in Cultural Anthropology...*, 207.
[46] Denzin, *The Research Act...*, 143.
[47] Lofland & Lofland, *Analyzing Social Settings...*, 26-7.

In addition to the student-tutor role, my identity in the interviews was also influenced by some of the issues I have discussed above. For two GPs, I was not a stranger – I was an ex-classmate - and we had a shared history that influenced the interviews in subtle ways. For one GP, I was a pregnant woman, and this had a significant impact on both the atmosphere and content of the interview. The point I want to make is that the notion that the researcher adopts a *persona* in qualitative research is flawed. One can neither bracket out personal and professional history nor 'control for' the unpredictable. Reflexive subjectivity is not an attempt to create a role in the interview, but rather it should involve the sort of awareness of self that I have tried to invoke here.[48]

4.4 ANALYSING THE DATA AND WRITING UP

Dey notes that, despite the plethora of approaches to qualitative research and analysis of qualitative data, there is an emphasis, common to all, on "how to categorise data and make connections between categories".[49] In this section I set out the way in which I tackled these two tasks of categorising the interviews and making connections between the categories I established.

The interviews were transcribed by two administrative staff in my academic department. I listened to each interview tape with the transcript in hand twice: the first time to make corrections, and the second to check for accuracy again and to record impressions and ideas which I thought might be lost once I was no longer working with the tapes. I then read through the transcripts two more times, began to make annotations and decided on an initial analytical strategy.

[48] McCracken incorporates the awareness of self into his method of qualitative inquiry in a "review of cultural categories", which includes a review of the researcher's role, expectations and understanding. This differs from my commentary only in so far as McCracken conducts this review *prior* to interviews.
[49] Dey I. 1993 *Qualitative Data Analysis: A User-Friendly Guide for Social Scientists*. Routledge, 6.

I used NUDIST, a qualitative analysis software package currently fashionable in Australia, to help analyse the data.[50] I treated NUDIST as a sophisticated filing cabinet: I used it to store my coding schemes, to facilitate the addition, subtraction, combination and relabelling of coded sections of text, to create simple two-by-two tables and to help develop tree structures. I made the decision to use NUDIST for pragmatic reasons. I shared an office at work, and had no workspace at home that I could spread out in. I had visions of children running all over my carefully arranged piles of text selections, and using a software package for coding simply made for a happier home and work life.

Following Silverman, I developed a number of 'rules' for my qualitative analysis.[51] First, I wanted to avoid excessive jargon and analysis, for I wanted the general practitioners to speak for themselves.[52] This rule implied that I should begin with the categories which participants themselves suggested and used, rather than impose an external set of categories.[53] To balance this, my second rule was to "avoid treating the actor's point of view as an explanation".[54] Lay accounts are no substitute for explanation and interpretation. Third, I treated the analysis as an iterative process, which would involve "repeated returns to earlier phases of the analysis as evidence becomes more organised and ideas are clarified".[55] The analytical process is a spiral, as back and forth movement occurs between data and interpretation, between the whole and the parts.[56] Fourth, simple enumeration techniques were acceptable, provided they

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[50] See Richards T & Richards L. 1991 The NUDIST qualitative data analysis system. *Qualitative Sociology* 14: 307-324; and Richards L & Richards T. 1987 Qualitative data analysis: can computers do it? *Australian and New Zealand Journal of Sociology* 23: 23-35.

[51] Silverman, Six rules for qualitative research... Some of these rules were clearer in hindsight, but the gist of them is in the notes I made at the time.

[52] Bernard, *Research Methods in Cultural Anthropology...*, 322-4.

[53] See Strauss AL. 1987 *Qualitative Analysis for Social Scientists.* Cambridge University Press, particularly on "open coding" and the use of "*in vivo* codes, terms used by the people being studied" (30, and 55-81).

[54] Silverman, Six rules of qualitative research..., 218 and Bernard, *Research Methods in Cultural Anthropology...*, 322-4.

[55] Dey, *Qualitative Data Analysis...*, 231.

[56] This is a simple interpretation of the "hermeneutic circle". For example, Addison's hermeneutic approach to research involved immersion in his participants' lives, followed by interpretation of their experience. A key interpretive flash allowed him to reorganise his transcripts, diagrams and models, which led to reinterpretation and deeper understanding. He checked his interpretation with participants who showed "no broader understanding of what was happening to them as they carried out their everyday tasks and responsibilities. This understanding of their limited range of reflective vision became a central theme of the developed account." See Addison RB. 1992 Grounded hermeneutic research. in Crabtree

took account of the nature and quality of evidence, the conceptual significance of particular cases, and the role of inconsistencies.[57] I included this 'rule' when I realised that I was, intuitively, counting how many GPs used a particular strategy, with what frequency and intensity. A careful reading of Silverman and Dey convinced me that "count[ing] the countable" could "deepen and extend qualitative analysis of linguistically-structured realities".[58] Finally, as my interpretation developed, I tried to locate the anomalies and to deal explicitly with them.[59]

4.4.1 Categorising data

With these 'rules' in mind, I began to look closely at the ways the GPs dealt with the questions in the first part of the interview guide.[60] I summarised the types of problems the GPs reported, coding every problem reported, and splitting and splicing codes as needed.[61] I repeated the process for the problems they chose to talk about in detail and their talk about why these issues were ethical problems.

My analysis proceeded relatively smoothly until I focused on the GPs' descriptions of how they had acted and why. Each story was unique and it seemed impossible to find commonalities between such disparate accounts. I floundered as I tried to take apart the GPs' recounting of their ethical problems and put it back together in a reconnected way. I began, and aborted, two coding schemes. (In retrospect, the schemes, while solidly grounded in a bioethical context, did not reflect the empirical material.) I felt as if I had been thrown into a pool of qualitative data and no-one had taught me how to swim.

BF & Miller WL. (eds.) *Doing Qualitative Research.* Sage Publications, 120. Brown *et al* adopt a similar approach in Reading for self and moral voice..., drawing on Dilthey and Ricoeur.

[57] See Dey, *Qualitative Data Analysis...*, 219-236 and Silverman, *Qualitative Methodology and Sociology....*, 138-155.

[58] Silverman, *Qualitative Methodology and Sociology....*, 140. This is not to suggest that the stripping of meaning that occurs in much quantitative research is at all acceptable.

[59] See Silverman, *Qualitative Methodology and Sociology....*, 20-22; Dey, *Qualitative Data Analysis...*, 220-236; and Bernard, *Research Methods in Cultural Anthropology...*, 319-345.

[60] This creation of categories using the questions in terms of which the research originated and developed is one of Dey's suggested ways to generate category sets (*Qualitative Data Analysis...*, 100).

[61] Dey, *Qualitative Data Analysis...*, 94-112

Why did I have so much trouble learning to swim in qualitative data? In part, my difficulties related, again, to the perspectives I brought to the research. I had inherited a particular 'Teach-Yourself-to-Swim' manual from my previous education and reading in bioethics. That manual had taught me that moral problem-solving involved a set of relatively clear and determinate steps:

- identify the key to the moral problem;
- locate a moral principle, rule or theory relevant to that problem;
- deduce from the principle, rule or theory the appropriate action to take.[62]

Sometimes problems contained more than one moral problem and/or it is possible to invoke more than one relevant principle. When this happened there was an interim step in the decision-making process:

- using logical argument, place the principles in order of priority.

I discuss the dissatisfaction with this model of bioethics in Chapter Two. One of the reasons given there is that the model does not provide an acceptable account of real life moral decision-making. I tried to apply it to the explanations my GPs had given me. After spending a fair amount of time treading water, I had to face the fact that I couldn't make this way of 'doing ethics' fit with their rationales for their actions. Most of the time the GPs didn't talk about moral principles, rules or theories. Even when they did, they certainly didn't follow the four easy steps that I knew about.

Ironically, when I made the jump to a different way of interpreting the data, I found that the GPs did indeed make some use of theories and principles in their moral deliberation. However, *they* didn't describe their deliberative approaches as moral theories or principles. I learnt to see the data in a new way by applying my second 'rule' more rigorously – do not treat the actors' point of view as an explanation – and for a time suspending belief in the value of principlist theories of bioethics.

[62] See Chapter Two for a discussion of the deductivist model in bioethics.

I also discovered the metaphor of the jigsaw puzzle that helped me to make sense of the categorising process in which I was engaged. Dey likens the classification of data into categories to the completion of a jigsaw puzzle.

> Our data start as a seamless sequence, from which we ourselves must first of all cut out all the bits of the puzzle. We must cut them out in ways which correspond to the separate facets of the social reality we are investigating, but which also allows us to put them back together again to produce an overall picture.
> ...Before I can fit a piece into the puzzle, I have to assess its characteristics and assign it some category or another. This bit is a corner, that's an edge, this blue bit is sky, that brown bit is earth, and so on. The categories we use are organising tools which allow us to sort out the heap of bits according to relevant characteristics. Gradually, all the blue bits make the sky, the brown bits the earth, the green bits the forest, and so on until we have built up a complete picture. The categories through which I initially organise the bits - flat-edged, blue, brown and green - lead on towards a new classification - sky, earth, forest - in terms of which I can finally describe the picture.[63]

I returned to the interview guide questions and adopted from it two "organising tools" to help me cut out the bits of my puzzle. Put very simply, I had asked of each GP, "what did you do?" and "why did you do it?" and I now turned these questions back on the texts. Because I was still confused by the volume of data, I prepared a summary sheet for each interview. These sheets mapped the actions each GP took and the reasons they gave for their actions. Using my two guiding questions I recorded each separate instance of an action or a reason for an action. For example, Figure 1 shows the summary I prepared of the actions Dr Dunt took and his explanations for those actions.

[63] Dey, *Qualitative Data Analysis, ...*, 40.

FIGURE 1

SUMMARY OF DR DUNT'S ACTIONS AND THE REASONS FOR THOSE ACTIONS

Dr Dunt[64] what did you do? why did you do it?

WHAT DID DR DUNT DO?
1. Took on a patient who wanted a home birth against the wishes of the obstretician. (12)[65]
2. Found a midwife (12)
3. Allowed a trial of labour at home (12).
4. Recognised dilemmas: "where do my priorities lie: with my patients on with my colleagues? (2) Am I right and am I wise to support a patient who feels entitled to decide where she will labour?" (12)
5. Thought about denying her medical assistance at delivery, but he couldn't tell her what to do (16)
6. Various labour and delivery scenarios were thrashed out during antenatal visits (22, 24, 26)
7. He made sure he listened to Pam and that Pam listened to him and understood. (28)
8. Made his role clear (28)
9. Faced the opposition of his colleague, who was offended that Dr Dunt would support this patient. (44)

WHY DID DR DUNT DO IT?
1. He saw good home obstetrics practised in England (20, 66)
2. He was anxious about having a stubborn patient who might risk the life of her baby. (20)
3. She satisfied him that if baby's life were at risk, she would go to hospital. (24, 56)
4. He doesn't, as a practitioner, "owe more to his colleagues than to his patients". (44)
5. He feared for himself - there were real risks and he wouldn't have been supported by the medical community if something went wrong. (48)
6. If you practise medicine, you should do so with your patients' interests, and patients are the best determinants of their own interests (50, 52)
7. It was Pam's body (52)
8. His role is as adviser (52)
9. If the risks of home delivery rose above hospital delivery, he would have said home was not safe. (64,66)

For a couple of weeks I used these 'summary sheets' as raw data for coding the GPs' actions and the reasons for those actions. Much of the material began to appear in codes within both of the two core categories. I moved material between codes, added some new codes, and amalgamated others. I moved continually backwards and forwards between data and classification, and the "categories through which I had originally organised" my bits of data gradually led on "toward a new classification" which I settled on to tell the story of how these GPs dealt with their moral problems. I transformed my two "organising tools" into two major themes encompassing two types of explanation for the GPs' actions: 'what did you do?' changed to 'what tactics did the

[64] Dr Dunt was actually a number at this stage in the analysis. I swapped to pseudonyms shortly after.
[65] The numbers in brackets refer to paragraph numbers in the original text.

GPs use to deal with their problems?' and 'why did you do it?' became 'what models of moral deliberation did the GPs use?' My notes from February, 1996 indicate this change of orientation, chiefly for the tactics theme.

> Memo15-2:
> There are two levels of explanations for general practitioners' actions. First, there are the strategies[66] and tactics that GPs use to deal with the ethical dilemmas they describe.
> Strategies (tactics, schemes, modus operandi):
> These are the concrete ways in which GPs resolve, get around, or ignore their moral problems. I have two main sources of information for these strategies. First, there are those strategies I identify by looking at my summary sheets on 'what did GPs do'? This leads to strategies like seeking information or advice from other sources, providing information to patients (by explaining consequences, etc.), referring on to avoid the dilemma, talking at length and on a number of occasions with the patient, listening to the patient, negotiating/compromising/ using the law as an out (as [a colleague] also said). If I go through those summaries, I can compile a list of strategies.
> Second, there is the material in the why done/processes node, which contains some formal ethical approaches, but also has practicalities like delay, law...
> This leads pretty naturally to the next question 'Why use those strategies?' which is answered by looking at the 'why done' material: The explanation should run something like:
> Why do the GPs use these ways to resolve their problems? What underpins these strategies and tactics?[67] Three concepts are central: the concept of good general practice, the concept of patient autonomy, and the concept of patients' best interests.

From here on the analytical tracks seemed clear (at least at the time). First I began to explore the notion that there were common approaches or 'tactics' which the GPs used to manage their moral problems.[68] From all the codes I had generated using the summary sheets, I selected those that seemed to indicate more-or-less routine ways to handle moral problems. This provided a list of 17 categories that I used to recode the original interviews. I completed this recoding, studied the material contained within each code, and began to combine, split, shuffle and reshuffle codes and their contents. I had two aims in mind while doing this: I wanted to reduce the number of categories to the smallest possible number, without sacrificing the distinctiveness of each category; and I wanted to gauge the relative significance of each tactic.

A number of the specific analytical tools I used to assist me are described in Chapters Six to Ten, for example, attempts to locate and deal with disconfirming evidence and the use of simple counting techniques. It is more appropriate to describe

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[66] Bear in mind that I later decided the word 'strategies' was inappropriate and I chose to use the word 'tactics' exclusively to describe the first level of analysis.
[67] These two questions were answered later using the theme of 'models of moral deliberation'.
[68] This is somewhat akin to the focus in Strauss, *Qualitative Analysis for Social Scientists...*, on strategies and tactics.

them there, as they relate to the description, analysis and interpretation of particular aspects of the data.

4.4.2 Telling a connected and convincing story

Thus far, I have described the analytical process I used to categorise the data. There is, however, another level to the analysis, concerning how these various categories were related to each other. In separating my account into a description of 'categories' and 'connections', I do not wish to imply that I first categorised and then connected. The earlier stages of my analysis did involve more categorisation, and the latter more attempts to craft a connected story, but the two processes remained interwoven. Together they led to an interpretation of the moral decision making of general practitioners that I found persuasive. This section concludes by discussing how I found, from amongst the many stories to tell, one which was convincing for me. Put into more formal language, I address here the way in which I interpreted the concept of validity in this study.

Against a backdrop of a wide range of moral problems, involving different people in different circumstances, and with different explanations for why certain actions were morally preferable, the GPs in my study talked about their actions and thought processes in a surprisingly homogeneous way. I argue in this thesis that their talk mirrors mainstream bioethics in a simplistic way - specifically principlist, casuist and virtuist theories – and that it also reflects the structural and financial organisation of their work. The structural and organisational theme is particularly important because it provides the connections between the various aspects of the thesis. I first developed this theme out of the GPs' talk concerning how they acted with respect to the moral problems they discussed. By the time I was nearing the end of the analysis, this theme had also emerged in the material about moral deliberation.

To speak of themes or concepts as 'emerging' from the data is misleading. It implies that concepts and themes just form themselves out of the data, or that they are

sitting in the data, waiting for the observant researcher to find them.[69] At one level, my conclusions did 'emerge' from the data. I adopted a 'bottom-up' approach to data analysis, which used the GPs' talk and the terms in which the research was begun to generate categories for analysis. However, I also moved beyond the GPs' categories to develop interpretations that they themselves would not have generated.[70] The relation between data and concepts, themes and interpretation was much more complex than the simple 'data-driven' model would suggest.

It is more appropriate to speak of an "*interplay* between data and conceptualization"[71], somewhat akin to the iterative and spiralling process mentioned above, than to think of the analysis as driven by the data. Even the notion of interplay, though, does not really address the issue of the sources of concepts, themes and interpretations. Bulmer has a helpful discussion of possible sources for the development and justification of social science concepts. He lists ten different sources of concepts, including professional definitions, relevant scholarly literature, the researcher's own prior experiences and values, "common-sense constructs" used in the social world being studied, and respondents' concepts and definitions. He suggests that the relative weight given to different sources will vary with the researcher's general orientation, the richness of existing literature, and the nature of the phenomena being studied.[72]

There are at least two factors, related to a number of Bulmer's categories, which have influenced the interpretation I have developed. First, I have already alluded to some of the ways in which my interest in bioethics coloured the framing and direction of the research. I began by framing the study as an "Ethics in General Practice" study, even though I took considerable care not to define for the GPs what an ethical problem

[69] Glaser BG & Strauss AL. 1967 *The Discovery of Grounded Theory.* Weidenfeld, tend to emphasise this approach. Bulmer M. 1979 Concepts in the analysis of qualitative data. *Sociological Review* 27: 651-677, shows how this way of explaining the connection between data and concepts is flawed.
[70] Addison, Grounded hermeneutic research..., 120, describes how the participants in his study had "no broader understanding of what was happening to them", yet recognised the account he fashioned of their lives. See fn 55.
[71] Bulmer, Concepts in the analysis of qualitative data..., 672.
[72] Bulmer, Concepts in the analysis of qualitative data..., 668-671.

was. I piloted the interviews with people who understood what I meant by values, morality and ethics. I brought to the interviews a style of interviewing that was influenced by my experience as an ethics tutor. Ironically, my bioethical orientation also, for a time, prohibited me from developing an interpretation of the data that made sense.

Second, the emphasis in this thesis on structural, financial and organisational factors has been influenced, partially, by other work that I did during the period I was developing and writing up the analysis. I worked part-time between 1994 and 1997 as an evaluation and support officer for a number of Divisions of General Practice in South Australia. During that period these Divisions, like others around Australia, moved from being new and struggling organisations to, in some cases, large and successful enterprises. They began with little understanding of their role and, by 1997, saw themselves as playing a key role in expanding the domain of general practice. I was able to be part of this changing scene, and through it I had many opportunities to discuss the nature and organisation of general practice with general practitioners, bureaucrats and academics. The meetings, workshops, papers, grant applications, forums, and informal discussions I attended and saw during this period sharpened my nascent fascination with the ways in which structures, organisation and finance help determine how work is practised and understood.

Both of these factors are, again, comments on the perspective and identity I brought to my research. Qualitative researchers have recognised that the 'self' the researcher brings to the research process is important to the way in which research questions are framed and field work is conducted. The point I am making in the above paragraphs is that, in a similar way, the researcher's identity influences how findings are analysed and interpretations are made.

The obvious danger here is one of reading themes, concepts and interpretations into the data, with faulty interpretation of data as a result. There is, in qualitative

research, some reluctance to admit the notion of misinterpretation of data, since it seems to run contrary to the view that there is no such thing as an objective account. But, one does not have to subscribe to a positivist search for the 'truth of the matter' to believe that it is possible to distinguish between better and worse interpretations. Put another way, the qualitative researcher needs to demonstrate that his or her account is a valid interpretation of the data. It does not need to be the *only* interpretation of the data to be valid.

Validity is a vexed concept in qualitative research. My interpretations follow those of Dey and Silverman. For Dey, valid accounts have two features: they demonstrate successfully how the concepts and themes used in the research are grounded in the data ('face' validity); and they show the fit between the researcher's concepts and "those already established in the field" ('construct' validity).[73] Silverman uses similar concepts to develop his definition of validity: "Does the account offer a watertight, logically-based interpretation of the data? Can it withstand plausible, rival interpretations?"[74] Convincing accounts attempt to be transparent in their display of data. They become valid if they appear to the reader to use and contribute to cumulative bodies of knowledge (Dey's face and construct validity).

Because validity rests, in part, on demonstration, telling the story of one's research, as I have done in this chapter, is an important task. I am, in a sense, laying down an audit trail that provides the reader with enough evidence to assess whether the concepts, themes and findings do indeed fit the evidence. The audit trail includes, in addition to the account of how I went about my research, a description of the 'techniques' I used to explore and interpret the interview data. Those 'techniques' include dealing with unexpected findings in a frank way, being open to disconfirming evidence and the five rules of qualitative analysis I described above. These techniques

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[73] Dey, *Analysing Qualitative Data...*, 254-261; quotation at 260. At p228, Dey defines a valid account as "one which can be defended as sound because it is well-grounded conceptually and empirically."
[74] Silverman, Telling convincing stories..., 72.

are used, where applicable, in later chapters of this thesis.[75] All of these processes contribute to an account that is intellectually honest.[76]

Validity relates also to locating the concepts and interpretation generated by the research in a wider field of theory. In a multi-disciplinary thesis, such as this one, there is no single body of theory that provides a backdrop and interpretive base. I am reliant instead on a range of theoretical perspectives. This does not, however, weaken the link between existing theory and the theoretical and practical contributions to knowledge that this thesis makes. The task is still, as Silverman suggests, one of taking formal theories and applying and developing them in new contexts, linking micro and macro relations, and "using lateral thinking which crosses substantive and conceptual boundaries". It is exactly in these areas that multi-disciplinary work has the most to offer, because it tends always to push the boundaries or to sit in the cracks.

I began this account of my research with a brief discussion of the way in which qualitative research understands the role of the researcher. I suggested there that the decisions researchers make - about methodological strategies, about access and entry to field settings, about 'sampling' procedures, about establishing and maintaining rapport, about what is observed, asked, recorded and coded, about how that data is interpreted and reported - are matters of deliberate choice. Providing a clear account of those decisions contributes to a convincing and valid account, in that it makes the research process transparent, and provides evidence for how findings were made. This chapter has been, then, an exercise in transparency. The second aspect of demonstrating validity which I have discussed, locating one's concepts and interpretations in a wider field, is addressed at points throughout the thesis.

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[75] See Silverman, Telling convincing stories..., 60-1, 70; and Bernard, Research Methods in Cultural Anthropology..., 320-2, on the "constant validity check".
[76] See Mills CW. 1970/1959 *The Sociological Imagination.* Penguin Books, on intellectual honesty in sociological research.

5 THE SOCIAL FRAMEWORK OF GENERAL PRACTICE IN AUSTRALIA

5.1 INTRODUCTION

Chapter One described the bioethical perspective on ethical decision-making and practice as a perspective emphasising individual choice, private relationships between doctors and patients, and cognitive processes oriented to rational, coherent and logical thought. This perspective stands in contrast to a sociological approach that attends to the ways in which social and structural factors influence ethical decision-making.

A sociological perspective on ethical decision-making and practice requires familiarity with the social, organisational and financial context of the world of those practitioners being studied. This chapter provides an account of that world for general practitioners in Australia and, more specifically, for the GPs who were interviewed for this study. It analyses what has been said in the professional arena about general practice and being a general practitioner and sets it in the context of the social and economic organisation of their work.

The chapter considers two questions: What does it mean to be a general practitioner? and What is general practice? There is a sizeable international literature that addresses these questions written, in large part, by general practitioners. A small subsection of this literature considers these questions from a philosophical perspective. For example, Toon's British study of the nature of general practice identifies three models of general practice - the biomechanical model; the hermeneutic or humanistic model, in the form of Balintism; and the public health or anticipatory care model, as articulated by Tudor Hart.[1] He also discusses the extent to which general practice can be described as a business and patients as consumers of services. Toon shows how each model of general practice generates different beliefs about good general practice, and how these beliefs are in turn grounded in different views of the nature of the human

[1] Toon P. 1994 *What is Good General Practice? A Philosophical Study of the Concept of High Quality Medical Care.* Royal College of General Practitioners, Occasional Paper 65.

person, the nature and purpose of illness, and the meaning of the doctor-patient relationship. For example, the biomechanical doctor regards humans as rational individualists; illness is treated as an impediment to the good life, and the role of the doctor is to attempt to cure, or at least ameliorate, the problems that patients present. The Balint doctor also focuses on individuals, but includes the patients' close family and friends in his or her treatment. Illness, for the Balint doctor, is regarded as part of life and the doctor's task is to help patients to understand their illnesses and to integrate their illness experiences into their lives. The anticipatory care doctor is less concerned with individuals, treating the community as the unit of care. While still regarding illness as essentially a negative experience, the anticipatory care doctor seeks to move beyond the problems with which the patient presents to include illnesses not identified by the patient.[2]

Christie and Hoffmaster and Smith and Churchill also attempt to define the meaning of general practice.[3] Their approach, discussed in Chapter Three, treats the definitions of family medicine and primary care offered by professional bodies as starting points, and uses case-based reasoning to give meaning and content to these definitions. At a more general level, Pellegrino and Thomasma provide a thoughtful and nuanced account of the nature of good medical practice.[4] Their account, however, deals with medical practice in Northern America, particularly in hospital settings, and ignores the organisational and anticipatory care issues that are central to Australian general practice.[5]

Toon notes that models of general practice, family practice or family medicine reflect as much the social and organisational context in which the work of general

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[2] See Toon, *What is Good General Practice?...*, chapter 8, particularly, for discussion of the values that underpin each model.
[3] Christie RJ & Hoffmaster CB. 1986 *Ethical Issues in Family Medicine.* Oxford University Press; and Smith HL & Churchill LR. 1986 *Professional Ethics and Primary Care Medicine.* Duke University Press.
[4] Pellegrino ED & Thomasma DC. 1981 *A Philosophical Basis of Medicine Practice.* Oxford University Press. See also Pellegrino ED & Thomasma DC. 1988 *For the Patient's Good: The Restoration of Beneficence in Medical Practice.* Oxford University Press.
[5] This is not intended as a criticism of Pellegrino and Thomasma's work. I agree with Toon that their model is a "well-argued" one, but it reflects the market-driven approach to the provision of medical services in the United States. See Toon, *What is Good General Practice?...*, 16-7, for similar comments

practice is done as they do philosophical argument about what good general practice ought to be like. This context varies considerably between countries. A study of general practitioners doing ethics in Australia can make use of these international accounts, but it must tread its own path to articulate what general practice is in this country.

This chapter approaches the questions 'What does it mean to be a general practitioner?' and 'What is general practice?' from two angles, arguing that there are two ways in which general practice and the general practitioner are understood in Australia. First, there is an *altruistic professional* model of general practice, which is neatly summarised in the definition of general practice offered by the Royal Australian College of General Practitioners (RACGP). A general practitioner is "a doctor who provides primary, continuing, comprehensive whole-person care to individuals, families and their communities".[6] This professional model is somewhat at odds with the way in which general practice work is structured, financed and organised in Australia. These structural, organisational and financial issues are related to a second way of understanding general practice, the *business* model, in which a general practice is a business unit, "whose objective is the provision of general practice medical services to its surrounding community".[7] The business model, far from being ignored in the professional literature, occupies an important place in it.

A number of recent reforms in general practice have attempted to address the dissonance between these two models, by trying to change the structural, financial and organisational framework of general practice in Australia. The reforms have, at least, the potential to decrease the dissonance between the professional and business

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on the limited applicability of Pellegrino and Thomasma's model for British general practice.

[6] Knight R & Northrop M. 1996 Introduction: An overview of general practice in Australia 1996. in Commonwealth Department of Health and Family Services. *General Practice in Australia 1996.* Australian Government Printing Service, xxvii. The origin of the definition is Royal Australian College of General Practitioners. 1984 Policy Documents, Policy 30, Definition of General Practice/Family Medicine (Adopted 27/1 Council; September 1984). See also Royal Australian College of General Practitioners. 1985 *The Vision of General Practice: Now and in 1995.* Arthur Anderson and Co., Melbourne; Murtagh J. 1994 *General Practice.* McGraw-Hill, 3; Strasser R. 1991 General practice – what is it? *Medical Journal of Australia* 155: 533. All offer essentially the same definition.

[7] RACGP Interpractice Comparison Survey - quoted in Knight and Northrop, An overview of general

understandings of general practice. The conclusion to this chapter includes some speculative comments about the likely impact of these reforms, suggesting that their aims are in line with a reorientation of general practice. However, the total amounts expended on the reforms and the nature of some of the projects funded make significant change unlikely.

5.2 A NOTE ABOUT SOURCES AND CONTEXT

This chapter is not a history and critique of changes in general practice policy over the last two decades, but it is important to set the argument developed about how general practice defines and understands itself in a broader context.[8] The reader is referred to Appendix Five for a summary of the developments in health policy, principally since 1975, that have had the greatest impact on general practice in Australia. The very brief account below highlights the most important issues.

The most significant changes in health policy, for the purposes this thesis, occurred in the period between 1985 and 1993. Before 1985, the turbulence surrounding the introduction, partial demise and reintroduction of universal health insurance in Australia unnecessarily complicates some of the debate about the nature and role of general practice. The period from 1985 onwards marks the beginning of an increasingly loud and distinctive general practice voice, one that has had clear and recognisable things to say about the nature of general practice.

Australian general practitioners have been represented in the political realm by a number of organisations, of which the Australian Medical Association (AMA) and the RACGP have been the most significant.[9] Traditionally, the AMA represented general

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practice..., xxvi.

[8] For a full analysis of health care and health policy issues in Australia, the reader is referred to Palmer GR & Short SD. 1989 *Health Care and Public Policy: An Australian Analysis.* (2nd edn) Macmillan; Sax S. 1984 *A Strife of Interests: Politics and Policies in Australian Health Services*. Allen and Unwin; Backhouse PJ. 1994 *Medical Knowledge, Medical Power: Doctors and Health Policy in Australia.* PhD, University of Adelaide. Backhouse includes a chapter specifically on changes in general practice policy. The following summary and the account in Appendix Five draw on these sources.

[9] A number of other organisations have played lesser roles. See Appendix Five for a brief discussion of their influence.

practitioners on industrial matters and the RACGP represented them on educational issues. Between 1985 and 1989, the RACGP became increasingly vocal in the political and industrial arena. Its gains in this arena were accompanied by consolidation of its position as principal speaker on issues related to education and professional standards in general practice. By 1989, when a range of changes to continuing education, vocational registration and the funding of services provided by general practitioners was introduced, the RACGP had secured its position as an independent political voice on the nature and role of general practice.

The period since 1990 has been a time of further rapid change for general practice in Australia, culminating in the introduction of a program of reforms from 1992 onwards called the General Practice Strategy and focused around workforce, standards and quality in general practice.[10] However, at the time I recruited and interviewed the GPs for the empirical part of this thesis (in late 1992 and 1993), the reforms were only beginning to be implemented, and they had made, at that stage, little impact on most general practitioners.

Accordingly, the analysis of general practice that follows focuses principally on the period between 1985 and 1993. It draws primarily on published materials that reflect the public voice of the profession (through documents from the RACGP) and the views of general practice leaders (through their textbooks or published articles). The reader is referred to Appendix Five for a description of these sources.

Two issues about the time period covered by these sources deserve comment here. First, I have made some use of material published before the formal period of recruitment and interviewing. These books and papers influenced the GPs' self-concept and their understanding of general practice, because general practitioners' views about themselves, their work and the nature of general practice are, at least in part, formed by

[10] The sentinel document summarising these reforms is: General Practice Consultative Committee. 1992 *The Future of General Practice: A Strategy for the Nineties and Beyond.* Australian Medical Association, Department of Health, Housing and Community Services and Royal Australian College of General

concepts, models and views they have encountered since they commenced working in general practice and even before. Put another way, widening the period under investigation to include documents and materials published from an earlier period allows for the slow gestation of professional self-concept and awareness. Second, some later documents are used, because they reflect on changes in general practice up to 1993 or they contain workforce data previously unavailable.

The availability of workforce data is a tricky issue. The establishment of a 'vocational register' in 1989 had made it possible, for the first time, to count doctors who identified themselves, however loosely, as general practitioners, as opposed to counting all non-specialist doctors and assuming that they were all general practitioners.[11] In addition, the introduction of the General Practice Strategy led to the creation of a General Practice Branch within the Commonwealth Department of Health and the existence of this branch and the allocation of funds for general practice provided an environment in which data relating to the supply and distribution of general practitioners, general practice service characteristics, the number, location and types of general practices, and financing of general practice could be gathered and analysed. Most of this data only became available during 1995 and 1996.[12] Data produced at this time has been included in this chapter when earlier data is not available or when earlier data might be expected to be of poorer quality.

It is reasonable to assume that the impact of the General Practice Strategy on general practice workforce and funding would not be immediate, and that data for 1994 and 1995 would still describe accurately the situation for general practice in 1993.

Practitioners.

[11] Dickinson J *et al.* 1996 The supply and distribution of general practitioners. in Commonwealth Department of Health and Family Services. *General Practice in Australia 1996.* Australian Government Printing Service, 27.
The vocational register was initially open to general practitioners with at least five years experience in general practice or who had undertaken post-graduate training in general practice. Since 1994, vocational registration has been open only to medical practitioners who have passed the RACGP fellowship examination. Maintaining one's registration involves undertaking an approved program of continuing medical education.

[12] For example, Commonwealth Department of Health and Family Services. *General Practice in Australia 1996.* Australian Government Printing Service, was published in 1996. It is the first report which brings much of this data together.

Extra support for this view comes from noting that the annual federal budget appropriations for the General Practice Strategy between 1992-3 and 1995-6 were small compared to total expenditure on general practitioner services.[13] For example, in 1994-5, the General Practice Strategy put about five percent of total expenditure on general practice services into alternative funding arrangements, and did so without tampering with the principal mechanisms through which general practitioners are paid. Such initiatives could hardly be expected to achieve major change in the ethos or outlook of general practice.[14]

The size of the budget allocation for the General Practice Strategy notwithstanding, it is difficult after 1995 to find commentary on general practice that does not assume that the recent reforms have been important in changing the nature of general practice. For example, in 1997 the RACGP published a new definition of general practice and the general practitioner.[15] The draft 'new' definition includes an explicit coordination role for general practitioners that was absent in a formal sense from the earlier definition. The introduction of this component relates partly to initiatives in integration and coordination associated with the General Practice Strategy. It must be said that the programs and projects introduced under the General Practice Strategy at least have the potential to change significantly the way in which general practitioners work in Australia, and they deserve some comment. The discussion at the end of this chapter returns to some of these recent changes in general practice and speculates on the way they might affect the analysis of general practice that has been

[13] The amounts available for alternative general practice funding arrangements for these years were: \$73.4m (1992-3); \$127.2m (1993-4); \$129.9m (1994-5); and \$211.4m (1995-6). (See Knight & Northrop, Introduction: An overview of general practice..., xxxi.) These figures can be compared with the total expenditure on non-specialist attendances during this period, even though not all of these services were provided by general practitioners: \$2, 238.9m (1992-3); \$2,366.9m (1993-4); and \$2,442.5m (1994-5). By 1994-5, about 85% of these services were being provided by vocationally registered general practitioners. (See Butler J. 1996 The financing of general practice. in Commonwealth Department of Health and Family Services. *General Practice in Australia 1996*. Australian Government Printing Service, 135-153.)

[14] See Section 5.5 for further comment on this issue.

[15] The definitions were adopted at the 26/27 July 1997 meeting of the RACGP Council. See Appendix 4 39/10 Council Minutes 26/27 July 1997. According to these minutes, "General practice is that component of the health care system which provides initial, continuing, comprehensive and coordinated care for all individuals, families and communities and which integrates biomedical, psychological, social and environmental understandings of health". "A general practitioner is a medical practitioner with recognised training, experience and skills, who provides and coordinates comprehensive medical care for

developed.

5.3 THE ALTRUISTIC PROFESSIONAL MODEL OF GENERAL PRACTICE

The definition of general practice and the general practitioner provided by the RACGP provides an excellent starting point for discussion of the altruistic professional model of general practice. This definition was mentioned in the introduction to this chapter and it is restated here. According to the RACGP, a general practitioner is:

> a doctor who provides primary, continuing, comprehensive whole-person care to individuals, families and their community.[16]

This section discusses the altruistic professional model of general practice using the components of the definition above, also noting the way in which organisational, financial and structural factors limit the capacity of general practitioners to provide services that meet the requirements of the definition. To a degree, the decision to discuss each of the components of the definition separately creates distinctions that are not present if the definition is viewed as a whole. There are clear overlaps between the various components: for example, continuous care is often taken to imply comprehensive and whole-person care. Although the boundaries between the meanings of various components are often blurred, separating them out does impose some order on what is often a confused presentation of the nature of general practice.

5.3.1 Primary care

General practitioners provide *primary care*, in the sense that they are the first point of contact with the health system for most Australians. Eighty percent of Australians visit a general practitioner at least once per year.[17] (By comparison, only five per cent consult an allied health professional at all.[18]) This figure is only relevant,

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individuals, families and communities."

[16] RACGP, Definition of General Practice/Family Medicine... See also fn 15 for the new version of the definition, adopted in 1997. This definition is widely quoted, with slight variations, in many places. I have chosen the RACGP version, because it is generally cited as the original source of the definition of general practice. See also Knight & Northrop, Introduction: An overview of general practice in Australia 1996..., xxvii; RACGP, *The Vision of General Practice...*; Murtagh, *General Practice...*, 3; Strasser, General practice – what is it?..., 533. All offer essentially the same definition.

[17] Knight and Northrop, Introduction..., xxvii; National Health Strategy. 1992 *The Future of General Practice.* National Health Strategy Issues Paper no. 3, Australian Government Printing Service, 17.

[18] National Health Strategy, *The Future of General Practice...*, 17. Allied health professionals here

of course, if we assume that primary care is equivalent to the provision of first level medical services. The RACGP's definition of primary care certainly focuses on this aspect:

> Primary care involves the ability to take responsible action on any problem the patient presents, whether of not it forms part of an ongoing doctor-patient relationship. In managing the patient, the general/family practitioner may make appropriate referrals to other doctors, health care professionals and community services. General/family practice is the point of first contact for the majority of people seeking health care. In the provision of primary care, much ill-defined illness is seen; the general/family practitioner often deals with problem complexes rather than established diseases.[19]

The focus in the altruistic professional model is on primary care provided to individuals. Despite the fact that the definition emphasises the general practitioner's capacity to deal with whatever problem the patient presents, be it social, psychological, economic, spiritual or medical, the emphasis is still on "ill-defined illness" and "problem complexes rather than established diseases". However, primary care can also be defined in other ways. The World Health Organization defines primary care as:

> ...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community...[20]

Essential health care does not need to refer only to local medical services provided to individuals; it can also reflect a range of broader policy initiatives, such as those set out in the National Health Strategy's document on the future of general practice. This document provides a definition of primary health care which includes building self-reliance, at both a community and an individual level; supporting community participation; intersectoral collaboration between health and other departments and organisations so that 'healthy choices become easy choices'; integration of health services with other services; special concern for high risk groups; and the appropriate use of technology.[21]

When primary care is defined in the National Health Strategy's way, it is clear that, although general practitioners are the principal providers of primary medical

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probably exclude acupuncture and chiropractic. Figures for the proportion of people who consult various 'alternative' practitioners are difficult to obtain, and of dubious validity.

[19] RACGP, Definition of General Practice/Family Medicine...

[20] World Health Organization. 1978 *Declaration of Alma-Ata.* World Health Organization, Alma-Ata.

[21] National Health Strategy, *The Future of General Practice...*, 33-34.

services for individuals, primary care is not limited to their input. Primary care requires involvement from a wide range of service providers, many of whom have little directly to do with the provision of health care. In addition, general practitioners have played only a minor role, if any, in community participation strategies and collaboration and integration with other health service providers. They have had very little systematic or planned contact with other health service providers and consumers with whom it might be possible to discuss whether the services general practitioners provide are in fact those that their local communities want or need.

In defining primary care in essentially medical and individualistic terms the altruistic professional model has reflected the views of its constituency, at least in South Australia. When South Australian general practitioners were surveyed in 1988, they also elided medical care with health care more broadly construed. One of the questions this survey asked of all general practitioners in the state was "From a general practitioner's viewpoint, can you suggest things which the South Australian Health Commission could do to improve *health services* in South Australia?" Many of the open-ended responses revealed that the general practitioners were unable to distinguish between the health care system and general practice. The nine most common types of responses included calls to increase general practitioner incomes, reverse the state government policy of country hospital closures, reduce or monitor the provision of allied health services, change general practitioner education, and cease perceived media and government 'doctor bashing'.[22] These issues have as much to do with protecting general practitioners' 'turf' as they have to do with the quality of health services more generally construed.

In summary, then, the altruistic professional model proposes and supports a primary care role for general practitioners, but it is primary care in the form of first-point-of-contact medical care, provided to individuals.

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[22] South Australian Health Commission, Australian Medical Association (SA) & Royal Australian College of General Practitioners (SA). 1988 *Review of General Medical Practice in South Australia. First Report: Identifying Problems and Issues in General Practice.* South Australian Health Commission, 38, 85-87.

5.3.2 Continuity of care

The second aspect of the altruistic professional model of general practice revealed in the RACGP definition is the provision of *continuity of care*. Many writers regard continuity as the cornerstone of general practice. Murtagh describes it as the "essence" of general practice, and McWhinney identifies it as a "crucial element in family practice".[23] Continuity is also offered by general practitioners as one of those characteristics that distinguishes general practice from other medical specialties.[24] Although there is substantial agreement that continuity of care is central to general practice, there is a range of views about exactly what it means. One definition – "uninterrupted responsibility of one doctor for a patient's care"[25] – is frequently quoted, but even this definition clearly means different things to different people and in different contexts. At least two meanings surface in the professional literature - a 'relational' meaning and a 'regular contact' meaning.

Continuity tends to take on a 'relational' meaning in situations in which the conceptual framework of general practice is being stressed and when the relationship between doctor and patient has great significance. Murtagh, for example, begins his discussion of continuity in this way:

> The essence of general practice is continuity of care. The doctor-patient relationship is unique in general practice in the sense that it covers a span of time which is not restricted to a specific major illness. The continuing relationship involving many separate episodes of illness provides an opportunity for the doctor to develop considerable knowledge and understanding of the

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[23] Murtagh, *General Practice...*, 4 and McWhinney I. 1989 *A Textbook of Family Medicine*. Oxford University Press, 15. McWhinney's other text (1981), *An Introduction to Family Medicine*, covers a similar terrain. A second edition of *A Textbook of Family Medicine* was published in 1997.

[24] See, for example, Docker J *et al.* 1994 *Report of the Knowledge, Skills and Attitudes Task Force*. The Royal Australian College of General Practitioners Training Program,Jolimont, Victoria, Australia, 8-9. This report attempted to define "what knowledge, skills and attitudes are important for general practice and therefore for the training programs preparing doctors for entry into general practice"(i). The draft of the report was published in February 1993, and the final report published in January 1994. The membership of the Task Force reads like a who's-who of general practice education in Australia. Eleven members were RACGP/FMP employees, six were general practice academics, two were general practitioners in private practice, and the Australian Council for Education Research was represented by its Director. Professor Neil Carson, Professor of General Practice at Monash University, conducted discussion groups for the report with 52 general practitioners in Sydney, Melbourne and Brisbane between October and December 1993. The report thus reflects views about the knowledge, skills and attitudes necessary for general practice right at the end of my period of focus.

[25] Pilotto LS *et al.* 1996 Sequential continuity of care by general practitioners: which patients change doctors? *Medical Journal of Australia* 164: 463. See also Veale BM *et al.* 1995 Consumer use of multiple general practitioners: an Australian epidemiological study. *Family Practice* 12: 303-8.

patient, the family and its stresses, and the patient's work and recreational environment.[26]

McWhinney's treatment of continuity is very similar:

> Continuity of care is based on the idea that physicians cannot be substituted for one another like replaceable parts of a machine. For a patient, there is a clear distinction between 'my doctor' - the one who knows me - and any other doctor.[27]

The RACGP also begins its discussion of the knowledge, skills and attitudes required for general practice with a "conceptual framework" which includes a discussion of continuity.[28] The framework includes a description of the work of a general practitioner that is intended to give meaning to the RACGP formal definition; in this description continuity is interpreted as:

> ... the ongoing relationship between the doctor and patient [which] is of paramount importance. Prolonged contact means that general practitioners use repeated opportunities to gather information at a pace appropriate to each patient and to build up a relationship of trust. They undertake continuing management of their patients with chronic, recurrent or terminal illnesses. They know when and how to intervene to promote the health of their patients and their families through treatment, prevention and education.[29]

Relational interpretations of continuity probably reflect, in part, the influence of the Balint movement on Australian general practice. As with British general practice, the actual number of general practitioners actively committed to Balintism has probably been very small, but Balintism has had an impact beyond its numbers, particularly through its impact on academic departments, vocational training and the College.[30] The key concept in Balintism is that patients bring to their general practitioners not only physical problems but also psychological problems, frequently disguised as physical ones. The general practitioner has an important role to play in guiding patients to understand and deal with the problems of their lives, using the doctor-patient relationship to bring about change. In Australia during the 1970s, the *Australian Family Physician*, the flagship journal of the RACGP, incorporated a similar interest in

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[26] Murtagh, *General Practice...*, 4.
[27] McWhinney, *A Textbook of Family Medicine...*, 16.
[28] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force...*
[29] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force...*, 8, quoting from the RACGP. 1977 Occasional Paper 4 'A system of training for general practice'.
[30] For the original text, see Balint M. 1957 *The Doctor, His Patient and the Illness*. Pitman. See also Hart JT. 1988 *A New Kind of Doctor: The General Practitioner's Part in the Health of the Community*. Merlin, particularly 97-9, and Toon, *What is Good General Practice?...*, 25-6, for evaluations of the influence of the Balint movement on general practice in the United Kingdom.

psychological understandings of illness and the role of the general practitioner.[31]

Not all discussions of continuity in general practice presuppose a relational interpretation of continuity. A second interpretation of continuity focuses on 'regular contact'. On this meaning, continuity is the capacity of the general practitioner to be available and accessible to his or her patients, with the exact details of availability and accessibility determined by the patient's circumstances, the urgency and nature of the problem, and whether the patient seeks help in- or out-of-hours. For example, the RACGP's draft entry standards for general practice accreditation includes the provision of continuity of care.[32] These draft standards relate not to individual general practitioners, but to the practices they work in. Fifteen draft standards describe the services required if a general practice is to meet the RACGP's minimum standards for service provision. Each standard is stated in terms of essential and desirable criteria, and each criterion is followed by a number of indicators against which compliance with the standard is measured. Continuity of care is expressed as "the practice makes all reasonable provisions for continuity of care". The criteria used to assess whether the continuity standard is being met give a clear indication of what the RACGP means in this instance by continuity of care. In order to demonstrate that it provides continuity, a practice must show that:

> it is available and accessible (for example, by ensuring that practice patients are normally able to obtain a consultation within two working days for non-urgent matters); ...
> it has developed agreed approaches within the practice on diagnosis and management; ...
> it has adequate medical records; ...
> it acts as a co-ordinator of care within the health system (for example, by demonstrating its knowledge of and interaction with a range of health professionals and community services in its area);...
> it employs health promotion and risk reduction strategies (for example, by providing

[31] For a discussion of this issue, see King C, Edwards J & Hicks N. 1991 'Good' general practice in Australia: The state of the art as seen through the *Australian Family Physician*. Unpublished manuscript, Department of Community Medicine, University of Adelaide.

[32] Royal Australian College of General Practitioners. 1993/4 *Entry Standards for General Practice Accreditation: Draft Standards for Field Testing and Trials*. RACGP Standards Development Project. The *Entry Standards...* were prepared by a working party of the RACGP under a grant from the Commonwealth Government to develop standards for voluntary accreditation of general practice. The final version of the standards was published in 1996.
The Commonwealth Government independently introduced a version of accreditation with its *Better Practice Program* (*BPP*) in 1994. See Ward J, Del Mar C, Colmer P, & O'Connell D. 1996 Quality and outcomes in general practice. in Commonwealth Department of Health and Family Services. *General Practice in Australia 1996*. Australian Government Printing Service, 169-199, for a review of both the RACGP *Entry Standards* and the *BPP*.

opportunistic preventive care and early case detection).[33]

Some of these meanings of continuity are discussed later in the chapter under the headings of comprehensive and whole-person care. In this section, the focus is on availability and access.

A second example of the 'regular contact' meaning for continuity is found in the Commonwealth Department of Human Services and Health's Better Practice Program. In 1994, the Commonwealth Government introduced its own version of standards for general practice with an accreditation program called the Better Practice Program (BPP). The aim of the program was to diversify funding for general practice, by rewarding practices that provided "quality care" with a payment based on a number of eligibility criteria.[34] A measure of continuity was central to the program, and both the eligibility criteria and the formula for allocating the payment included components that focused on continuity of care. The BPP definition of continuity relates solely to access and availability. The three eligibility criteria were based on the RACGP standards, and one of them focused on continuity using versions of the criteria described above. The payment formula was based, in part, on a 'Patient Continuity Index' that measured the "extent to which patients attending a particular practice receive their general practice services from that practice versus all other practices".[35]

In principle, the relational and regular contact interpretations of continuity go hand in hand. General practitioners who are available and accessible to their patients and who see them regularly are in a better position to pursue and form stable and trusting relationships. Murtagh's "strategies to enhance continuing care" hinge on this link between access and availability, on the one hand, and relationship building, on the other.[36] For him, availability is one of the *attitudes* held by the good general

[33] RACGP, *Entry Standards...*, 15 *et passim.*
[34] Commonwealth Department of Human Services and Health. 1994 *Introducing the Better Practice Program: Information Kit and Application Form.* 1.2.
[35] Commonwealth Department of Human Services and Health, *Introducing the Better Practice Program...*, 4.2.
[36] Murtagh, *General Practice...*, 4-5.

practitioner, and he groups it with being competent, caring, responsible, and trusted. One of the key ways in which Murtagh demonstrates his availability is through the home visit, which is a "goldmine of information about intrafamily dynamics".[37] He even suggests making "impromptu family visits" to evaluate the family dynamics.[38]

In reality, however, the fact that the relational interpretation is usually applied to individual general practitioners, whereas regular contact interpretations are related to the practice in which general practitioners work, points to significant problems with attempts to bring the two interpretations together. The general practitioner is in the best position to establish a trusting and stable relationship with patients if he or she is in regular and continuing contact with patients and if patients know their personal doctor can be contacted when needed. The relational interpretation of continuity makes most sense in the context of solo practice where one general practitioner is always the point of contact.[39] Most general practitioners in Australia, however, do not work in solo practice: across all surveys, less than one third of all general practices in Australia are solo practices.[40] In addition, the proportion of general practitioners in part time practice is rising, as the proportion of general practitioners who are female rises, and part time practitioners are relatively less able to be available and accessible to their patients.[41] These factors paint a picture of general practice that suggests that the relational version of continuity, which implies a relationship between one doctor and one patient in which

[37] Murtagh, *General Practice...*, 4.
[38] Murtagh, *General Practice...*, 10.
[39] Mc Whinney, *A Textbook of Family Medicine...*, 16-8, proposes that the general practitioner deal with the likely conflict between endless demands on his or her time and a "satisfactory personal and family life" by sharing on call arrangements with a small number of colleagues, or by retaining sole responsibility for the small number of patients who are seriously ill or in special need and using a deputising service for other patients.
[40] See Bridges-Webb C *et al.* 1992 Morbidity and treatment in general practice in Australia 1990-1991. *Medical Journal of Australia* 157: Supplement S14. Bridges-Webb's findings show that in 1990-1, 26% of general practitioners were in solo practice. Young D & Liaw T. 1996 The organisation of general practice. in Commonwealth Department of Health and Family Services. *General Practice in Australia 1996*. Australian Government Printing Service, 111, suggest that there is general agreement that about 30% of general practices are solo. In South Australia in 1988, 28% of general practitioners were solo practitioners (SAHC, AMA(SA) & RACGP(SA), *Review of General Medical Practice in South Australia...*, 10).
[41] Dickinson *et al*, The supply and distribution of general practitioners..., 61. It is difficult to establish how many general practitioners individual patients consult. Health Insurance Commission data for 1989-90 suggests that 42% of patients who consulted a general practitioner at least once per year had received all their general practice care from one general practitioner (National Health Strategy, *The Future of General Practice...*, 37-8). See also Veale, Consumer use of multiple general practitioners...

the general practitioner provides all aspects of care, is perhaps a disappearing dream.

If we choose to focus on the provision of continuity of care by practices rather by individual practitioners, how well does general practice in Australia measure up? There is relatively little data available with which to answer this question. If the BPP is used as an indicator of practices that are providing an acceptable level of accessibility and availability - an appropriate level of regular contact - then at least 40% of practices met the BPP standards in 1997.[42] (Of course, the figure is probably higher for all general practices in Australia, since not all eligible practices applied for a BPP grant.) There is slightly more information available about the choices patients make. The Australian system allows patients complete freedom of choice in choosing a doctor, and there is anecdotal evidence that patients tend to shop around between practices, depending on their needs. There is a perception that patients visit 24-hour clinics (very large group general practices which offer services around the clock and tend to bulk-bill all patients) with simple problems, particularly out-of-hours, and that they visit their 'regular' general practitioner with complex and serious problems. The 24-hour clinics' popularity out-of-hours probably relates to the fact that general practitioners in smaller practices are less accessible at these times.[43] A 1990 study found that, while 96% of patients claimed to have a regular doctor, up to 20% had visited another general practitioner from a different practice during the year.[44] Data from the BPP suggests that, on average, each general practice provides about only two thirds of the general practice services which its regular patients receive each year.[45] On this evidence, it seems that there is a reasonable, but not exemplary, level of continuity (defined as access, availability and regular contact) when the variable being measured is practices, rather than practitioners.

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[42] Admittedly, this takes us out of the period I have selected for review, but earlier information about take-up of BPP grants reflects the start-up period for any new program.
[43] National Health Strategy, *The Future of General Practice...*, 37-8.
[44] Lloyd P, Lupton D & Donaldson C. 1991 Consumers in the health care setting: an exploratory study of factors underlying the selection and evaluation of primary medical services. *Australian Journal of Public Health* 15: 194-201, quoted in National Health Strategy, *The Future of General Practice...*, 37.
[45] Young & Liaw, The organisation of general practice..., 110. This figure probably over-estimates the commitment of patients to one practice, for it is based on practices that applied for BPP money. Practices which were unlikely to meet the BPP continuity criteria would not apply for funds in the first place. The BPP now represents about 40% of practices in Australia, and larger practices have been quicker to embrace the program than smaller and solo practices (personal communication, J Beilby, Senior Lecturer, Department of General Practice, University of Adelaide).

In summary, continuity is central to the altruistic professional model of general practice care. Its interpretation, however, takes at least two forms – a relational meaning and a regular contact meaning. The links between the two meanings are strongest when an individual general practitioner provides all the services his or her patients receive. Yet, this model of patient care seems to be practised by relatively few general practitioners. Even when the provider of continuity is a practice, rather than an individual practitioner, continuity seems to be one of those values which is stronger in rhetoric than in reality.

5.3.3 Comprehensive care

The third aspect in the altruistic professional model of general practice is the provision of *comprehensive care*. Comprehensive care relates to the fact that general practitioners are generalists: they deal with all people and all problems brought to them. For Roger Strasser, a senior general practitioner and professor of general practice, comprehensive care means that general practitioners see "unselected patients with undifferentiated and unorganised problems", reflecting a "community spectrum of unwellness".[46] Both serious and minor, often self-limiting, problems are brought to general practitioners, and the way in which they sort these problems can contribute significantly to the course of an illness.

The Australian Treatment and Morbidity Survey (ATMS) provides the best source of data about the nature of problems patients bring to their general practitioner.[47] The ATMS in 1990-1 indicated that general practitioners routinely see and treat a very large variety of medical conditions. Overall, in this survey there were 149 reasons given for every 100 encounters, although most patients (62%) mentioned only one problem. Most reasons for an encounter were expressed in terms of symptoms, and when these symptoms were grouped together, the most common presenting complaints were respiratory (12%), musculoskeletal (11%) and general symptoms (6%).

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[46] Strasser, General Practice – what is it?..., 533.
[47] Bridges-Webb, Morbidity and treatment in general practice in Australia..., S23-S27.

The distribution of problems that the general practitioners in the ATMS managed was slightly different from the problems with which patients presented. The two most frequently managed individual problems were hypertension (6.4%) and upper respiratory tract infections (4.8%). They were followed by asthma, osteoarthritis, acute bronchitis, and immunisation (all between 2.2 and 2.5%), and anxiety, sprain/strain, other arthritis, depression and contact dermatitis (all between 1.4 and 1.7%).

How do general practitioners deal with the problems with which patients present? In 64% of encounters, general practitioners in the ATMS offered a prescription (and in three-quarters of these encounters, or 48% of all encounters, they offered no other treatment).[48] In consultations in which other treatments were offered, 25% of these treatments concerned therapeutic procedures carried out by general practitioners (such as bandages, dressings or removal of ear wax), 12% concerned another procedure (such as advising rest or exercise), and 63% involved counselling or advice (for example, about treatment or nutrition). No treatment at all was offered in 19% of encounters.[49]

General practitioners also carry out a number of other activities to assist them in managing the problems their patients bring. Pathology tests were ordered in 13% of encounters and X-rays ordered in 6% of encounters reported in the ATMS. At least one test was ordered in 18% of all encounters.[50]

[48] Bridges-Webb, Morbidity and treatment in general practice in Australia..., S33. This is a similar figure to that available from 1993 data from the Pharmaceutical Benefits Program, which documented a prescription rate of 65 prescriptions per 100 general practice Medicare services. See Pegram R, Calcino G & O'Connell D. 1996 General practitioner service characteristics. in Commonwealth Department of Health and Family Services. *General Practice in Australia 1996.* Australian Government Printing Service, 92.
[49] Bridges-Webb, Morbidity and treatment in general practice in Australia..., S42-S43.
[50] Bridges-Webb, Morbidity and treatment in general practice in Australia..., S46-S49. Information on tests and investigations ordered is also presented in: Pegram, Calcino & O'Connell, General practitioner service characteristics..., 83-88. This data, for the June 1995 quarter, is from the Health Insurance Commission, but it is not directly comparable, since it presents data as tests per 100 general practitioner patient contacts. Where direct comparisons can be made (for particular types of tests and investigations), general practitioners taking part in the ATMS appeared to order less tests and investigations than all general practitioners, as measured by Health Insurance Commission data. This may be because there has been a steady increase in tests and investigations ordered through general practice over the last ten years. (The number of imaging services ordered through general practice increased by about 60% between

In addition to their direct service provision role, general practitioners fulfil an important role as gatekeepers to other services. In Australia, patients can only consult specialist medical practitioners if they have a referral from a medical practitioner. General practitioners are the main source of these referrals. In the ATMS, 6.5% of patients were referred by general practitioners to a specialist and 2.1% of patients were referred to another health professional (half of these to physiotherapists).[51] The RACGP Interpractice Comparison Survey in 1995 recorded similar figures, with general practitioners referring patients to specialists in 5.3% of encounters, principally to surgeons, physicians or physiotherapists.[52]

The RACGP's draft *Entry Standards* emphasise this gate-keeping and coordination role of the general practitioner. They recognise the importance of the referral role of general practitioners, expecting that a practice which meets the minimum standards for service provision will ensure that its doctors "can describe a variety of local medical services such as diagnostic services, hospitals and consultant services...[and] local allied health services" and report the practical procedures followed for referral.[53] The *Entry Standards*, however, go further than this. They also suggest that general practitioners should be able to "describe a variety of local community, social and other health services" and their interaction with these services.[54] According to the draft standards, the general practitioner has a central role to play as a coordinator and integrator of health services for his or her patients.

The coordination role in a community setting is not as easy as it appears, for many aspects of general practice culture and work militate against it. First, traditional hospital-based training has not prepared general practitioners to practise in community settings. The first report of the South Australian General Practice Education Task Force

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1984-5 and 1994-5.)

[51] Bridges-Webb, Morbidity and treatment in general practice in Australia..., S44-S46. Patients do not require a referral to consult a physiotherapist in Australia.

[52] RACGP Interpractice Comparison Survey, quoted in RACGP, *Entry Standards...*, 15 *et passim*. See also Pegram, Calcino & O'Connell, General practitioner service characteristics..., 97.

[53] RACGP, *Entry Standards...*, 17-8.

[54] RACGP, *Entry Standards...*, 17.

(a follow-on from the *Review of General Medical Practice*) notes that many of the illnesses that general practitioners encounter are rare in the public hospitals in which medical students train. Patients request help for problems which formerly were not a "common part of general practice", for example in nutrition, health screening, and alternative health practices.[55] The changing demography of the population is also affecting the work of general practitioners, with larger numbers of older people presenting with multiple problems "embedded in wider domestic and social issues".[56] The advent of graduate general practice training has gone some way toward developing a community base for general practice, because it complements hospital placements for registrars with placements in accredited general practices. However, it places registrars only in practices and organisations that provide medical service experience, and such organisations do not routinely deal with the "wider domestic and social issues". Even if the training program could offer this experience, many general practitioners now working have not been part of that training scheme.

Continuing medical education for general practitioners has also mirrored the medical and hospital focus of undergraduate and graduate training. The first report of the South Australian General Practice Education Task Force included a compilation of continuing medical education activities over 12 months from September 1989 to September 1990.[57] The metropolitan, principally tertiary level, hospitals were significant providers of continuing education seminars, courses and programs for general practitioners during this period. It must be noted that the overall coordination of continuing medical education rests with the RACGP and that many of these programs would have had a strong community focus. Even so, programs related to wider issues that the General Practice Education Task Force had identified – for example, nutrition, health screening, alternative health practices, social and domestic issues – were conspicuously absent from this list.

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[55] General Practice Education Task Force. 1992 *Report on the First Term of Reference.* South Australian Health Commission, 2-4.
[56] General Practice Education Task Force, *Report on the First Term of Reference...*, 3.
[57] General Practice Education Task Force, *Report on the First Term of Reference...*, Appendix C, 40-47.

Second, the payment structure for general practice tends to isolate general practitioners from the rest of the health system, not to integrate them into it. [58] General practitioners are funded to provide a set of discrete services, not to co-ordinate care across a continuum and with a range of service providers. There is no funding provided to support general practitioners' consultation with other health services providers. In addition, the fee-for-service payment system does not encourage general practitioners to refer patients on, particularly to services that are outside the traditional health care system and unlikely to send the patients back. The 1988 first report of the *Review of General Medical Practice in South Australia* clearly documented this fact, reporting the defensiveness and worry that general practitioners felt with respect to non-medical service providers.[59]

Third, considerable concern has been expressed about 'deskilling' in general practice. The increasing specialisation of medical work has resulted in many general practitioners having a reduced scope of work. There has been a substantial decline in general practice participation in procedural work in obstetrics and elective surgery over the past twenty years, and the development of disciplines such as geriatrics and palliative care has tended to push general practitioners out of these areas.[60] Skill deficiencies in these areas have meant that, in many cases, the referral role, rather than being an aspect of the general practitioner's wider role as a provider of comprehensive care, has signified instead a decline in general practitioners' skills.

In summary, then, comprehensive care, in theory, means that general practitioners treat all problems that all patients bring to them. There is clearly evidence that general practitioners are presented with and manage a wide range of medical problems.

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[58] The role of the General Practice Strategy in enhancing the general practitioner's coordination functions is discussed at the end of this chapter.
[59] SAHC, AMA (SA) & RACGP (SA), *Review of General Medical Practice in South Australia...*, 63 *et passim.* See also National Health Strategy, *The Future of General Practice...*, 38-9.
[60] National Health Strategy, *The Future of General Practice...*, 35-6. See also Bridges-Webb C. 1996 General practice in Australia from 1788 to 1990: a personal commentary. in Commonwealth Department of Health and Family Services. *General Practice in Australia 1996.* Australian Government Printing Service, 4-7, 12-14; and SAHC, AMA (SA) & RACGP (SA), *Review of General Medical Practice in*

However, their ability to provide truly comprehensive care has been undermined by their education (undergraduate, graduate and continuing), by the fee-for-service payment system in which general practitioners work, which discourages coordination with other service providers, and by the hospital-based system in which they train. The deskilling of general practitioners has also limited their role as providers of comprehensive care.

5.3.4 Whole-person care

The fourth element in the altruistic professional model of general practice is the provision of *whole-person* or *whole-patient care*.[61] Care of the 'whole person' clearly overlaps with provision of comprehensive care but, in the general practice literature, the term usually relates to the use of a 'patient-centred' approach. A patient-centred approach expresses the general practitioner's commitment to understand the patient's perception of his or her illness, drawing on an understanding of relevant physical, psychological, family and social factors.[62]

Whole-person care bears some similarities to the model of general practice proposed by Balint. Like Balintism, whole-person care encourages the general practitioner to treat the presenting illness as one aspect of problems in the patient's life. Indeed, Pietroni, a leader in the holistic care movement, suggests that Balint himself would probably not have joined the British Holistic Medicine Association, but he would certainly have been sympathetic to its aims.[63]

Murtagh devotes a chapter in *General Practice* to explicating the nature of the "whole person approach to management".[64] He suggests that it has two elements – a disease-centred focus and a patient-centred focus. The disease-centred focus uses the

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South Australia...

[61] These two terms are used interchangeably in the literature.

[62] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force*..., 8, quoting from the RACGP. 1977 Occasional Paper 4 'A system of training for general practice'.

[63] Pietroni P. 1986 Would Balint have joined the British Holistic Medicine Association? *Journal of the Royal College of General Practitioners* 36: 171-3. See also Toon, *What is Good General Practice?...*

[64] Murtagh, *General Practice*..., 71-76.

traditional medical approach to take a history, examine the patient and order any special investigations, with the aim of making a diagnosis and treating the disease. A patient-centred focus includes the "psychosocial hallmarks" of the patient, and the general practitioner using this approach inquires about the patient's emotional reaction to the illness, and the effect on family and relationships, on work and income, and on the patient's psychological state, attitudes and spirituality.

According to Murtagh, management of the patient and his or her condition needs to take into account both the disease- and patient-centred approaches. The general practitioner operates under the disease-centred approach when he advises rest, drugs, intervention, surgery or other invasive techniques. He uses the patient-centred approach when he provides psychological support, reassurance, and education; encourages self-responsibility; offers anticipatory guidance and health promotion advice; recommends changes to lifestyle; and investigates support through family and friends, self-help groups, and alternative therapies. A patient-centred general practitioner also takes the time to ensure that the patient is followed up in appropriate ways.

The RACGP Knowledge, Skills and Attitudes Task Force notes that a corollary of taking a 'whole-person' approach to care is that the general practitioner will acquire and use a wide range of skills in his or her work.[65] These skills will not be limited to clinical, procedural and technical skills; in addition, they will focus particularly on the development of skills in:

- communication - active listening, collecting information, exploring concerns and expectations, giving information, explanation and advice, communicating with special groups, telephone and written communication;
- patient management - in explaining, educating, sharing a management plan, the implications for families, workplace and community, advocating for the patient, brief counselling to provide reassurance and support, specific counselling in smoking cessation, lifestyle and stress, opportunistic prevention

[65] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force…*, 15-19.

and health promotion, referrals;

- education - "'bringing about learning'" in patients.[66]

To what extent are general practitioners able to provide care for the whole person as described above? The RACGP's 1985 survey of general practitioners' views about their work and their future found that almost 100% of general practitioners (both the RACGP member and non-member expert panels) believed that "quality general practitioner care requires a doctor who can diagnose and manage the emotional or social problems of patients as well as their physical ailments".[67] Nearly two-thirds of general practitioners surveyed in New South Wales in 1987 "strongly agreed" that recognising and treating emotional and psychological problems was central to their role.[68]

Some general practitioners clearly see the provision of a number of services related to whole person care as part of their role as a general practitioner. However, evidence from other studies shows that not all general practitioners think this way. The 1988 survey of general practitioners in South Australia asked the same questions of South Australian general practitioners as had been asked of their New South Wales counterparts. Only one third of South Australian doctors strongly agreed that the recognition and treatment of emotional and psychological problems was important in their work.[69] The South Australian general practitioners also went against the grain with their views about the sort of work that they should be doing in the future. They were asked which services they currently provided and which services they thought they should provide in the future. The doctors responded that more procedural services, including medical hypnosis, obstetrics, anaesthesia and surgery, should be provided, while less services should be provided in management of common illnesses, continuing care of chronic illness, well baby checks, marital counselling, preventive health care and

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[66] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force...*, 15-17.
[67] RACGP, *The Vision of General Practice...*, 13.
[68] Cockburn J. *et al* 1987 Measuring general practitioners' attitudes towards medical care. *Family Practice* 4: 192-99, quoted in SAHC, AMA(SA) & RACGP(SA), *Review of General Medical Practice in South Australia...*, 45.
[69] SAHC, AMA(SA) & RACGP(SA), *Review of General Medical Practice in South Australia...*, 47-48.

family planning.[70]

A recent qualitative study of general practitioners' attitudes towards health promotion for older people reveals a similar ambivalence about taking responsibility for care of the whole person.[71] The general practitioners who took part in focus groups expressed a range of attitudes toward health promotion, from the abstract concept ("all good medical care is health promotion"), to a broad concept ("a broad range of activities"), to a concrete concept ("specific preventive activities"). Their attitudes to particular health promotion strategies were also diverse. While some general practitioners were positive about new resources, many were cautious, because of the likely impact on their workload. A small proportion was resistant to all strategies offered. Generally, the strategies for changing general practitioners' behaviour that the focus group participants favoured were those which had been shown to be least effective in trials of continuing medical education! (The more successful strategies, when the outcome measured is a change in attitude and/or behaviour, are things such as information sessions with general practitioners in their surgeries, and these strategies take up consulting time.)

As with the provision of comprehensive care, a number of organisational aspects of general practice work make it difficult for general practitioners to practise 'whole-person' care. First, 'whole-person' care often requires time, and the Medicare Benefits Schedule (MBS) discourages longer consults. The MBS recognises a wide range of medical services that can be provided by general practitioners. Eighty percent of the services general practitioners provide, however, are 'level B' items, which involve a "selective history, examination and implementation of a management plan for one or

[70] SAHC, AMA(SA) & RACGP(SA), *Review of General Medical Practice in South Australia...*, 43-44. The report suggests that some caution needs to be used in interpreting these results, because of the way the questions were worded. It uses the familiar comment "more research is clearly required", perhaps to cover an embarrassing finding.

[71] Kerse NM, Murphy MJ, Flicker L & Young D. 1997 Health promotion and older people: a qualitative study of general practitioners' views. *Medical Journal of Australia* 167: 423-427. Again, this study is outside my 1985-1993 period. One of the aims of the development of alternative funding models through the General Practice Strategy has been to increase general practitioners' receptiveness to health promotion. If anything, the findings of this study should represent a more positive view of this aspect of whole-person care than would have been the case four years earlier.

more problems or service of less than 20 minutes involving components of level C or level D".[72] 'Level C' items account for a further almost 7% of service items, and they involve a "detailed history, multiple system examination, arranging investigations and implementing a management plan for one or more problems, all of this lasting at least 20 minutes or service of less than 40 minutes involving components of level D service".[73] Of all of the services general practitioners provide, level B consults provide doctors with the best money for effort, as Table 1 shows. Anecdotally, it is known that most general practitioners capitalise on this by booking patients at 10- or 15-minute intervals. There is also evidence from the RACGP Interpractice Comparison Survey in 1995 that the median time general practitioners in that survey spent with patients was 17 minutes.[74] The RACGP Draft *Entry Standards* (and the Better Practice Program criteria) enshrine this booking pattern, by suggesting that practices that meet the minimum standards will have an "*average*" consultation time of "not less than 10 minutes".[75]

TABLE 1

TIME AND CONTENT BASED FEE SCHEDULE 1995

Type of Service	Description	Fee
Level A	Obvious problem requiring short history, possible examination and management.	$11.50
Level B	Selective history, examination and implementation of a management plan for one or more problems or service of less than 20 minutes involving components of level C or level D.	$24.30
Level C	Detailed history, multiple system examination, arranging investigations and implementing a management plan for one or more problems, all of this lasting at least 20 minutes or service of less than 40 minutes involving components of level D service.	$43.85
Level D	Exhaustive history, comprehensive examination of multiple systems, arranging investigations and implementing management of one or more complex problems.	$64.60

[72] Pegram, Calcino & O'Connell, General practitioner service characteristics..., 67-74. The source of data is an analysis of Medicare benefit claims for June 1995 quarter.
[73] Home visits account for 3% of services, and 'level A' consultations – an "obvious problem requiring short history, possible examination and management" – for 2%.
[74] Quoted in Butler, The financing of general practice..., 160.
[75] RACGP, *Entry Standards...*, 9, criterion 1.2.2, italics in original.

The tendency for the MBS to promote '10-minute' medicine means that aspects of care which might require longer than this are discouraged. For example, opportunistic health promotion requires a general practitioner to take the time to explain risk factors for diseases like cancer and heart disease, and to develop strategies with patients that they can use to change their behaviour. These sorts of activities take more time than a 10-minute consultation, initiated for other reasons, allows.[76] On a broader level, whole-person care, if it is to be 'patient-centred', requires that the general practitioner listen carefully to patients' stories, explore the concerns patients have about their problems, explain and advise clearly, and probe sensitively, perhaps to discover that 'hidden problem' that a patient really wants to talk about, but has not had the courage to mention.[77] These behaviours are central to being patient-centred, and they are just about impossible in a 10-minute consultation.

The way in which general practitioners are funded also means that other activities that might enhance whole-person care are not facilitated. For example, general practitioners who have recall systems to monitor patients fund the development and maintenance of these systems from their practice takings. Unless such systems actually deliver more patients to the door, there is no financial benefit in having a recall system, and little incentive for the general practitioner to provide it. Similarly, as mentioned above, whole-person care may require that the general practitioner be familiar with care provided by other health service providers. Again, there is no funding mechanism under the MBS to pay general practitioners to talk with other health professionals and attend case conferences about their patients.

In summary, the altruistic professional model includes a focus on whole-person care, incorporating the patient's needs, wishes and understanding into the consultation, and providing care which acknowledges the physical, social, psychological and spiritual

[76] See National Health Strategy, *The Future of General Practice...*, 29-30.
[77] Balint-type approaches extend this further to include the 'hidden problem' which patients do not yet recognise themselves.

aspects of a patient's life. The fee-for-service funding and the specific arrangement of the Medical Benefits Schedule, militate against the provision of care in this fashion.

5.3.5 Care for individuals, families and their community

The final aspect of the altruistic professional model of general practice focuses on care for individuals, families and their community. Some definitions refer to "individuals, families and their communities", others to "individuals, families, and the community". The definition quoted at the beginning of *General Practice in Australia 1996* uses the latter version, perhaps because it is reinterpreting the more traditional definition in the light of recent developments. The original RACGP document uses "their community" and I have stuck to this version as it reflects more accurately the context in which general practitioners engage with communities, which is primarily through their interaction with individual patients.

The notion of providing care to individuals is clear enough, and requires little further comment. It has been assumed in the material described and discussed above. The notion of care for the family is more complicated, and that of care for communities more difficult still. This section takes each in turn, although, as with the other aspects of this definition, they should not be seen as being completely independent of each other.

5.3.5.1 Care for families

The idea of caring for families has a long tradition in general practice in Australia. The RACGP renamed its journal the *Australian Family Physician* in 1972, and the post-graduate training program for general practice, when it was established in 1974, was called the Family Medicine Program. In the Unites States, family medicine was formally established in 1969 when the American Board of Family Physicians was authorised as the body to certify family physicians.[78] Stephens, a professor of family

[78] A set of papers discussing the development and current state of family medicine was published in *Marriage and Family Review*, volume 10, in 1987, and then repackaged as Doherty WJ, Christianson CE & Sussman MB. (eds.) 1987 *Family Medicine: The Maturing of a Discipline*. Haworth Press. The reader

practice, a self-confessed "insider", notes that the meaning of the 'family' in family practice was contested and unclear from the early stages of the discipline.[79] She suggests that the term, "the family as the unit of care", gained currency, and was adopted by the 'family medicine' arm of the family practice movement. Stephens does not state clearly what alternative meaning for family was available, but she implies that it related more to the care of individuals, in the context of, or with an understanding of, that person's family background – the notion of an 'individual-in-a-family'.[80]

The Australian professional literature has a similarly mixed approach to the meaning of family. Murtagh has both interpretations of family in his text. He includes a chapter on "The family" which contains a discussion of the nature of family therapy, the characteristics of healthy families, presentations of family dysfunction, evaluating family dynamics, family-based medical counselling, marital disharmony and basic counselling for couples. Most of this chapter is about treating families, whether in a crisis precipitated by illness or because of marital problems. Here Murtagh clearly thinks that the family is the unit of care. However, he also includes material on counselling individuals which addresses the way in which family dynamics and support can impact on the patient – for example, questions like 'how do you feel about your home life?'.[81] This approach relates more to the idea of treating the individual in a family context.

McWhinney suggests that there are five levels of physician involvement with

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is referred to these papers for an essentially insiders' account of the establishment and status of the discipline.

[79] Stephens GG. 1987 Developmental assessment of family practice: An insider's view. In Doherty WJ, Christianson CE & Sussman MB. (eds.) *Family Medicine: The Maturing of a Discipline.* Haworth Press, 1-21.

[80] Hoffmaster B & Weston W. 1987 The patient in the family and the family in the patient. *Theoretical Medicine* 8:321-332 also note two similar interpretations of 'care for families', describing them as "treating the family in the patient and treating the patient in the family. The former concentrates on the individual and the manner in which early experiences in the family of origin influence psychological development and recognizes that unresolved issues can be played out through relationships with other family members or caregivers or manifested in physical symptoms. The latter emphasizes that successful management of a patient's problem requires the involvement of the whole family" (322). See also King, Edwards & Hicks, 'Good' general practice in Australia... King *et al* make the same point about how the family was portrayed in the *Australian Family Physician*, noting the presence of two strands, one focused on individuals-in-families and the other on the family *per se.*

[81] Murtagh, *General Practice...*, 9-14.

families.[82] At one end of the spectrum there is minimal involvement, at the other family therapy. In family therapy:

> the physician can carry out a planned course of therapy for a dysfunctional family. He or she requires the insight and skill to intervene in such a way as to change how the family functions.[83]

In between these extremes, the family physician may involve families in a collaborative way, but without any special knowledge of family development or dynamics. At the next level, the physician will add to the collaborative approach a knowledge of family development and of how families respond to stress. At the fourth level, the family physician will complement his or her care for a family with a formal assessment of family function and the development of a plan to assist a family to address its problems. McWhinney notes that few family physicians function at the family therapist end of the spectrum. Most content themselves with working in an informal way with individuals in families, and bringing members of a family together for discussion where possible.

It is important not to make too much of Murtagh and McWhinney's views about the notion that the family is the unit of care in general practice. The RACGP between 1985 and 1993 is almost silent on what family means in the provision of general practice care. Its paper on the knowledge, standards and attitudes required for general practice mentions the need for general practitioners to "include and integrate" family factors into their consideration of health and illness, which would imply an 'individual-in-a-family' interpretation. It also mentions the general practitioner's responsibility for health promotion with "their patients and their families", which might mean educating the family to support the individual (the individual-in-a-family interpretation again) or could mean working with the family as a unit to promote health.[84] The extent to which the College's draft *Entry Standards* mention the family at all is minimal; where they do, it is in the context of taking a "family history" or using family members as interpreters when there is a language barrier.[85] If these two mentions of family imply anything at all

[82] McWhinney, *A Textbook of Family Medicine*...deals in detail in chapter 10 with the meaning of family, the role of the family physician in providing care for families, and "the traumas of family life".
[83] McWhinney, *A Textbook of Family Medicine*..., 203.
[84] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force*..., 8.
[85] RACGP, *Entry Standards*...

about how the *Entry Standards* define family, it is an 'individual-in-a-family' interpretation. The RACGP's *The Vision of General Practice* mentions the family only once, and that is in the context of 'expert patient' views about the need for total patient care.[86]

There is also very little quantitative evidence that would support the notion that general practitioners in Australia provide the kind of care envisaged within Murtagh and McWhinney's strong versions of family-oriented care. There is an item in the Medical Benefits Schedule that general practitioners can claim for family therapy, but it is not in the top 25 services claimed, which account for 95% of all services claimed.[87] It could be argued that general practitioners doing family counselling need not bill this service as 'family therapy'. They would still be likely to bill it as a level D item, for it would require at least a 40-minute consultation. Even if all level D items were family therapy (an extremely unlikely situation), they would still account for only 0.6% of all services provided by recognised general practitioners.[88]

It is hardly surprising that general practitioners are not engaged in providing family counselling or family therapy, for their undergraduate training contains nothing in this area. Even graduate training in general practice has no emphasis on the particular skills needed to provide family therapy. In addition, those general practitioners who might set out to provide therapy for families are likely to find themselves defeated by the current fee schedule, which discourages long consults. This is not just a matter of less remuneration. Structuring one's work around a series of long consults may require the general practitioner to organise his or her time quite differently. For example, a predominance of long consultations can leave the general practitioner underemployed when an occasional patient does not turn up for an

[86] RACGP, *The Vision of General Practice...*, 12.
[87] Pegram, Calcino & O'Connell, General practitioner service characteristics..., 69.
[88] Level D items are expected to involve an "exhaustive history, comprehensive examination or multiple systems, arranging investigations and implementing management of one or more complex problems". They are also, because of the way level C items are defined, at least 40 minutes long. Pegram, Calcino & O'Connell, General practitioner service characteristics..., 67,73.

appointment.[89]

Notwithstanding the views of Murtagh and McWhinney, the RACGP literature suggests that the professional altruistic model of general practice probably leans toward a weaker notion of care for families, that of care for the 'individual-in-a-family'. That literature implies that focusing on the family is not a central aspect of the Australian general practitioner's work, beyond taking a "family history". At most, one could say that the notion that general practitioners would include a question or two about what is going on at home for patients, how the patient's spouse feels about an illness, and what family responsibilities the patient has, is, in principle, compatible with normal consulting routine. Anything more is clearly unlikely in the context of consultations that are about ten minutes long, on average.

5.3.5.2 Care for communities

The distinction made between the 'family-as-the-unit-of-care' and caring for the 'individual-in-the-family' applies just as well to caring for communities. One way to interpret the idea of caring for communities is to focus on the general practitioner's responsibilities to the community as a whole and, through this, to individual patients.[90] This notion of the 'community-as-the-unit-of-care' gets an occasional airing. The RACGP's *Vision of General Practice: Now and in 1995* reports that all expert panels – general practitioners and others – believed that by 1995 general practitioners would be much more involved in "the identification of community needs for health and medical services" and in "health care planning agencies".[91] The RACGP's draft *Entry Standards* pick up this emphasis in the standards relating to health promotion, defining one of the criteria for the provision of health promotion and disease prevention services as

[89] There is some evidence from a recent evaluation of a course in counselling for general practitioners that working in one-hour blocks can be difficult. General practitioners who took part in that course complained that when they allowed one-hour slots for counselling, they had to turn regular patients away. If the long-consult patients then cancelled, they were left frustrated and "drinking cups of coffee". Wittwer T, Braunack-Mayer, Moss JR, Hepworth J & Worsley T. 1998 *Upskilling in Counselling for GPs. Final Report for the Adelaide Hills Division of General Practice*, General Practice Branch, Department of Health and Human Services.
[90] This view of general practice is at the centre of Tudor Hart's "new kind of doctor".
[91] RACGP, *The Vision of General Practice...*, 8.

identification and cooperation with "recognised local health promotion and public health programs".[92]

Although the RACGP's expert panel survey in 1985 reported that general practitioners would be much more involved in health care at the community level by 1995, there was little evidence by 1993 to show that this had occurred. The joint RACGP, AMA and Commonwealth Government blueprint for reforms to general practice made it quite clear that general practitioners were not significant players in health care beyond the delivery of individual patient care:

> There is a realisation that general practitioners have become isolated, not only as individuals, but also as a group, excluded from involvement in many aspects of the health system, including hospital care of patients, teaching and research, and local or regional health planning.[93]

A major component of the General Practice Strategy has been directed toward finding ways to develop a role for general practitioners in community activities such as health decision-making at the local level, population health activities, regional planning, and the implementation of national goals and targets. The vehicle for this activity has been expected to be the Divisions of General Practice, locally based networks of general practitioners. The likely impact of Divisions on the nature and work of general practice is discussed at the end of the chapter. For now, it is enough to note that, in 1993, general practitioners did not really provide services geared to the community-as-the-unit-of-care. Again, the fee-for-service system has been at least partly responsible for this state of affairs. There has been no way to pay a general practitioner who wishes to sit on an area health board, give health education talks in the local school, or develop a community-wide health promotion project. General practitioners who take on these projects have been unpaid, and not compensated for practice income foregone while they are otherwise engaged. In addition, general practitioners who aspire to involve themselves in these community activities have few skills to offer that might them make

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[92] RACGP, *Entry Standards...*, 20, criterion 1.7.4. This criterion is, however, desirable, rather than essential.

[93] General Practice Consultative Committee, *The Future of General Practice...*, 5. See also National Health Strategy, *The Future of General Practice*; SAHC, AMA (SA) & RACGP (SA), *Review of General Medical Practice in South Australia..*; General Practice Education Task Force, *Report on the First Term of Reference...* They all document (and lament) the isolation of general practitioners from other aspects of the health system.

them welcome in community organisations. An educational background in medicine does not provide them with expertise in the management of area health boards or in the development of health promotion projects. Nor does it provide the skills they need to teach in a classroom.

What of the notion of care for the 'individual-in-the-community'? This focuses on the way in which the general practitioner's awareness of and consultation with health services and resources in the community can enhance the care he or she provides for individual patients. This is the co-ordination and integration role discussed under the headings of primary and comprehensive care above. It is a major heading in the RACGP *Entry Standards*, and the emphasis is clearly on the way in which communication, consultation and interaction with community health services improves patient care.

> General practices can help patients to make optimum use of the full range of health services available in the community. This requires well-developed channels of communication between general practices and other health workers, community health services and hospitals.[94]

However, as noted above, this role is limited by the fee-for-service structure of general practice and the lack of training general practitioners receive in working collaboratively with other health agencies.

In summary, the altruistic professional model of general practice includes a variety of expressions of the notions of care for the family and for communities. There is little evidence that general practitioners treat either the family or the community as the unit of care. In fact, the organisation of general practice and the educational background and experience of general practitioners make it difficult for them to provide care even for individuals-in-families or in-communities.

5.3.6 Summary

Section 5.3 has considered the characteristics of the altruistic professional model of general practice. At every turn, there is evidence that being the sort of general

[94] RACGP, *Entry Standards...*, 17-18.

practitioner this model prescribes is difficult, at least in part because of the organisational and financial structure of general practice in Australia. The next section brings together the components of this commentary on the work and organisational structure of general practice, to suggest that there is, lurking in the background, a second model of general practice. This model – the business model – is also important to an understanding of what general practice is and what it means to be a general practitioner.

5.4 THE BUSINESS MODEL OF GENERAL PRACTICE

The picture developed of general practice so far tells only part of the story. Not all of the literature about the nature of general practice refers to activities that can be subsumed under the altruistic professional model discussed thus far. Another side of general practice is revealed when we turn to a second model of general practice that is quoted in *General Practice in Australia 1996*. That model uses what is defined as a "structural, financial and organisational approach", which apparently "disregard[s] the nature of the discipline", and it defines a general practice as :

> A business unit owned and controlled by one or more GPs whose objective is the provision of general practice medical services to its surrounding community. A practice may be a self-contained unit or it may operate in association with another (ie share one or all of room, support staff and facilities for economic reasons) and it may employ other GPs and paramedical personnel on a full-time or part-time basis to fulfil its objectives.[95]

Young and Liaw's disclaimer suggests that the 'business model' and the structural, financial and organisational approach that fostered it have nothing to do with the "nature" of general practice. This section shows that such a view is misguided, because the general practice professional literature itself incorporates the business model of general practice into its discussion of the nature of general practice.

Before turning to primary sources in the professional literature, the picture of general practice work presented so far needs to be filled out. Some of the organisational, financial and structural aspects of general practice in Australia have

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[95] Knight & Northrop, Introduction: An overview of general practice in Australia 1996… , xxvi, and

already been discussed above. This section augments that discussion with a summary of who works in the business of general practice, how they are paid, and how they spend their time.

In 1994-5 there were approximately 24,000 non-specialist medical practitioners, amounting to 15,000 full-time equivalents, working in Australia. Over two thirds of this workforce was vocationally registered (that is, entitled to charge a higher rebate because they were certified as general practitioners), and they provided about 90% of all unreferred consultations. They worked in between 5,000 and 6,000 practices, with about 30% in solo practice, 35 to 40% in small groups of two to four general practitioners, and 30 to 35% in larger group practices.[96] The situation in South Australia in 1988 was broadly comparable. There were 1232 general practitioners resident in South Australia, of whom 28% were in solo practice, 13% in two person practices, and 58% in group practices of more than two. [97]

The practices in which general practitioners work have a range of financial structures. Young and Liaw report that, in 1993, 44% of all practices were incorporated, with a higher proportion of solo practices using this legal form. Group practices tended to be either partnerships (25% of small group practices and 49% of large group practices) or associateships (39% of small group practices and 29% of large group practices). Sixty-eight percent of practices employed a practice manager or accountant, with large group practices more likely to do this than solo or small group managers.[98]

The general practitioners who work in group practices are usually either partners or associates. Young and Liaw note that, in a survey of general practitioners in the Hunter region in New South Wales, 27% of general practitioners were in solo practice,

Young and Liaw, The organisation of general practice…, 109.

[96] See Young & Liaw, The organisation of general practice…, 110-112; Knight & Northrop, Introduction: An overview of general practice in Australia 1996… See also Hicks N. 1973 Some notes on the doctor "shortage". *Medical Journal of Australia* 2:393-6, for an account of the situation in the 1970s.

[97] SAHC, AMA(SA) & RACGP(SA), *Review of General Medical Practice in South Australia…*, 10-12.

[98] Young & Liaw, The organisation of general practice…, 119, quoting data from the RACGP 1993 Interpractice Comparison Survey. The difference between the partnership and associateship model relates to the ways in which costs and profits are shared out between practitioners.

52 % were partners or associates, 4% were employees with the intention or opportunity to become a partner, and 10% were employees.[99]

Nearly all general practices employ non-medical staff. Young and Liaw's review of the RACGP's Interpractice Comparison Surveys suggests that, in 1993, an average of 1.6 support staff (receptionists, nurses, officer managers, cleaners, etc) were employed by solo practitioners, and group practices employed an average of 1.1 staff per general practitioner.[100]

The principal form of payment for general practitioners is fee-for-service. As noted above, general practitioners are paid based on the number of services they deliver, and patients can recover most of that fee from the Health Insurance Commission. The rebate to patients is set at 85% of a schedule fee defined by the Commonwealth Government, but general practitioners are free to charge whatever they like. They can choose to charge only the 85% rebate, or 'bulk-bill' their patients, and in 1993-4, 77% of all general practice attendances were bulk-billed.[101] There is anecdotal evidence that many general practitioners, even if they do not routinely bulk-bill all patients, choose to bulk-bill all patients who are Pensioners or on Department of Social Security Benefits.[102]

General practitioners do not spend all of their time generating income through fee-for-service. They may carry out other activities that generate income, for example, by working on a sessional or salaried basis in public and private hospitals. The South Australian survey of general practitioners indicated that work of this nature contributed relatively little to general practitioner incomes; on average respondents spent 93% of their time in self-employment.[103] It is also important to note that there is much work done by general practitioners that does not create income in a direct way. The fee

[99] Young & Liaw, The organisation of general practice..., 117.
[100] Young & Liaw, The organisation of general practice..., 119.
[101] Butler , The financing of general practice..., 152. The proportion of all attendances bulk-billed has risen steadily over the last decade, from 52.5% in 1984-5 to 77% in 1993-4.
[102] Butler, The financing of general practice...,150. There is no quantitative evidence available on what proportion of general practitioners bulk-bill all patients or, for those who do not, on what proportion of their patients they do bulk-bill.
[103] SAHC, AMA(SA) & RACGP(SA), *Review of General Medical Practice in South Australia...*, 11.

schedule, as originally created, was designed to allow time for non-fee generating activities such as using surgery time to develop practice policies, communicating with staff, and undertaking continuing education. The evidence that is available suggests that general practitioners spend about 60% of their time engaged in direct consultations with patients.[104]

Estimating general practitioners' incomes is complicated. The Health Insurance Commission does not have data on non-Medicare funded services, and income derived from these sources is difficult to estimate.[105] Two surveys, however, give some indication of the likely size of general practitioners' incomes and the costs associated with running a general practice. The South Australian survey in 1988 asked general practitioners, among other things, for details of their gross and taxable incomes. Eighty-two percent of respondents answered these specific questions, and the 172 respondents who did not were not significantly different from their colleagues who did, in terms of average age, hours worked, proportion of time in self-employment and their assessment of a fair taxable income. The mean gross income for full-time general practitioners was $97,816, and the mean taxable income $44,430. Practice costs on average accounted for 50% of income.[106] The RACGP Interpractice Comparison survey in 1995 found that the median total fee income per medical practitioner was $181,775. Median practice costs were 53.8% of total fee income.[107]

The majority of general practitioners, then, are self-employed people who manage and provide services in a business that 'sells' general medical care, packaged up as discrete items of service. Yet, this model is complicated by the fact that, although general practice services are provided to individuals, the payment mechanism introduces another player in the form of government. This means that general

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[104] See Pegram, Calcino & O'Connell, General practitioner service characteristics..., 99-100.
[105] Butler, The financing of general practice...,156-7.
[106] SAHC, AMA(SA) & RACGP(SA), *Review of General Medical Practice in South Australia...*, 21-24.
[107] Butler, The financing of general practice..., 160-1. That is, the median taxable income in the RACGP Interpractice Comparison survey in 1995 was $97,794. By way of comparison, a senior lecturer in Australian academia had a taxable income of about $42,000 in 1988 and, including a promotion, about $68,000 in 1995.

practitioners are caught between two different ways of thinking about their services. A consultancy conducted for the RACGP in 1987-8 remarked upon this, noting that 'remuneration' was the term used by the RACGP to describe general practitioners' incomes, and suggesting that this term was not compatible with the ethos of general practice, for it:

> "normally impl[ies] income from paid employment; it is not a word normally applied to the situation of independent small businesspeople, who earn revenues and incur costs, with any surplus being their net income, and the reward they receive for risking capital.[108]

General practice fees are overwhelmingly 'rebate-driven'. The Commonwealth Government foots the bulk of the bill and, because it sets the rebate that patients can receive, to a large extent controls the fees general practitioners set. In reality, the only strategies open to general practitioners who wish to increase their income are providing more services, and attending to the other side of their business – the costs they incur in running a practice. They need to ensure that their practices are run efficiently. The business of general practice requires that general practitioners have skills in practice management and organisation.

Young and Liaw's comment in the introduction to this section suggests that an understanding of the business side of general practice, and the associated business skills, are not part of the general practitioner's core identity as a general practitioner. However, two of the RACGP documents that have been used in this chapter to develop the altruistic professional model of general practice also include material about the financial, organisational and structural side of general practice.[109] For example, when the RACGP undertook the field study reported in *The Vision of General Practice* in 1985, it wanted to determine "majority opinion from health care experts and the

[108] This RACGP document is dated June 30, 1988 and the quotation is found on page 2. In 1987 the RACGP had commissioned a consultant to report on the role of the RACGP in pursuing better remuneration for its members. Both the terms of reference, implicitly, and the report itself, explicitly, acknowledge the difficulties that the College, as a body concerned primarily with education and standards, faced in trying to develop a more industrial role. The fact that the report was commissioned at all and that, as far as I can establish, it has not been made public, indicate the direction in which College thinking was proceeding, and the sensitivity of the topic. For reasons of confidentiality, I am unable to cite this report. However, a copy is lodged with the Head of Department, Department of Public Health, University of Adelaide, and can be perused by examiners, if necessary.

[109] The RACGP, *Entry Standards...* are an exception. They include standards related to the business of general practice only in practice management standards, focused on quality of care in the practice.

community regarding the quality of care and how these standards should relate to the way general practitioners practise".[110] The survey included questions about primary care, preventive care, health promotion, and public health, patient education, coordination of community resources, the quality of general practice care, vocational training, continuing medical education, assessment of clinical competence, vocational registration, and record keeping, all issues in keeping with a focus on professional standards. In addition, the survey reported on a range of issues that related mainly to the financing and organisation of general practice. For example, the general practitioner expert panels thought that they would need enhanced business skills in the future; that Medicare was likely to have a negative effect on incomes; that the exclusion of health promotion and preventive care items from the Medical Benefits Schedule limited quality of care; that general practitioners should have the right to set or arrange a suitable fee with the patient; that increased government control over fees was undesirable; and that bulk-billing diminished the quality of care. Of the 51 graphs reporting professional opinions, 40 related to issues that fitted into the 'altruistic professional' model discussed above, and 11 related to business, organisational, structural and financial issues. All this appeared in a document about quality of care and standards in general practice, suggesting that, for the RACGP, the core identity of general practice does include issues related to the business of general practice.

The *Report of the Knowledge, Skills and Attitudes Task Force* also includes material that seems to reflect a business model of general practice. The report suggests that the general practitioner needs a broad range of skills, which can be viewed under three main headings: consulting skills, practice management skills, and educational skills.[111] Nineteen of the total 51 skills identified are practice management skills associated with the running of the business. They involve staff management, policy making (both for the practice and an understanding of government, organisation and institution policy), financial management, maintenance of record systems, and

[110] RACGP, *The Vision of General Practice...*, 2.
[111] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force...*, 15.

familiarity with information technology. The *Task Force* report does not consider the 'big picture' that *The Vision of General Practice* did; instead it focuses its attention on the skills that the general practitioner needs on a daily basis.

One other primary source document sits just outside the period of interest in this chapter, but provides other evidence that professional concerns in general practice incorporate an interest in practice organisation and management. *The Organisation of Family Practice* was prepared by the Practice Management Committee of the RACGP, and published in July 1984.[112] The foreword to this monograph, written by Richard Finch, President of the RACGP, places it in the same category as the "Textbook of Practical Obstetrics" to which Finch turned as a junior country general practitioner-obstetrician. He expects that beginning general practitioners will use it just as they used that obstetrics book: they will "full of anxiety and trepidation, consult it and then, emboldened, go forth and deal with the problem[s]".[113] *The Organisation of Family Practice* covers a wide range of issues related to establishing and maintaining a profitable and satisfying general practice: it includes what kind of practice and where for what kind of practitioner; the design of premises; staff selection and job descriptions; medical equipment and surgery furnishings; design, content and storage of medical records; the role of computers; office routines and booking patterns; practice accounting; how to manage practice finances (including credit arrangements, decisions about motor vehicles, and property investments); insurance and superannuation; practice organisational structures; relevant business and common law; continuing education and self-audit; relationships with patients, colleagues and staff; professional associations and community resources.

Most of the chapters in *The Organisation of Family Practice* are essentially about the practicalities of how to set up and run a general practice. They include detailed

[112] Royal Australian College of General Practitioners. 1984 *The Organisation of Family Practice: A Handbook for Students, Intending Entrants, Trainees and Established General Practitioners.* Prepared by the Practice Management Committee, RACGP.
[113] RACGP, *The Organisation of Family Practice...*, 2.

information that is quite specific to the needs of a general practice, but the general principles of personnel and organisational management could be applied to any small business. For example, the chapter on "office methods" provides guidelines on "appointment information", "telephone technique" and a "receptionist check list" all of which should be included in the practice manual. Chapter 16, on "getting on with patients, colleagues and staff", includes practical points on courtesy (get patients' names right), telephone manners ("The staff should have some formula that not only identifies the practice but includes some indication (however untrue) that the call is welcomed and the caller recognised") and on how to deal with delays politely and sensitively.

The summary to Chapter 16 indicates that *The Organisation of Family Practice* is not just a manual on how to establish and maintain a small business:

> For patients we are all human beings
> For staff we are all part of the same team
> For colleagues we are all doctors
> For paramedicals we are all professionals
> We all seek the same end. The effective care of the whole patient.[114]

This conclusion coheres with that small, but significant, part of *The Organisation of Family Practice* devoted to the consideration of what Finch describes as the "ethics and philosophy of general practice". He includes under this rubric sections encouraging general practitioners to maintain their skills with continuing education, advising the need for self-audit in general practice, and promoting the use of community resources. As with the other chapters, these sections are practical in nature, but they share much in common with material in other RACGP documents on the knowledge, skills and attitudes needed to be a good general practitioner. For example, the chapter on community resources lists where community resources might be found, what needs they can meet and how the general practitioner can access them, before describing briefly the likely content for a "Practice Directory" of community resources. The 'take-home' message from this chapter is:

> No matter how competent and caring a doctor you are, you can not always satisfy all of a patient's needs from your own resources. It is part of your responsibility to perceive needs and see that they are met. This can often only be done by good management of the available community resources.[115]

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[114] RACGP, *The Organisation of Family Practice...*, 72.
[115] RACGP, *The Organisation of Family Practice...*, 81.

What is important about these three documents is not that they discuss 'business' issues, but that they do it in the context of a discussion of professional standards, knowledge, skills and attitudes. They assume that being a general practitioner involves attention to both "primary, continuing, comprehensive whole-person care [for] individuals, families and their communities" *and* to the knowledge, skills and attitudes associated with the business management of general practice and with the structural, financial and organisational aspects of general practice work. It is difficult to escape concluding that a complete understanding of general practice and general practitioners draws both on an altruistic professional model of general practice, on the one hand, and the business of practice management in its structural, financial and organisational context, on the other.

These two models of general practice do not necessarily sit comfortably together. Being an altruistic professional and delivering "primary, continuing, comprehensive whole-person care" is often inconsistent with running a good business and it is also hard to sustain within the organisational framework of general practice in Australia. Yet, the professional literature presents general practitioners with both models of general practice. What evidence is there that general practitioners develop and maintain these models in their work?

Two pieces of work that I undertook with colleagues in the mid 1990s suggest that the 'altruistic professional' and 'business' models of general practice exist not only in the professional literature but also in the behaviour of practising general practitioners.[116] The report of a set of focus groups with general practitioners on the health issues for their local community provides one example of general practitioners' capacity to hold to

[116] I also accumulated a considerable amount of 'anecdotal' evidence in conversations with general practitioners while working as a research and support officer for Divisions of General Practice in South Australia. I occasionally asked carefully chosen general practitioners what they thought of the two models of general practice, and they seemed to agree that Australian general practice had elements of both. In retrospect I recognise that I should have kept good fieldnotes from these conversations. In the absence of such notes and the more formal research framework which generally accompanies them, I would describe the status of these conversations as less than that of formal fieldwork but more than mere anecdote.

both 'business' and 'altruistic professional' models of general practice at the same time. In 1994 one of the urban Divisions of General Practice in South Australia commissioned a needs analysis to identify health issues for their local community.[117] The views of local general practitioners were canvassed by involving them in ten focus group discussions, each involving up to ten doctors. The participating general practitioners interpreted 'health issues' in two quite distinct ways. A "patient-oriented" interpretation took 'health issues' to refer to the health needs of particular patient groups, the problems with which patients presented, and the availability and accessibility of health services for patients. A second "GP oriented" interpretation understood 'health issues' to refer primarily to the financial, political and practice management issues that doctors face in their work as general practitioners. Across the whole population of the groups, discussion was about equally balanced between the two themes.

The presence of the two models of general practice was also apparent in a consultancy conducted for the Commonwealth Government on the ethical and legal issues associated with funding Divisions of General Practice. The report of that consultancy also concluded that both altruistic professional and business models of general practice (or "health business" and "doctor business" in the terminology of that report) were apparent in consultations with general practitioners.[118]

Both pieces of work cited above were carried out after the introduction of the General Practice Strategy. It is appropriate now to consider whether that Strategy has been able (or is likely) to reduce the tension between the two models of general practice.

5.5 THE GENERAL PRACTICE STRATEGY

The fact that the business of general practice and its organisational, structural and

[117] Braunack-Mayer AJ & Hicks N. 1994 *Needs Assessment for the Adelaide Central and Eastern Division of General Practice*. General Practice Program, Department of Human Services and Health.
[118] Hicks N, Reynolds C & Braunack-Mayer A. 1996 *Ethical Issues Associated with Sources of Funding for Divisions of General Practice*. Prepared for the Divisions Strategy Group Ethics Committee, General Practice Branch, Department of Human Services and Health.

financial corollaries are, to some degree, inconsistent with the altruistic professional model of general practice is no startling revelation – many of the structural impediments to good general practice were recognised by the RACGP, AMA and Commonwealth Government in *The Future of General Practice*, although that document obviously does not describe the conflict between the two models of general practice as it has been described above. The General Practice Strategy was developed to address many of the problems that had been identified with general practice. This section speculates on the likelihood that aspects of this strategy will be successful in reducing the conflict between the formal definition of general practice and its business practice.

The General Practice Strategy was introduced in 1992-3. The annual budget for the program has grown from $110.9m in 1992-3 to $238.7m in 1995-6. Formally, the General Practice Strategy budget includes support, training and evaluation arrangements, of which the greatest beneficiary is the RACGP training program. The majority of the budget, however, goes to alternative general practice funding arrangements: in 1995-6 only $27.3m of the total $238.7m went to support, training and evaluation arrangements.[119]

One of the important initiatives in the strategy has been the establishment of Divisions of General Practice. Other important elements in the strategy have been the Better Practice Program and the Rural Incentives Program. In May 1997, the Better Practice Program involved about 40% of all general practices in Australia, whereas about 75% of all general practitioners were members of Divisions. The Rural Incentives Program is concerned with a wide range of rural health issues, including rural general practice. This section takes the Divisions arm of the General Practice Strategy as an example because its influence is probably the most widely spread at the moment.

Divisions of General Practice are geographically based organisations of general practitioners that aim to integrate general practice into the wider health system and to

[119] Knight & Northrop, Introduction: An overview of general practice in Australia 1996…, xxxi.

provide opportunities for general practitioners to be more involved in education, research and the delivery of health services which are not based on fee-for-service. The Government rationale for funding Divisions is that their existence will improve health outcomes for patients through enhancements to general practice. They are expected to achieve this in a range of ways:

- providing a mechanism for individuals and groups to contact local general practitioners and for general practitioners to respond as a group to local health issues;
- allowing general practitioners to be involved in health policy decision making at the local level;
- improving the quality of health service delivery at the local level in order to provide better access to available and appropriate health services;
- addressing issues to meet the special needs of groups such as Aboriginal and Torres Strait Islanders, people from non English speaking cultures and people with low incomes;
- facilitating the introduction of other elements of the general practice strategy e.g. accreditation, peer review and training initiatives;
- enhancing the quality of educational and professional development opportunities for general practitioners and undergraduates;
- improving the cost effectiveness of service delivery at the local level, thereby contributing to a more appropriate allocation of Commonwealth funding.[120]

Divisions are set up as incorporated associations or companies limited by guarantee. Each division has an elected board of management and a staff of between two and about 20. Characteristically, there is a part-time general practitioner Executive Director and non-general practitioner administrative and project staff from a wide range of backgrounds. Membership of the division is open to all general practitioners who work within the division's boundaries; market research conducted for the

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[120] Commonwealth Department of Human Services and Health. 1995/6 *Application for Projects (including*

Commonwealth Department of Human Services and Health at the end of 1995 indicated that, at that stage, 75% of general practitioners were members of Divisions.[121]

Divisions receive funding from the Commonwealth Government in two ways: an infrastructure grant which sustains the core functions of the division, and project grants which fund a wide range of activities including "health promotion, mental health, cardiovascular, co-operative projects involving GPs and allied health professionals, GP involvement in shared care programs, general practice liaison with local hospitals and hospices, and health care projects for people with chronic conditions such as diabetes and asthma".[122] In June 1996 there were 118 Divisions in Australia and expenditure on them under the Divisions and Projects Grants Program over the 1995-6 financial year had totalled $57.6m.[123]

To what extent will Divisions and the broader General Practice Strategy be able to bring about a rapprochement between the altruistic professional and the business models of general practice? Before attempting to answer this question, it is worth noting that the Divisions arm of the General Practice Strategy 'picks off' only certain aspects of the altruistic professional model of general practice. For example, the Divisions program focuses particularly on developing in Australian general practice a sense of responsibility for the health of the local community and its project and program orientation reflects this. It has been less concerned to enhance the capacity of general practitioners to be providers of holistic care or care for families. In other words, the program's model of general practice is closer to Tudor Hart's anticipatory care doctor than it is to Balint's hermeneutic model of general practice.[124]

Seeding Grants). Divisions and Project Grants Program, 1-2.

[121] Buckpitt J. (Head, Divisions and Projects Branch Program) 1996 Talk to Training Day for Field Support Staff, February 16, 1996, General Practice Program, Department of Human Services and Health.

[122] Commonwealth Department of Human Services and Health. 1995/6 *Application for Projects (including Seeding Grants).* Divisions and Project Grants Program, 3.

[123] Butler, The financing of general practice… Divisional fund arrangements changed at the end of 1997. The previous distinction between infrastructure and projects was abolished and all divisions moved to a capped block grant from January 1998. (See Commonwealth Department of Health and Family Services. *Circulars.* from the General Practice Branch between June and December 1997). Budget capping is likely to have the most significant detrimental impact on the most 'successful divisions', which have had large numbers of projects.

[124] The comment at the beginning of this chapter that any model generated in another country must be

Notwithstanding the limits of the Divisions arm of the General Practice Strategy, any attempt to answer the questions must be speculative, since it is early days yet for the Strategy. Certainly, many Divisions have tried to involve general practitioners in decision-making about and coordination of local health services, in health promotion, illness prevention and population health activities at the local level, in cooperative projects with other health professionals, in the services provided by local hospitals, and in education programs to develop skills in new areas or in recover of skills which previously were central to general practice.

There has also been considerable pressure from Government for Divisions to develop relationships with local communities, in the form of both carrots and sticks. For example, successful applications for project grants must demonstrate that "consultation with the relevant sections of the health care system and consumer organisations has been undertaken".[125] There is a protocol that Divisions can follow to demonstrate that they have indeed undertaken "consumer consultation". In addition, some Divisions have formed consumer reference or advisory groups; others have included a "consumer" on their boards of management. Divisions have also been eligible to apply for funds to employ a consumer liaison officer.

Yet, if the analysis of general practice presented in this chapter is correct, the extent to which Divisions will be able to achieve change in general practice will not be due to their ability to get general practitioners involved in health promotion, in education, in hospital based work, or in a more consultative relationship with the community. Rather, it will be linked to the Divisions' capacity to move general practitioners away from an exclusive reliance on fee-for-service income and into alternative funding arrangements. There is only sketchy evidence that this is happening.

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treated with caution because of the different organisational, structural and financial frameworks of general practice in each place is worth noting again. The models of general practice noted in the introduction are relevant, but none quite capture the nature of general practice in Australia.

[125] Commonwealth Department of Human Services and Health. 1995/6 *Reference Manual.* Divisions and Project Grants Program, Appendix 6: Consumer Organisations, 136-139.

As noted at the end of section 5.2, in 1995-6 the total amount expended by the Commonwealth Government on alternative general practice funding arrangements was still less than 10% of the total budget for general practice services.[126] Not every cent of this 10% finds its way into general practitioners' pockets to lure them into new areas of work. Divisional budgets, for example, often include significant payments for office running, travel and the employment of non-general practice staff. Therefore, the amount of money that is realistically available to actually fund general practitioners' participation in alternative funding arrangements is probably considerably lower than 10% of the total budget.

Even if there were a sizeable shift to alternative funding arrangements, it is still not clear that the current approaches really offer the right kind of incentives. Shared care projects provide a good example of the mixed messages that these alternative funding models send to general practitioners. Shared care projects generally involve collaboration between specialists and general practitioners in the planning, management and provision of health care for patients.[127] Typically, shared care projects involve the identification of suitable patients, training for general practitioners, the development and use of protocols, backup support services for the general practitioner, and agreed arrangements for formal communication between specialists and hospitals and general practitioners. They may also include general practitioner attachments to hospitals and specialist clinics.

Obstetric shared care projects have been particularly popular with Divisions, and half of all Divisions now have shared obstetric care projects of some sort.[128] General practitioners who are involved in obstetric shared care generally provide antenatal care

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[126] See fn13 and Knight & Northrop, Introduction: An overview of general practice in Australia 1996..., xxxi and Butler, The financing of general practice, 135-153.
[127] Harris M & Powell Davies G. 1996 Integrating general practice with other health services. in Commonwealth Department of Health and Family Services. *General Practice in Australia 1996.* Australian Government Printing Service, 216-232.
[128] Harris & Powell Davies, Integrating general practice services..., 218-220. See also Integration Support and Evaluation Resource Unit. 1997 *From Projects to Programs. Sharing Obstetric Care: A Guide for Divisions of General Practice.* Draft (1) for Comment, prepared by the Commonwealth-funded Unit responsible for assisting divisions to develop, implement and evaluate projects that integrate general practitioners into the broader health system.

only, in their surgeries, to patients who will usually deliver in hospital, where their care during labour, delivery and post-natally is provided by hospital staff. In addition, patients usually have appointments at the hospital at least twice during their pregnancies. The interface between general practitioners and the hospital is often conducted through non-general practitioner staff, principally midwives. Shared obstetric care projects certainly expand the general practitioner's role, perhaps encouraging care that is more comprehensive. In addition, the capacity to care for patients during their pregnancies means that patients may receive greater continuity of care.[129] However, shared obstetric care does not necessarily integrate general practitioners into the hospital setting (since midwives often fulfil this function) or involve general practitioners in caring for the community. Moreover, it offers no challenge at all to the dominant fee-for-service model, because the general practitioners continue to be paid on a fee-for-service basis for the care they provide. Indeed, perhaps one of the reasons for the popularity of shared obstetric care projects is their comfortable fit with the *status quo* of fee-for-service.

Even when divisional projects do not directly replicate a fee-for-service model within the project, this model of service delivery still has a powerful influence. Because it is so central to Australian general practice, it is possible that general practitioners can view the availability of funds under the General Practice Strategy as yet another source of payment for discrete services. For example, several of the early divisional projects involved general practitioners taking part in activities that they had previously 'done for nothing'. This included things like case conferencing with other health professionals, giving talks at schools, or sitting on committees as representatives of general practice. There is some anecdotal evidence that Divisions' ability to pay general practitioners to carry out these activities has undermined the altruism that many

[129] This will depend on what time span for continuity is chosen. If it is taken over the long term, shared obstetric care allows the general practitioner to maintain contact with patients through their pregnancies. However, as general practitioners tend to provide only antenatal care, obstetric shared care also introduces yet another care provider into the patient's orbit while she is pregnant and having her baby. Over the short term, adding this extra care provider can make for less continuity of care.

general practitioners exhibited.[130] What was once an accepted part of the general practice culture has become yet another service for which general practitioners can be paid.

In conclusion, the General Practice Strategy certainly has aims which are consonant with a reorientation of general practice that would see less dissonance between aspects of the altruistic professional model of general practice and the structural, financial and organisational factors which influence it. At the moment, the total amount available for alternative funding arrangements is not large enough to make a significant impact. Moreover, at least some of the alternative funding is going into projects that do little to change the nature of general practice work.

5.6 CONCLUSION

In this chapter, I have outlined two ways of understanding general practice – an altruistic professional model and a business model. I have suggested that a wide range of financial, structural and organisational factors ensure that general practitioners find it difficult to practise exclusively with the altruistic professional model of general practice. In addition, these factors also reflect and encourage a business mentality in general practice, and this business model of general practice is also present in professional documents. Many of these issues will surface again later in the thesis when I explore how the GPs I interviewed deliberated about and dealt with moral problems. In a sense, then, this chapter provides the context for that exploration.

[130] The 'anecdotal evidence' referred to here includes considerable material accumulated during my period of work as a research and support officer for Divisions of General Practice in South Australia. As such, its status is intermediate between 'hear-say' and 'formal data'.

6 THE GPS AND THEIR ETHICAL PROBLEMS

6.1 INTRODUCTION

This chapter introduces the GPs whom I interviewed for this thesis and describes the ethical problems they discussed and why they thought their problems were ethical ones. I suggest that the way in which the bioethics literature defines an ethical dilemma captures only some of the GPs' views about why their problems were ethical problems. The bioethics literature has defined ethical dilemmas in terms of conflict and choice between values, beliefs and options for action. While some of the views of some of the GPs in this study about the nature of their ethical dilemmas certainly accorded with this definition, other explanations of the ethical nature of their problems revolved around the public notoriety of the issues they were discussing, concern about their relationships with patients, and their anxiety about threats to the GPs' integrity and reputation. Some of these explanations are not easily incorporated into a model of morality focused exclusively on conflict and choice. The variety of views about what makes a problem a moral problem indicates that the moral domain is perhaps wider and richer than mainstream bioethics would generally allow. Three following chapters go into more detail about how the GPs deliberated and what relation their deliberation had to the conventions of bioethics.

6.2 THE GENERAL PRACTITIONERS

The 15 general practitioners I interviewed came from a wide variety of backgrounds. Table 2 summarises their socio-demographic characteristics. The GPs ranged in age from 30 to 63 years, with the largest group being aged between 30 and 40 years. Twelve of the 15 were male and 13 were born in Australia. Eight worked in metropolitan Adelaide, in both inner and outer suburbs; the other seven were based in rural settings, including small country towns (of less than 2,000 people), industrial towns (of about 5,000 people) and small rural cities (of more than 10,000 people). Ten gave a religious affiliation when asked, although two of these implied their affiliations were only nominal. Eleven GPs

worked in private practices, two were currently doing locum placements and two worked in publicly funded community health services. Nine of the 15 were either partners in their practice or associates with a view to partnership. This summary provides an overview but does not create a picture of each GP. Below, I set out a brief biographical account of each GP.[1]

TABLE 2

CHARACTERISTICS OF GPS IN STUDY

Characteristic	Number
Age	
30 - 40 years	8
41 - 50 years	4
51- 60 years	2
61 years +	1
Gender	
male	12
female	3
Nationality	
Australian born	13
Overseas born	2
Location of work	
large rural town (10,000+ people)	1
small rural town (<2,000 people)	4
rural industrial (about 5,000 people)	2
suburban	8
Religion	
Anglican - practising	3
Anglican - nominal	2
Baptist	1
Catholic	1
Christian, not otherwise specified	2
Hindu	1
Agnostic/nil/unsure	5
Practice type	
solo	1
private practice: 2-3 medical personnel	4
private practice: 4-8 medical personnel	5
private practice: very large (18 medical personnel)	1
locums	2
community health service (2-3 medical personnel)	2
Employment status	
partner	8
associate with view	1
employed	6

Dr Alderson was a partner in a large group practice in a major rural town. He was 50 years old, Anglican and married with teenage and adult children. Dr Alderson's schooling had been in non-government schools and he had studied medicine at the University of Adelaide. Since graduation he had worked in a wide range of rural settings, including, when his children were young, in New Guinea. He had been in his current

[1] These biographical accounts have been altered slightly in a few cases to protect the GPs' anonymity.

practice for "many years". When I telephoned him, Dr Alderson said that "something that had troubled him from way back, working in isolated settings, was having to treat his own family". Since he had moved to a larger country town he had gradually gathered a large number of patients who were social acquaintances and friends and this also troubled him. At interview, he was a quietly spoken, gentle and thoughtful man, who was clearly troubled by the issues he discussed. The interview took place in Dr Alderson's office, which was next to a major road, and much of the conversation was unclear on the tape recorder.

When I telephoned **Dr Bright** he began by talking about complaints patients had made against him. He was interested in ethics for two reasons, he said, one related to problems in general practice and the other to "making the public aware of their own responsibilities". He also mentioned that he was president of a local Christian group, "but then, everyone has political or religious bias, don't they?" I interviewed Dr Bright in his home. He was 63, Baptist, married "with children and grandchildren". His professional career had begun in Adelaide, but ranged from Canberra to rural Australia and New Guinea and then back to suburban Adelaide, where he had spent most of his working life. He'd sold his practice three years earlier, and was now doing locums when he had the opportunity: he had just returned from a three month working holiday in Tasmania. Dr Bright did not mention his earlier comments about patient responsibilities during his interview. Instead, he talked about ethical problems "before birth". After some opening comments about contraception, he launched into a lengthy discussion of termination of pregnancy. I gained the impression that many of Dr Bright's comments were well rehearsed; he did, nonetheless, respond thoughtfully when asked to step outside his prepared speech.

My initial conversation with **Dr Dunt** was brief and to the point. He was happy to take part in the study, because he thought that medical students needed more "behaviour teaching" and "ethics is only human behaviour". I interviewed Dr Dunt during his lunch hour in his solo practice in a country town. He was 52, married and a "devout agnostic". His educational history included government schooling in suburban Melbourne, medical school at Melbourne University, and experience in rural base hospitals and the East End of London. Later in his career he did a practice swap with a general practitioner in rural England. Dr Dunt's surgery was small and the room where we sat to talk (a disused laundry) dingy and cramped. Dr Dunt, himself, was nothing like his surroundings. He had prepared three pages of notes, describing two dilemmas, and he began by reading these out to me. Each vignette ended with questions for discussion. I asked him to select one to discuss in more detail, and he chose "pregnant Pam" who approached him for medical support for her home birth after being put off by other medical practitioners in the town. Dr Dunt's comments and responses to my questions were thorough and well organised. He concluded the interview by giving me a brief lecture on the nature of philosophy. I left the interview impressed by his thoughtfulness and saddened that he seemed to have no one to talk philosophy with.

Dr Elwin, 32 and married without children, had been working as a locum general practitioner for 6 months when I interviewed him in his home. Prior to that, he'd been overseas travelling for six months, and before that, he'd spent four years working in the suburbs of Adelaide. He was clear that his next move would be to the country, and he also named the region in which he wished to work. Dr Elwin had grown up in Adelaide and attended a government secondary school. He completed his medical degree at the University of Adelaide in 1984, and by 1990 he had acquired a Diploma in Obstetrics and become a Fellow of the RACGP. His response to my question about his religious affiliations was: "Ooh. That's a difficult one. Um, agnostic. Not that [I'm] touchy." Dr Elwin opened the interview with 6 issues he'd jotted down, and he chose, after some lengthy preamble, to talk in detail about "the issue of the professional situation" - how doctors should behave when there were differences of opinion about what constitutes good treatment, and, "tying in with that, the issue of who's actually responsible for the patient's care" (19). We talked for almost two hours, and the interview ended with a tour of recent renovations to his home.

Dr Johnson was an 'associate with a view' in a three-person practice in a seaside suburb of Adelaide. He was 36, married with children and Catholic. All of his schooling had been within the Catholic education sector – at a convent, primary school and secondary college. He studied medicine at the University of Adelaide, and "struggled very much to get through my course", taking eight years instead of six. He'd worked since internship at general practices all over Adelaide and had finally settled in his current practice almost three years earlier. He expected to stay in his current practice "indefinitely", but he was pessimistic about what the future held for general practice as a profession. When I telephoned him to arrange the interview, Dr Johnson was the only doctor who had real concerns about confidentiality. He seemed reassured by the processes to assure confidentiality and anonymity that I had in place. I interviewed him in his practice during his lunch hour. During the interview, he was easygoing and pleasantly informal. His earlier concerns about confidentiality were not surprising, as he chose to talk about medical mistakes and honesty.

I interviewed **Dr Kingsford** at the end of a morning's session in his three-person practice in a small country South Australian town. The surgery was small, but neat and well kept both inside and out. Dr Kingsford was 57, married with adult children, and firmly stated he was "Church of England". After primary and secondary education at an elite private boys' school, he had studied medicine at the University of Adelaide. Following internship and a couple of short hospital terms, he began work in rural general practice, then opened an urban general practice in a new housing area in Adelaide. Eleven years later, worn out by the "extremely busy practice", and with a marriage breakup behind him, he moved back to the country. He had now been in the same practice for 18 years and he had no intention of moving.

> 121[2]...I will continue to stay in the country, I think. I've got interests. I live just out of the city on a farm and we have a lot of horses, cattle and sheep and I think this is a big interest to me, living in the country. Plus I like the country medicine and you get to know the people here. I mean, they're all your friends, everything, I mean you're in the local Lions Club. You get involved with people on the Advisory Board, Doctor for the council area, and all the people, your friends. I don't think they'd let you leave.

Dr Kingsford had expressed an interest in "doctor-doctor" ethics when I initially rang him. It was an interest he had developed when he sat on a committee that investigated complaints against doctors. During his interview, however, he discussed a "recent example" from his work. A young woman with facial injuries serious enough to require hospitalisation had consulted him, claiming that her father had assaulted her. Over the next few days Dr Kingsford had to make a statement to the police, and the woman's father also came to see him. His dilemma related to how to handle the complex family dynamics in this situation.

When I telephoned **Dr Little** to discuss the study with him, he was not sure he was going to "be much use". He was no longer working in mainstream general practice, but he did mention that he had considerable country general practice experience. Dr Little was 48, Anglican and married with children. He had grown up in outback Australia, studied medicine in Adelaide, and moved to the country after two years postgraduate experience. Twelve years later he returned to Adelaide to study humanities at university and he was now nearing completion of his arts degree. He continued to work "on the edges" of general practice, in community health and as a locum. For the last five years he'd worked in a community casualty service. I interviewed Dr Little at my workplace. He began with a long list of ethical problems that he had collected over the years. I asked him to select one to talk about, after requesting that he put the issue of termination of pregnancy to one side. Dr Little started with "sick certificate requests because it's a fairly simple sounding thing but it can involve some interesting complexities" (10). We also spent some time talking about the difficulties associated with being a locum. At the end of his interview, we talked for a while about Dr Little's interest in philosophy and how he could pursue this with further study. When we parted he asked if I was interested in joining a group of "Christian philosophers" who met regularly at his home. I later took up this offer and enjoyed meeting with a diverse group of Christian philosophers, chaplains, theologians and health professionals for the next two years until this group folded. During this time, Dr Little invariably introduced me as "the academic doing that study of GPs and ethics I took part in".

I interviewed **Dr Masters** early in the afternoon in the government-funded suburban Community Health Centre in which she was employed. The Centre offered a range of health services, including medical services provided by three doctors. It was a bright and pleasant building, situated in an older suburb. Dr Masters had been a little unsure when I had spoken with her on the telephone. She had said she was not sure what an ethical problem was but, after some non-directive prompting, she suggested discussing termination of pregnancy. Dr Masters was 42, married for the second time with children. She alluded to a difficult divorce a couple of times during her interview. She described her religion as "Christian". After schooling in England and university study in London, she completed her first house year, and then came to Australia. She spent some time in paediatrics before joining a government-funded family planning service. She left that organisation to work for the Community Health Service that still employed her. When I interviewed her she was working part time in community health, and doing occasional sessions in family planning and paediatrics. Dr Masters talked in her interview about the difficulties she faced as a Christian in "send[ing] people off for abortions" (6). Dr Masters was a warm and friendly woman, who maintained excellent eye contact. I thought that she gained as much from the interview as I did.

Dr Newton was a partner in a two person inner suburban practice. The practice building was small and slightly run-down. Children clearly mattered to this practice: the floor was littered with toys and a sign

[2] Numbers at the beginning of quotations and in parentheses after a quotation refer to paragraph numbers in the text of the interviews.

politely stated that families with children were given preference in appointment times. Dr Newton was 44, married with two children, and she was not sure about her religious affiliation. She had attended a private girls' school in Adelaide, studied medicine at the University of Adelaide, and had worked in paediatrics and general practice since graduation. Most of her general practice experience had been in her current practice. Her father had started the practice, and Dr Newton had initially worked with him and then taken a partner when he retired. When I first contacted her, she asked whether "intraprofessional issues – for example, referrals – were still ethical problems". She had three recent examples of this in her work that she would like to talk about. The tape recorder went on and off during the interview, as Dr Newton checked frequently that I did want to hear about what she wanted to discuss. At the end of the interview, after the tape recorder had been turned off, she got to what seemed in retrospect to be the core of the matter - the "ownership of patients".

I interviewed **Dr Owen** on a Saturday morning at his home in a seaside town in rural South Australia. Over the telephone Dr Owen had said that he faced ethical problems all the time in general practice; he had recently bought a "bioethics book"[3] and he was keen to discuss the issues. Dr Owen was 35, married with young children. He had studied medicine at the University of Adelaide, and completed general practice training in both Australia and Britain. Since returning to Australia, and joining a four-person practice in rural South Australia, he had become a trainer for the Family Medicine Program and an examiner for the Royal Australian College of General Practitioners (RACGP). He described his religion as "I suppose, Church of England". Dr Owen provided a list of six cases that he had encountered recently. From these he chose to talk about two in greater detail, the first a young mother with a history of abusing her children who wanted her tubal ligation reversed so that she could have more children, and the second a doctor who was drunk at work.

Dr Silverman was enthusiastic when I telephoned him. He was unconcerned about confidentiality and anonymity, and very cooperative about finding a suitable time for the interview. Dr Silverman worked in a five-person practice in a South Australian town with an industrial base. He was 32, "loosely Anglican" and married with 2 young children. I interviewed him at 9.00am in the morning, before he began consulting. Even at that time, the practice seemed busy. Dr Silverman chose to discuss a patient he was seeing at that time: a young woman with a sexually transmitted disease who wouldn't tell her boyfriend. He was as eager in person as he had been over the telephone, talking with enthusiasm about the people involved and his own part in the story. He peppered his conversation with anecdotes from his work, a fact which made it a little difficult to keep him to the one topic.

I interviewed **Dr Sing** at the end of his working day around 7.00pm. I had waited 45 minutes to see him, and this had given me the chance to have my first good look at the '24-hour clinic' in which he worked. According to the board behind the reception desk, the clinic used the services of 18 doctors. The building itself was impressive: lots of large black leather lounges, television sets, and a very well equipped play area for children. A pharmacy, dentist, physiotherapist and coffee shop were also located under the same roof. Dr Sing was 45, married with children, and Hindu. He had grown up and done his initial medical training in a South East Asian country, and followed this with training in England and New Zealand in paediatrics. He had migrated to Australia four years earlier, and worked since then as a general practitioner. He found his current work convenient; the hours and pay were excellent, and he had time to devote to his family. He thought his future was probably in general practice, but I formed the impression that, if a better offer came along, he would take it. Despite his initial reticence about being interviewed "because time is a problem", Dr Sing was a voluble participant, full of anecdotes. From the list of 6 possible areas that he'd prepared, he chose to discuss the identification and treatment of "drug addicts".

I interviewed **Dr Stamos** in the large group practice in a new outer urban area of Adelaide in which he worked. Dr Stamos was 30, single and a graduate of the second and newer medical school in Adelaide. He stated his religion as "nil". His schooling had taken place in Catholic primary and secondary schools. Since graduation, Dr Stamos had completed a Diploma of Obstetrics and worked as a night registrar, locum and general practitioner. He was now in his fifth year in his current practice. When I asked him about his future plans, Dr Stamos replied that they were "To get out of medicine":

> 114. I'm in my final year of my law degree at the moment. How come? Not for ethical reasons, but for purely lifestyle reasons. Yes, I think the public that no matter which government wins the next election, I don't think life being a doctor is going to be particularly fun, especially if the Labor Party

[3] The book was Mitchell KR & Lovat TJ. 1991 *Bioethics for Medical and Health Professionals. History, Principles and Case Studies.* Social Science Press. At this time, this was the only Australian bioethics text written primarily for medical students and practitioners.

wins.

Dr Stamos hoped to move into legal practice as soon as possible but recognised that there was significant unemployment in the legal profession that might make it difficult. Dr Stamos discussed euthanasia during his interview; he was clear and concise, with a cynical edge to many of his comments.

Dr Williams was employed in a four-person practice that was based in two small country towns. I met her at the end of a busy morning at the surgery, and followed her to her home in my car. She was 34, agnostic, married with no children, and she had just sat her RACGP Fellowship examinations. She was not sure about what the future held for her, but it was unlikely she would remain where she was, although she was interested in rural general practice. She was somewhat cynical about her current position as the employed "token female doctor" in a practice owned and run by men. Dr Williams had done some reading in ethics during her undergraduate years in medicine, and our paths had crossed once before. She began her interview with a list of 6 cases and from them chose to talk about a patient who had asked her to help conceal from her husband that she was pregnant and wanting a termination. The interview was taxing: a thunderstorm raged outside, the tape recorder blew up, and we talked about an area that was difficult for both of us. Very little of the interview made it to a transcript.[4]

I arranged to interview **Dr Winters** in my office while he was visiting Adelaide with his wife and young family. Dr Winters was 33, Christian, and was a partner in a three person practice in a country town with an industrial base. He'd grown up and gone to school there, before moving to Adelaide to study medicine. After three years in hospital placements he returned to the country, where he thought he was likely to stay. When I first telephoned him, Dr Winters was not sure whether he could think of an ethical problem to discuss, and he wondered if I had any ideas. I assured him that anything that "made him think" would be appropriate, and he then suggested that termination of pregnancy was an issue for him, because of his religious convictions. He followed this through in his interview. Our talk together was friendly and, at times, full of laughter.

6.3 THE PROBLEMS

The GPs met the request to describe an ethical problem they had encountered in their work in a range of ways. Dr Dunt presented three pages of closely written notes, describing two separate ethical problems, set out as case studies. At the other extreme, Dr Winters opened the interview with the words "I can't think of anything to talk about". (He did name a topic when I repeated my request for an ethical problem associated with his work as a general practitioner.) In response to the opening question: "tell me about an ethical problem you've experienced in your work" the GPs identified 44 problems. Six described only one problem or issue, four listed two or three problems and five provided a list of five or six problems from which they selected one or two to discuss.

Their 'problems' fitted into one of three categories. First, there were general issues (for example Dr Bright began "I suppose the main ethical problems a lot of doctors face are those, let us say, before birth"). There was a second group of issues presented in the

[4] See Chapter Four, section 4.3.2, for more detail.

context of a story. For example, Dr Silverman, began:

> 2. I suppose the most obvious problem would be contact tracing with STDs.
> *3. Can you think of an example of that that you can tell me about?*[5]
> 4. I've got a young lady in hospital that I've just discharged this morning. She is 19 years old and she presented with severe viral pain, was seen over the weekend by a couple of doctors at the hospital, none of whom were too sure what was going on, was given various creams which didn't make any difference. Came in here on Monday and had quite obvious genital herpes, cultures of which have subsequently shown positive herpes simplex type one.
>
> Dr Silverman

The third group contained quite specific stories and narratives. For example, Dr Dunt began his interview by reading the following account from his notes:

> 12. Second case is Pam. Now I obtained pregnant Pam second hand. She was seeking a home birth, with a trained midwife with full medical involvement. The first medical response she had caused her to seek me out. Pam quickly proved to be decisive, determined, not easily moved. She was well-informed, and understood risk as few people do. She had commenced nursing training and felt appalled by standard medical ward management and she quickly ceased nursing. It was important that her care was local and that labour occurred in her own home. Problems: 1) there was no local midwife service outside of the hospital; 2) our local obstetrician was strongly opposed, on principle, to any elective home birth. He did most of the caesarians; 3) despite my own obstetrical experience, including many unplanned home births I did not give unqualified support. I needed time to assess and time to find a midwife. Progress: Pam attended ante-natal visits regularly and our long discussions satisfied me that we could obtain a satisfactory home labour. We found an interested midwife but she was warned off by the obstetrician... Pam found another midwife. Nearing term it was clear that this would be a trial labour. The usual courtesy trip to the obstetrician occurred at 32 weeks that we normally do proved a disaster as he gave Pam and midwife the short straw. My relationship with the obstetrician had always been very good, but I was now, also, under attack. I needed to know who would be responsible for a caesarian section if it proved necessary. The obstetrician's medical defence advice was that he would risk prosecution if he simply refused. Labour commenced with the midwife in constant attendance and I made frequent assessments. After six hours with Pam, alert and on her feet, she had nearly reached full dilatation without any descent. Transferral to hospital was accepted easily by Pam where a caesarian was promptly and safely carried out. Pam returned home in less than 48 hours. Over the past twelve months she has proven to be her own type of good mother. For example, persisting with breast feeding to success where all others would have failed. Pam has remained determined and not always a rational person as I initially recognised. The obstetrician has since moved interstate, unrelated.
> 13. Dilemmas: where do my medical priorities lie: with my patients or with my colleagues? 2) Am I right and am I wise, to support a patient who feels entitled to decide where she would labour? Why did I not decide otherwise? Once convinced Pam was fully determined ....
>
> Dr Dunt

Dr Kingsford launched into the following account of a recent case:

> 2. Yes, I guess ethical problems crop up to a minor degree on a lot of occasions. Well, I suppose one recent example was a girl that came to see me, about a 19-year-old girl who had been assaulted by her father. She said a very hard slap on the face, necessitating me putting her into hospital... She improved - she was quite upset, naturally - and came along with her boyfriend, saying that her father assaulted her and that she was laying charges against him. She had had this argument with him, and he'd lost his temper, struck her, and she was moving out of the home and staying with her boyfriend's mother. Now, this was all quite satisfactory, and she reported it to the local policeman, who later then came down to see me, and I gave them a statement about this and she was still about to obtain a restraining order against the father so that he couldn't approach her. From the other point of view I then saw the father who came to see me a few days later. He'd just been married, he'd been married for the second time, and had a baby at the [city women's hospital] who'd had a lot of - who

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[5] Italics in quotations from the text refer to my questions and comments.

was premature, the mother, his wife, had to be induced because of very severe pre-eclamptic toxemia, and the baby had some problems due to prematurity with breathing and it was needing to be on oxygen and had needed a lot of support in the months before this and caused quite a bit of tension in the family. He's a person that I've known for quite some time and he denied the whole state of affairs. He denied that he'd struck her, so this was the dilemma - it was her word against him. And the doctor, who was myself, of course in this case, was knowing both people concerned in the dilemma too - who to believe, really, and how it happened.

Dr Kingsford

Table 3 shows the ethical problems the GPs mentioned in this opening section of the interview. I have used the labels that they gave to these problems.

TABLE 3

ALL ETHICAL PROBLEMS MENTIONED BY THE GPS

Problem	Number
Relationships with colleagues	10
Abortion	4
Sickness certificates	3
Confidentiality	3
Paternalism	3
Chronic drug abuse	3
Euthanasia/care of the very ill	2
Treating family and friends	2
Domestic violence	2
Concealing information for patient	2
Treatment of minors	2
Contraception	1
Patient changing doctors	1
Euthanasia	1
Making mistakes	1
Worker's compensation patients	1
Cardholders with medication requests	1
Treatment of senile patients	1
STDs and relationship problems	1

By far the largest category related to situations when the general practitioner believed a patient was being given inappropriate care and/or advice by medical colleagues. This category included what to do about incompetent or negligent colleagues, how to present professional differences of opinion to patients, deciding with whom to side when patients

and colleagues disagree, and the treatment of patients who are being mismanaged when one is in a care-taker role only.

Of these 44 problems, the GPs then discussed 23 in some detail (see Table 4). The GPs who had provided a list were encouraged to choose the problem(s) with which they felt most comfortable. If they did not nominate a problem, I asked them to discuss an issue that I had not heard elsewhere. Most of the discussion which followed revolved around these problems.

TABLE 4

ETHICAL PROBLEMS DISCUSSED BY THE GPS

Problem	Number
Relationships with colleagues	4
Paternalism	3
Abortion	3
Confidentiality	2
Treating family and friends	2
Chronic drug abuse	2
Patients changing doctors	1
Euthanasia	1
Making mistakes	1
Domestic violence	1
Concealing information for a patient	1
Sickness certificates	1
Worker's compensation	1

These findings certainly do not provide a frequency distribution of the ethical problems encountered by Australian general practitioners, and this is not to be expected of a qualitative study such as this.[6] However, broadly speaking, the problems the GPs in this study identified reflect the published literature on ethical problems in general practice.[7] As

[6] The methodology I used to elicit problems for discussion spread the 'problem net' quite widely and may have led to a greater diversity of responses than would arise in a survey of general practitioners' ethical dilemmas. The issue of generalisation of findings is taken up in the final chapter.

[7] See Chapter Three on studies of ethics in general practice for a discussion of these issues.

such, they share two of the characteristics of those problems: first, measured against the 'neon' issues of bioethics they appear mundane and commonplace; second, rather than a focus on moral crises which occur but rarely in general practice there is an emphasis on issues that arise frequently.[8]

It is tempting, at this point, to make much of the differences between the ethical problems of these GPs and the ethical problems identified and discussed in much of the bioethics literature. There are good reasons, however, for not making too much of the differences. As noted above, this thesis does not attempt to set out the range or frequency of moral problems in general practice; that task would have required a different methodological approach. My intention is rather to explore models of reasoning about ethical problems in general practice. A catalogue of cases is less helpful to this task than an exploration of how the cases get into the catalogue. The more important question, therefore, is why the GPs thought these problems mattered or, in other words, why these problems were ethical problems for them. In any case, I take up the point about generalisation in Chapter Eleven.

6.4 THE PROBLEMS AS ETHICAL PROBLEMS

How did the GPs in this study come to define their problems as ethical or moral ones? In the bioethics literature, an ethical dilemma is defined as a situation in which, on moral grounds, a person ought both to do and not to do something.[9] Such a definition implies that issues of conflict and choice are central to moral dilemmas. Most bioethics ethics texts

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[8] See particularly Christie RJ & Hoffmaster CB. 1986 *Ethical Issues in Family Medicine.* Oxford University Press, xi-ii *et passim*; Smith HL & Churchill LR. 1986 *Professional Ethics and Primary Care Medicine: Beyond Dilemmas and Decorum.* Duke University Press, for a similar conclusion about the difference between ethics in general practice and in hospital and specialist medicine. See also, for Australian parallels, A Doctor's Dilemma: assorted articles on ethical issues in general practice. *Australian Family Physician* 1994; 23:1028-1092, and *Ethics in the Consulting Room.* 2 videos prepared by the Royal Australian College of General Practitioners.

[9] There is disagreement within analytical philosophy about whether moral or ethical dilemmas exist at all. See, for example, Sinnot-Armstrong W. 1988 *Moral Dilemmas.* Basil Blackwell, 1-3, 29 *et passim* and Lemmon J. 1962 Moral dilemmas. *Philosophical Review* 79:139-158. I do not take up the question of proving (or disproving) the existence of moral dilemmas in this thesis. Rather, I am concerned with exploring the meaning people give to the problems they describe as 'moral' or 'ethical'.

suggest that moral dilemmas or ethical problems invariably involve conflict, choosing between equally desirable or undesirable alternatives, or balancing options. For example, Beauchamp and Childress suggest:

> Moral dilemmas occur in at least two forms. (1) Some evidence indicates that act *x* is morally right, and some evidence indicates that act *x* is morally wrong, but the evidence on both sides is inconclusive...(2) An agent believes that, on moral grounds, he or she both ought and ought not to perform act *x*...the reasons behind alternatives *x* and *y* are good and weighty, and neither set of reasons is dominant.[10]

Mitchell and Lovatt, in an Australian bioethics text, agree that "[a] moral dilemma, by its nature, involves conflict. Some evidence might suggest that doing X is morally right and other evidence suggest that doing X is morally wrong."[11] In the general practice ethics literature, also, the same definition prevails. The first chapter of Campbell and Higgs' introductory text on "everyday moral choices" is called simply "Choices".[12] Christie and Hoffmaster similarly agree that "moral problems are conflicts of values".[13]

I asked the GPs in this study to explain why the problem or problems they were discussing were ethical problems for them. In all, the GPs offered 24 different explanations for why these problems were ethical problems (see Table 5).[14] Most GPs defined their problems in terms of conflicts and choices, but only two of these definitions were similar to the formal and general definitions offered in bioethics texts. More commonly, the GPs interpreted questions about why the problems they were describing were ethical problems in a personal way, with the majority of these personal definitions containing the elements of conflict and choice. Not all of the GPs, however, provided definitions that focused on choice and conflict. The personal responses also included explanations revolving around issues of relationships with patients and threats to the GPs' integrity and reputation, and a

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[10] Beauchamp TL & Childress JF. 1994 *Principles of Biomedical Ethics.* (4th edn) Oxford University Press, 11.
[11] Mitchell & Lovat, *Bioethics for Medical and Health Professionals...*, 20.
[12] Campbell AV & Higgs RH. 1982 *In that Case. Medical Ethics in Everyday Practice.* Longman and Todd.
[13] Christie and Hoffmaster, *Ethical Issues in Family Medicine...*, xv.
[14] This number does not equate to the number of problems the GPs presented, as a number of GPs offered more than one explanation for why the issue was a problem and two GPs did not explain why these problems were ethical problems for them.

third group of explanations focused on the public notoriety of the issue they had chosen to discuss. I describe this variety of explanations in more detail below, beginning with the 'public notoriety explanations'.

TABLE 5

WHY IS THIS AN ETHICAL PROBLEM? RESPONSES BY GPS*

Type of response	Number of responses
Self-explanatory/public notoriety	4
General/formal definition invoking choice and/or conflict	2
Personal responses:	
Involving choice and/or conflict	11
GP's reputation and integrity threatened by situation	5
Relationships with patients are in danger	2
TOTAL	**24**

* excludes two GPs who did not answer this question.

Four of the GPs answered the question about why these problems were ethical problems by emphasising the *public notoriety of their problems*. These GPs had all used abortion or euthanasia as their example of an ethical problem and their responses suggest that they took the ethical significance of the problem for granted. In three explanations, the GP suggested that abortion or euthanasia were ethical problems because they involved killing. The tone of voice they used in this section of the interview implied that it ought to be obvious to anyone that abortion or euthanasia was a moral problem.[15] It was only Dr Masters who explained *why* it was so obvious that abortion and euthanasia were moral problems:

> *43. We've talked about that one particular ethical problem. Before I ask you some concluding questions, what would you describe as an ethical problem, reflecting on what you've talked about? What makes abortion an ethical problem for you?*
> 44. I'm not really sure. I guess it was just, you know, sort of just under sort of, as an issue that comes up sort of in the media and that comes up across the board at times and I guess most of the doctors would have to at one stage or other come to a decision because it tends to be controversial and it does tend to get flack at times. I think people, you know, most doctors have had to at some time or other in their career come to terms with what they consider to be right, you know, regarding

[15] After one of these interviews, I noted that asking 'why was this problem an ethical problem?' made me feel rather stupid. Only an idiot would ask why abortion is a key moral issue.

abortion. And, yes, so I guess that's why I count it as ethical.

Dr Masters

Dr Masters' response implies that these problems were ethical ones for the GPs involved because 'every one says so'. Responses such as the one offered by Dr Masters suggest that these GPs, at least, have been led in their interpretation of the nature of ethical dilemmas by the dominant interpretation of medical ethics in philosophy, their profession and the media, one which emphasises life-and-death decision-making and *in extremis* situations. A number of writers in general practice ethics have complained that the agenda in bioethics has been driven for too long by these 'neon' issues - problems associated with high technology, beginning and end of life questions and, more recently, resource allocation.[16] They have argued that the ethical significance of other more mundane and subtle problems of medical work has been ignored. The GPs who identified ethical problems as ethical because they are in the public eye seem excellent examples of the preoccupation with 'neon' issues. This is not to suggest that their concerns were any less significant, only that they may have been primed to identify problems such as these as ethical ones by their public notoriety.

Two GPs offered an abstract or *formal definition* of the nature of moral and ethical problems. Dr Elwin's definition was one of these:

65. Why would you say that these ...problems...are ethical problems?
66. It's a question of definition of ethics, isn't it? Because they relate to your conduct and your professionalism as a general practitioner. That it's a situation where there are several different courses of action, all of which can result in particular outcomes and none of the outcomes is particularly optimal for some reason or other, and you're choosing betwen several different courses of action none of which you like 100% and you've got to try and balance in your mind which course of action is appropriate and that often bears back to your own sort of upbringing. What you see as being valuable and what you see as being important in life as much as in, as much as in your sort of professional management. It often relates to your own morals and your own values and what you see as being important as to which course of action you choose and that's why I see it as being ethical because it relates back to your own morals and your own ideas of what is right and what is wrong and what is the greater thing that needs to be preserved at the expense of the lesser thing - that value's more expendable.

Dr Elwin

[16] Christie & Hoffmaster, *Ethical Issues in Family Medicine...* and Smith & Churchill, *Professional Ethics and Primary Care Medicine...*

Even though only two of the GPs gave definitions that generalised the elements of choice and conflict, the GPs collectively provided eleven definitions in which the notions of choice and conflict were explained in the context of the problem they were describing. These GPs approached the question personally and answered it in terms of why it had been a problem *for them*. In eight cases they talked about choices related to *whose beliefs, values or interests should take priority*. For example, Dr Winters and Dr Masters described abortion as a moral problem for them, in part, because their own personal beliefs about abortion were difficult to sustain in the face of community and patient expectations.

> 2… I'm firmly opposed to abortion for just about all reasons, not totally exclusively but there may extenuating circumstances... I have a real problem with women (and they're generally younger women), falling pregnant and then coming and seeking abortion almost without thought. And the way the legislation is at the moment - the criteria is just we, the requirements are fairly broad and can be interpreted fairly liberally. So it's very easy just to say, "yes, okay, this will cause you mental trauma", sign a form and off they go and see a gynaecologist for a termination of pregnancy. I respect the right of the individual that under the current legislation they have that right. Nevertheless, I'm opposed to it, so this does create somewhat of a dilemma for me, personally…
> *9. And what's your reason to be opposed to termination?*
> 10. I guess (1) I've been brought up like that, so I can't deny that that's probably part of it, so my basic belief (which has a religious basis). But also extending on from that, I don't see that life is arbitrary - I mean at some stage, a politician or someone has said that before such and such a date a termination is legal, by the law. After such and such a date it isn't. I just have trouble coming to terms where this arbitrary line is drawn, where life does and doesn't, is and is not valuable. And I know the whole argument about women's rights, but the, just the whole scenario, I still have trouble with it, I don't understand. Does that answer the question?
>
> Dr Winters

Dr Elwin, in addition to offering a general definition of the nature of ethical problems, also explained why the problem he discussed was an ethical problem for him, by using the idea of a conflict between expectations:

> 19. The difference is between my expectations of what constitutes good treatment and another doctor - either another general practitioner's expectations or another specialist's expectations of what constitutes good treatment. And, tying in with that, the issue of who's actually responsible for the patient's care…
>
> Dr Elwin

Dr Little's explanation of why the dilemmas he described were ethical ones focused on conflicts of interest. Whose interests were being served by the decisions he made?

> *66. What makes those problems and the ones you were describing earlier to do with sick certificates ethical problems for you? What has made them ethical problems for you?*
> 67. The sick certificate ones are ethical problems in that you are giving a formal professional opinion that this person is not fit to work and should be paid by his boss for being off, rather than just have an unpaid day. So you're involving the third party there in having to pay for what you're certifying.

> And in the prescribing patterns and so on it's an ethical problem in that is it really the best care for this patient that's being provided? And is it the best cost structure of practice that's being provided? And is it ethical to make enough fuss to upset the patient of the practice that you're being paid to look after while the fellow's away? You are the locum. You're there in his place.
>
> Dr Little

For three other GPs, their interpretation of an ethical problem was expressed in terms of *conflict between alternative possible actions.* These GPs thought that their problems were ethical dilemmas because they involved choosing the best option from an array of possible solutions. Dr Newton was trying to decide how actively she should pursue patients who had left her for another doctor, and Dr Johnson's concern was with how honest he should be and whether he should reveal his mistakes to his patients. Dr Kingsford's response emphasised that he needed to decide how to present information to the police. There were a number of things he might have said to the police, and part of his dilemma related to what he said and what he left unsaid.

> *21. Why would you describe it as an ethical problem? What makes it an ethical problem for you?*
> 22. Because, knowing the family for a long time, and there's a sudden split in the family, it's a matter of, it's an ethical problem - do you take this particular line, do you take a side. The ethical problem comes where you've got to make a statement to the police, knowing that the father would be disagreeing with what you're saying. And there's a possibility of losing his confidence and his wife's confidence, who had needed a lot of support with the baby that she'd had that was ill. So there's the dilemma, you see, and that's the ethical problem, as I see it.
>
> Dr Kingsford

The concepts of choice and conflict are clearly important in all of the interpretations of 'ethical problem' described above, but, if we restrict our definition of 'ethical dilemma' only to ideas of conflict and choice, some of the nuances of the GPs' understanding of the nature of their ethical dilemmas is lost. For example, Dr Kingsford's interpretation above of the nature of his ethical dilemma was really less about choices and conflict than it was about his relationship with his patients. For him, what really mattered about this problem was that he was trying to care for all members of this family; even in the face of "a sudden split", he wanted to maintain good relationships with them all. Dr Winters similarly made clear in his interview that abortion was an issue for him partly because he felt his "therapeutic relationship" with his patients was in jeopardy when he could not, for reasons of conscience, provide them with the medical services they wanted.

Five more of the GPs' definitions stepped outside of the bioethics definition of an ethical dilemma to focus on something quite different: *the notion of threats to the GPs' integrity or reputation.* For these GPs, their problems were problems principally because either they were hurt by what was happening to them, or there was a significant chance that they might be hurt. Dr Williams, for example, was quite clear that her dilemma did *not* revolve around what decision to make or how to make it.

> 3...It's all got to do with a woman who became pregnant to her husband and desperately did not want the child because she, it was a second marriage and they'd already had one child from the marriage and she was 39 and - so, she asked me to conceal from her husband that she was pregnant and to organise a termination. And so that brought up various issues about concealment and, you know, knowing that you couldn't really conceal it and yet trying to.
> 10...I mean, for me, it wasn't particularly an ethical problem because I'm, what I believed and what [I wanted to do] were at one. And that is that she was the one that was pregnant, she was the one, you know, it was her decision about what happened and, although it was sad and difficult that she knew that she couldn't bring the child, and, in those circumstances then you could make a decision. But the difficult decision came in, the difficulty, I suppose for me, came in her feeling and her need to conceal it from her husband.
> *11. Right.*
> 12...Now, you know, I mean, the way that I went into that, I mean, I felt the problem was in the concealment, but in a way it's not a problem, too...But it was extremely distressing for her, and I suppose I found it difficult because of this.
>
> Dr Williams

At this point in the interview Dr Williams' focus was on how the situation was difficult and distressing for her patient. As the interview progressed it became clear that the nub of the dilemma was that the situation was also difficult and distressing for Dr Williams. She found this particular situation a problem because she was infertile herself, and her own feelings of inadequacy, guilt and anger came to the fore whenever she took care of women seeking abortions particularly if their reasons for an abortion did not seem compelling to her. Toward the end of the interview she talked about her anger at what she perceived to be the injustice in these situations. She found herself spending a good deal of her working life caring for women who didn't want to be pregnant, when she desperately wanted a child and couldn't have one. Dr Williams' dilemma only really made sense when it was defined in

terms of her own pain and suffering; it was her emotional integrity that was at stake.[17]

Dr Dunt's response was very different, but it also revealed a focus on a threat to his integrity and reputation:

> 46. The biggest problem for me was to fear for myself. There were very real risks.
> *47. In what sense?*
> 48. If anything had gone wrong that I could be in any way blamed for. I made very serious risks, I knew it. I would get no support. I knew that too. So, and I thought considerably [about it]. I like my practice. I don't wish to be barred from practising medicine. That risk was there.
>
> Dr Dunt

These views about the nature of ethical dilemmas are important, since they stand outside of mainstream bioethics accounts of the nature of ethical dilemmas. The dominant interpretation of an ethical dilemma does not easily incorporate dilemmas that are focused around concern for oneself. In fact, Beauchamp and Childress suggest that problems of this nature are, at least, of lesser significance and, perhaps, not ethical dilemmas at all. They argue that self-interest and a concern for one's reputation, on the part of the physician, may force hard choices, but these are not hard *moral* choices.[18] For some of the GPs in this study, though, it was exactly their concern for themselves and their reputation that made the dilemmas a reality.

The mainstream bioethics model of an ethical dilemma also has relatively little room for emotion and personal pain. For some of the GPs in this study, their moral problem centred on their own emotional reaction, and issues of choice, options and decisions between alternatives were only of secondary importance. The incorporation of virtue ethics into mainstream bioethics has helped to rehabilitate the emotions but, as I suggested in Chapter Two, the focus in virtue theory tends to be on the thoughtful and considered cultivation of character traits, rather than on emotional reactions to specific situations.[19]

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[17] Although it is only speculation, it was also Dr Williams' need to protect herself from another upsetting interview or telephone call that stopped her from contacting me when I wrote to her after the interview to seek her cooperation in filling in gaps in the transcript.
[18] Beauchamp & Childress, *Principles of Biomedical Ethics...*, 12.
[19] Of course, the emotional reaction to a specific situation is, in one sense, the public face of a virtue.

The literature on 'caring' theories of ethics that has grown out of Carol Gilligan's work on responses to moral situations provides another model that also seeks to incorporate an emphasis on emotions and relationships.[20] Gilligan argued that women's moral development is typically distinct from men's; they construe moral problems as "issues of relationships or response", and these problems are resolved, in part, by "maintaining relationships and response" or by re-establishing "the connections of interdependent individuals to one another..." The successful negotiation of a moral problem depends on "whether relationships are maintained or restored".[21] Men, on the other hand, typically see morality in terms of rights, obligations and justice. Moral problems are resolved by isolating the competing values or obligations and choosing impartially between them. Gilligan has not claimed that all women perceive moral problems from this 'care' perspective, or that all men are oriented toward a 'justice' perspective. She suggests merely that women tend to affirm a care perspective more often and men a justice perspective more often, and each perspective can often be found in the reasoning of both men and women. Gilligan's psychological account has its parallels in philosophical ethics.[22] Annette Baier, for example, maintains that modern moral philosophy has been oriented almost exclusively toward universal rules and principles, with their focus on impartial contracts between disinterested individuals.[23] This catches only part of the moral life. She suggests we need to build into our understanding of morality an 'ethics of care' which takes into account love, trust, and relationships.

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[20] Gilligan C. 1984 *In a Different Voice:Psychological Theory and Women's Development.* Harvard University Press.

[21] Lyons NP. 1988 Two perspectives: on self, relationships and morality. in Gilligan C *et al.* (eds.) *Mapping the Moral Domain.* Harvard University Press, 21-45.

[22] There is an overlap here between 'caring' theories of ethics and 'feminine ethics'. See Gudorf CE. 1994 A feminist critique of biomedical principlism. in DuBose ER, Hamel R & O'Connell LJ. *A Matter of Principles? Ferment in US Bioethics.* Trinity Press International, 164-181, particularly on the distinction between "feminine ethics", of which Gilligan's work is taken as an example, and "feminist ethics". The latter focuses on the ways in which patriarchy in medicine and philosophy has subordinated the experiences of women to those of men. For an example of feminist ethics, see Sherwin S. 1992 *No Longer Patient: Feminist Ethics and Health Care.* Temple University Press.

[23] Baier A. 1985 What do women want in a moral theory? *Nous* 19:53-63.

The GPs' responses to questions about why these problems were ethical problems provide some support for the view that the moral domain is wider and richer than mainstream bioethics definitions of the nature of moral problems have allowed. I am not suggesting that relational- or care-oriented models of ethics provide a *better* account of the nature of moral problems and morality. To do this would be to deny the evidence I have presented which indicates that the majority of the GPs' explanations about moral problems did revolve around conflicts between values and choosing between alternatives. However, the GPs used both of these models, implying that, for them, the moral domain could include a number of ways of thinking about moral problems and morality.

6.5 CONCLUSION

The GPs in this study provided accounts of the nature of their moral problems that included both the mainstream bioethics definition of a moral dilemma and definitions focused on relationships, harm and public notoriety. Some of these definitions sit uncomfortably with the dominant model of an ethical dilemma, based on the notion of conflict and choice between competing alternatives. For the most part, though, the GPs defined their ethical problems in ways that were consistent with notions of conflict and choice. The conclusions to be drawn from the material presented in this chapter can be tentative only, but they suggest that the explanation mainstream bioethics offers of the nature of ethical dilemmas is a fair approximation of the definition the GPs offered, but it does not account for the whole of the picture. We need, at least, to consider that there may be other, different ways to understand the nature and process of moral deliberation and decision-making. The chapters that follow take up this challenge.

7 APPEALING TO PRINCIPLES: PRINCIPLISM-IN-USE

7.1 INTRODUCTION

This chapter is the first of three about the ways in which the GPs I interviewed deliberated about moral problems. The following introductory comments apply to all three chapters.

Three sources inform this account of the GPs' moral deliberation. First, I have used the GPs' responses to questions about why they acted as they did, embedded as they were in their talking about the 'what' of their strategies - what they did, what they didn't do, what they thought other doctors might do in their shoes. A second source comes from their talk about those aspects of their lives which they thought had some general influence on the ways in which they dealt with moral issues - aspects related to their background, education, upbringing and significant life events. Finally, I have used the definitions of various ethics terms they were asked to supply towards the end of the interview.

The three chapters together deal with how the GPs responded to the classic questions of ethics: "why did you do that?" and "where [did you] turn to find out what is right and good and appropriate?"[1] The bioethicists discussed in Chapter Two offer clear answers to these questions. For them, doing ethics involves invoking principles (principlism), reasoning by analogy from case experiences (casuistry), or drawing on settled dispositions consistent with being a certain kind of person (virtue theory).

For each of these moral theories an empirical corollary is conceivable; it is possible to construct an interpretation of each moral theory that matches the experiences that lay people have of moral deliberation.[2] Principlists and casuists, particularly, have

[1] Smith HL & Churchill LR. 1986 *Professional Ethics and Primary Care Medicine.* Duke University Press, 7.
[2] The terms 'lay person' and 'lay people' here and elsewhere are rather loose terms for people who do not count themselves as having particular training and expertise in moral philosophy and/or bioethics. They approximate to Jonsen and Toulmin's people "in the middle" or the "ordinary morality" that Green, Gert

been keen to assert that their own brand of moral theory matches the moral reasoning that lay people use. Their arguments, however, have been based primarily on their own experiences of doing ethics, rather than on descriptions and analysis of lay experiences and lay moral deliberation. Even when one turns to empirical studies of moral deliberation, there is relatively little evidence available to assess the fit between moral theory and the forms of moral deliberation that lay people use. The studies that do exist either assume that moral theory and lay moral deliberation are the same thing (the quantitative surveys and case reports of ethical problems in general practice tend to do this) or they address the question of fit between moral theory and lay moral deliberation only tangentially (sociological studies of general practice tend to be of this type).[3]

This chapter, and the two that follow it, assert that there are links between moral theory, as articulated by bioethicists, and lay people's experiences of doing ethics, but that they are not the same things. The distinction that I draw between moral theory and the GPs' moral deliberation is somewhat akin to the distinction Kaplan makes between reconstructed logic and logic-in-use. Kaplan suggests that:

> "...scientists and philosophers use a logic - they have a cognitive style which is more or less logical - and some of them also formulate it explicitly. I call the former the *logic-in-use*, and the latter the *reconstructed logic*.[4]

Kaplan suggests that there are many logics-in-use. Put another way, there are many different ways in which scientists, philosophers and social scientists (the object of Kaplan's interest) and general practitioners doing ethics (the object of my interest) go about doing their work. Kaplan also notes that there are obviously many reconstructed logics, and the literature on the history and philosophy of science provides ample evidence of them.[5] The point of Kaplan's distinction is that logic-in-use and reconstructed logic are not the same things. A reconstructed logic is an "idealization of scientific practice", showing us what science would look like if it were pure but leaving

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and Clouser refer to. (See Jonsen AR & Toulmin S. 1988 *The Abuse of Casuistry. A History of Moral Reasoning*. University of California Press and Green RM, Gert B & Clouser KD. 1993 The method of public morality versus the method of principlism. *Journal of Medicine and Philosophy* 18: 477-89.) See section 2.6 in Chapter Two for a discussion of these bioethicists' understanding of the moral reasoning of lay people.

[3] Chapter Three discussed these studies in more detail.

[4] Kaplan A. 1964 *The Conduct of Inquiry*. Chandler Publishing Company, 8.

[5] See Charlesworth M. 1982 *Science, Non-Science and Pseudo-Science.* Deakin University Press, for a brief introduction to scientific method as set out by Bacon, Popper, Lakatos, Kuhn and Feyerabend.

largely unsaid what actually happens.[6]

Viewed from the perspective of how lay people do moral reasoning, the bioethicists' principlism, casuistry and virtue theory are reconstructed logics - idealised accounts of how moral deliberation is done. This thesis offers, by way of contrast, an account of the logic-in-use of a group of general practitioners - an account of the cognitive styles that the GPs used to deal with moral problems. I argue that the styles of moral deliberation the GPs I interviewed used were similar in form and content to principlist, casuist and virtuist approaches to moral reasoning, in other words, that the GPs' cognitive styles were examples of principlism-, casuistry- and virtue theory-in-use. In each case, however, the similarities with the reconstructed logics of principlism, casuistry and virtue theory are limited. The skeletal outlines of principlist, casuist and virtuist approaches are there, but the GPs did not develop them with anything like the sophistication and intellectual rigour that 'professional' principlists, casuists and virtuists would require of themselves. The GPs' principlism-, casuistry- and virtue theory-in-use were, at best, naive and, at worst, inconsistent, incoherent and illogical.

The preceding summary implies that the GPs' ethical logic-in-use was distinguishable from the reconstructed logic of bioethics only in so far as it could be described as bad reconstructed logic. Indeed, there are good reasons why we ought not to expect too much of the GPs by way of moral expertise. These GPs were in unfamiliar territory and the difficulties that they had with the business of doing ethics illustrate this. Their difficulties arose, in part, because the moral deliberation I was trying to elicit required them to make explicit those principles, values and reasons that were largely part of their "settled morality".[7] Most of the time, we tend to have "enough shared assumptions about our values and their expressions in action that we do not need to articulate the process explicitly".[8] It is often only in the morally controversial cases that we recognise the need to make clear the reasons behind our

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[6] Kaplan, *The Conduct of Inquiry...*, 10-11.
[7] Hoffmaster B. 1990 Morality and the social sciences. In Weisz G. (ed.) *Social Science Perspectives on Medical Ethics.* Kluwer Academic Publishers, 244.
[8] Smith & Churchill, *Professional Ethics and Primary Care Medicine...*, 7.

actions. As noted in Chapter Six, most of the GPs in this study were dealing with issues that are often regarded as commonplace, part of the ethics of every-day existence. So, it is not surprising that they might find it hard to explain why they acted as they did, or that they might get 'caught out' and be guilty of poor logic or inconsistency.

The notion that the GPs in this study were just bad ethicists could imply that moral deliberation and resolution are merely matters of individual and private cognition. The analysis in Chapters Two and Three suggests that this is far from the case because moral deliberation is also influenced by social and structural factors. In this chapter and the two that follow, I explore the ways in which these social and structural factors influenced the GPs' interpretation and use of principles, cases and virtues. The two models of general practice discussed in Chapter Five - the altruistic professional model and the business model - had a significant impact on the way in which principlist, casuist and virtuist approaches were used in the GPs' moral deliberation. These three chapters argue that the GPs' principlism-, casuistry- and virtue theory-in-use reflected both theory akin to that of bioethicists and the social, organisational and financial context of the world in which they worked.

7.2 PRINCIPLES IN THE BIOETHICS LITERATURE

The bioethics literature is replete with references to principles and their corollaries: rules, norms, and laws. I covered much of the debate about the role of principles in bioethics in Chapter Two, and at this point I merely comment briefly on the nature of principles and how they are used in moral deliberation.

Beauchamp and Childress refer to principles, rules and norms in their discussion of the nature of moral theory. While they do distinguish between these terms, they follow the widely held view that both rules and principles can be defined as "general action guides specifying that some type of action is prohibited, required or permitted in certain circumstances".[9] The difference between principles, on one hand, and rules and

[9] See Beauchamp TL & Childress JF. 1994 *Principles of Biomedical Ethics.* (4th edn) Oxford University Press. See also Solomon WD. 1978 Ethics II: Rules and principles. In Reich WT. (Ed.) *Encyclopedia of*

norms, on the other, lies in the level of specification: rules and norms have a more clearly delineated content and they are narrower in scope. If the principle under discussion is respect for autonomy ("a norm of respecting the decision making capacities of autonomous persons"[10]), rules which might be adduced from the principle include confidentiality and privacy. Beauchamp and Childress' understanding of the role of principles in moral reasoning has changed since 1979 to a 1994 formulation in which they recognise three roles that principles might take in moral decision-making - a deductivist role, an inductivist role and a coherentist role - and they now favour a coherentist approach to moral deliberation. The coherentist approach treats justification in ethics as a matter of pruning and adjusting the detail of particular cases and judgments to the more general requirements of principles, fitting everything together into a coherent whole.

Within the coherentist model, there are at least three ways in which principles can be used. They can override cases in a way akin to deductivism, so that the principle determines in absolute fashion what actions or moral judgements are required. Second, principles can be related to cases through specification, in which the meaning and scope of the principle is developed in a way which makes it more specific for and relevant to the particular situation. Specification offers a way to deal with conflict between principles by developing principles in ways that reduce the potential conflict between them. Finally, Beauchamp and Childress suggest that principles can be balanced against each other in moral judgement. Balancing requires attention to both the meaning of principles and to their relative weight in a particular situation.

Most of the debate in bioethics has revolved around how principles ought to be used in moral deliberation and, as with empirical work in ethics generally, relatively little literature focuses on the way in which principles are used in everyday lay

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Bioethics. (1st edn) Volume 1, Macmillan and Free Press, 407-413, for a summary of Beauchamp and Childress' position. The quotation comes from Solomon's account of the nature of rules and principles (408). The second edition of the *Encyclopedia* has no entry on rules or principles as such, but discusses them within the framework of an entry on normative ethical theories.

[10] Beauchamp & Childress, *Principles* (4th edn)..., 38-9.

discussion. Johnson's work on the implications of "second generation" cognitive science for our understanding of how moral reasoning works is a significant exception.[11] Johnson has suggested that there is a pervasive "folk theory" of moral deliberation that privileges principles and rules, which he terms a "moral law folk theory". This folk theory, which covers "what counts as a moral issue, how moral reasoning works, and what this means for how we ought to live our lives", holds that "moral reasoning is principally a matter of getting the correct description of a situation, determining which moral law pertains to it, and figuring out what action that moral law requires for the given situation".[12] Johnson's view is that this moral law folk theory is wrong because it is premised on faulty and outdated psychology, metaphysics, epistemology and theories of language. He argues that moral experience is metaphoric and he uses "linguistic evidence concerning the way we ordinarily talk about morality... and... patterns of inference in our moral reasoning that are based on metaphorical concepts" to support his case.[13]

One does not need to accept Johnson's framework or his conclusions to agree with his starting point.[14] The question for this chapter is: did the GPs use principles in their moral reasoning and, if they did, what form did those principles take and how were they used?

The GPs in this study practised a form of principlism-in-use. These principles can be described in truncated form as the principle that 'patients should make their own decisions' and the principle that 'doctors should do what's best for their patients'. Translated into Kaplan's terms, and using the language of bioethics, these principles equate to a principle of respect for autonomy-in-use and a principle of beneficence-in-

[11] Johnson M. 1993 *Moral Imagination. Implications of Cognitive Science for Ethics.* University of Chicago Press. See page 8 for the use of the term "second generation" cognitive science.
[12] Johnson, *Moral Imagination...*, 7.
[13] Johnson, *Moral Imagination...*, 35.
[14] For a critique of *Moral Imagination...*, see Hilberg NS. 1995 Book review of 'Moral Imagination. Implications of Cognitive Science for Ethics'. *Review of Religious Research* 37: 89-90 who argues that, in *Moral Imagination*, Johnson assumes, rather than shows, that our moral experience is metaphoric. His earlier work provides a better defence of the thesis that our concepts are "grounded in our bodily experiences and understood metaphorically in light of this experience" (90). See also Crigger B-J. 1996 Where do moral decisions come from? *Hastings Center Report* 26: 33-38, for a review of *Moral*

use. In each case the GPs applied their principles to the situation at hand with the aid of specification. In the case of the principle that 'patients should make their own decisions', they interpreted the principle to mean that 'doctors should not impose their beliefs on their patients' and that 'doctors should provide a balanced account of things'. In the case of the principle that 'doctors should do what's best for their patients', they contextualised the principle in terms of both 'biomedical best' and 'whole-person best'. The real test case for principlism for these GPs came, however, when they were faced with conflicts between their two principles. The GPs had two main strategies to deal with potential conflict. First, they specified the conflict out of existence; second they used the principles in ways that were illogical or inconsistent. At all levels, from the specification of the principle to the relating of principles to each other, there were indications that the social and structural context of general practice had left its mark. The discussion and analysis that follows develops these themes in more detail.

7.3 RESPECT FOR AUTONOMY

Modern bioethics probably owes its existence to concerns about the failure to respect patients' wishes.[15] Despite trenchant criticism from all quarters, this principle still holds a central place in bioethical discussion and it has a similar status in public discussion about consumers' and citizens' rights in health care. Given the dominant role that autonomy has played in contemporary discussion about medical ethics and doctor-patient relationships, and its increasing prominence in legal cases, not to mention the presumption of autonomy in dominant liberal individualism, it is hardly surprising that it should find expression in the GPs' moral deliberations. Nor is it surprising that that expression should mirror the way in which the concept of autonomy has been developed in the bioethics literature.

The GPs in this study who referred to the belief that 'patients should make their own decisions' clearly were using a version of the principle of respect for autonomy in

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Imagination.

[15] Childress JF & Fletcher JC. 1994 Respect for autonomy. *Hastings Center Report* 24:34.

their moral deliberation. They adduced from this principle two rules: that 'doctors should not impose their beliefs on their patients' and that 'doctors should provide a balanced account of things'. In the sections that follow I argue that these formulations of the principle of respect for autonomy reflected both the individualism and rationalism of bioethics' interpretation of autonomy, and the altruistic professional model of general practice.

7.3.1 Respect for autonomy in the bioethics literature[16]

Bruce Miller, in an important and frequently cited article in the *Hastings Center Report* in 1981, noted that there were at least four ways in which the concept of autonomy was used in medical ethics.[17] The first sense he identified, autonomy as free action, related to situations in which people (patients) are seen to be acting in ways which are both voluntary and intentional. On this understanding, an autonomous decision with regard to medical treatment would be made if the patient had given permission for treatment (this would make it voluntary) and knew what treatment was to be given (this would make it intentional).

Miller's second sense, of autonomy as authenticity, picked up the notion that autonomous decisions ought to reflect people's long term authentic values.[18] In order to make autonomous decisions, people need to have some sense of what they value and care about, and some insight into those values.

Miller's third sense, of autonomy as effective deliberation, focused on rationality and cognitive reasoning abilities. This understanding leads us to the view that people make autonomous decisions when they can appreciate that they are in situations which

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[16] This section offers only the briefest of introductions to the considerable bioethics literature on autonomy. I have selected Miller's work because it relates to the GPs' respect for autonomy-in-use. For a more comprehensive introduction to respect for autonomy in the bioethics literature, see Beauchamp and Childress, *Principles* (4th edn)..., chapter 3; Lindley R. 1986 *Autonomy.* Macmillan; and Dworkin G. 1988 *The Theory and Practice of Autonomy.* Cambridge University Press.

[17] Miller B. 1981 Autonomy and the refusal of lifesaving treatment. *Hastings Center Report* 11:22-28.

[18] Gillam L. 1991 The slippery notion of competence. in Proceedings of the Conference *Frail, Elderly, Fairly Treated? Meeting the Ethical Challenges of Aged Care.* Alexander Theatre, Monash University, November 20, 1991.

call for decisions, they are aware of the alternatives and the consequences of the alternatives, they evaluate both, and they choose an action based on that evaluation. This sense of autonomy requires people to have a number of different cognitive abilities: they must be able to understand the information they receive; they must be able to remember information for long enough to process it; they must be able to follow a chain of thought, and to reason through consequences; they need some ability to deal with probability; and they need to be able to appreciate what different outcomes might be like.[19]

Miller's final sense of autonomy - moral reflection - involves deep and meaningful reflection about one's values, life plans and attitudes, and a readiness to accept those values and life plans as one's own. Being morally reflective does not imply that you have to invent your own values. Many people do in fact surrender their decision-making to some external authority after thinking carefully about all that the authority stands for. They have, in a sense, decided to make some one's, or some institution's, values their own.

Miller did not suggest that his typology was exhaustive. He did, however, intend his catalogue to be taken as moving from weak to strong versions of autonomy. Yeide suggests that the senses of autonomy that have dominated bioethical discussion are in the middle of Miller's typology.[20] Writers in bioethics commonly assess autonomy in terms of the rationality and/or authenticity of decision-makers. The extremes require either too much or too little of us: on the one hand, defining autonomy only as free action yields too little to be meaningful; on the other hand, demanding that autonomous actions involve deep moral reflection seems to expect too much of people.[21]

This reliance on rationality and authenticity of decision-makers has implications

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[19] Gillam, The slippery notion of competence..., 36.
[20] Yeide H. 1992 The many faces of autonomy. *The Journal of Clinical Ethics* 3: 270.
[21] Yeide also notes that the dominant definitions of autonomy - as authenticity and rational deliberation - reflect "the manner in which we structure our economic life" (Yeide, The many faces of autonomy..., 270).

for how interactions between health professionals and patients are understood in bioethics. One example of those implications comes from a paper by Brock and Wartman about what may be going on in patients' minds when they make apparently irrational choices.[22] They suggest that many 'irrational' decisions by competent patients reflect ways of thinking which others (and particularly doctors in this case) do not share. For example, patients may have an unreasonable bias toward the present, may weight the risk of suffering or pain unusually, or fear of pain or the medical experience may get in the way when they are thinking about treatment. Although Brock and Wartman do not state it explicitly (and to be fair to them, they do say that one must respect irrational decisions made by competent patients), underlying their arguments there is a presumption that these different ways of weighting experiences and values are really distortions of thinking which limit patients' abilities to make rational decisions. Really autonomous patients do not suffer from these delusions - really autonomous patients make really rational decisions.

Linked to this notion, that autonomous people are people who make rational decisions after thoughtful and thorough deliberation, is the theme of individualism discussed in Chapter Two. Autonomy, as understood in traditional bioethics, is the province of individuals. Autonomous people may seek information from others when deciding what to do but, at the end of the day, they make their own independent decisions. In fact, this individualist thread runs through all of Miller's senses of autonomy. If autonomy is taken to mean free action, autonomous individuals are those who are able to stand alone without restraints imposed by others. Similarly, autonomy as authenticity or as moral reflection derives its strength from the idea that it is individuals who are authentic or morally reflective - it is individuals who are aware of their own personal values, understand them and hold to them. There is a role for community values, but only in so far as individuals take them on board and make them their own.

[22] Brock DW & Wartman SA. 1990 When competent patients make irrational choices. *New England*

All these versions of autonomy, then, seem to turn on the image of the individual as an autonomous agent who reaches rational, authentic decisions apart from social constraints.[23] All versions assume that patients are rational agents who seek help only when they need it, give thoughtful and thought-out histories, ask pertinent questions if they want more information, and understand what they are told. They then make logical decisions about the best treatment choices, consistent with other decisions they have made in the past. All this is unsullied by competing demands from family members or their work, by a desire to please the doctor, by what they may have read in a magazine or newspaper the day before, or even by needing to get home from the consultation before the children arrive home from school. In this world in which the individual reigns supreme, the best way to respect another's autonomy is not to interfere. The autonomy-respecting general practitioner, in this individualist and rationalist environment, recognises the distinctiveness and independence of his patients, keeps his distance, and refuses to interfere in decisions which are theirs to make.[24]

7.3.2 Respect for autonomy-in-use: 'Patients should make their own decisions'

Just as the formulation of respect for autonomy in the bioethics literature can be characterised as rationalist and individualist, so also the rationalist and individualist themes could be seen in the GPs' interpretation of their principle that 'patients should make their own decisions'. They focused on two aspects of that principle - that 'doctors should not impose their beliefs on their patient' and that 'doctors should provide a balanced account of things'. Dr Winters' discussion about how he responded to requests for abortion provides an excellent introduction to and summary of the GPs' understanding and use of the principle that 'patients should make their own decisions'.

Dr Winters began his interview by telling me that the most significant ethical

Journal of Medicine 322: 1595-1599.

[23] Anspach RR. 1993 *Deciding Who Lives - Fateful Choices in the Intensive Care Nursery.* University of California Press, 35. See also Chambliss DF. 1993 Is bioethics irrelevant? *Contemporary Sociology* 22: 649-652.

[24] Childress J. 1982 *Who Should Decide? Paternalism in Health Care.* Oxford University Press, 56, develops this theme.

dilemma for him was when women came requesting a termination of pregnancy.

> 2...the biggest one is when women come for termination of a pregnancy. I have fairly firm personal beliefs and obviously, well, with a religious basis. So, I'm firmly opposed to abortion for just about all reasons, not totally exclusively but there may extenuating circumstances of which it may be condoned, such as the life of the mother is in extreme danger or something,- I don't know, maybe. But I have a real problem with women (and they're generally younger women), falling pregnant and then coming and seeking abortion almost without thought. And the way the legislation is at the moment - the criteria is just we, the requirements are fairly broad and can be interpreted fairly liberally. So it's very easy just to say, "yes, okay, this will cause you mental trauma", sign a form and off they go and see a gynaecologist for a termination of pregnancy. I respect the right of the individual that under the current legislation they have that right. Nevertheless, I'm opposed to it, so this does create somewhat of a dilemma for me, personally. The way I've got around it, and I'm not totally happy with it, is, I work in a group practice and so what I have said to people when they - I mean a lot of them are patients, a number of them are patients that I see reasonably regularly and have a fairly good relationship with and I explain to them why I have a personal problem with this, and they often understand that, and I usually say, "if you want to do this you'll have to go and see another doctor in the practice". Now really all that is doing, I mean it sort of appeases my conscience somewhat, but really all it's doing is getting someone else to sign the little piece of paper and this individual is going to go through with this anyway. So, it's just a rubber stamp, and whether I'm the rubber stamp or someone else is the rubber stamp it doesn't really seem to make a lot of difference to me. I just have a problem with it.
>
> Dr Winters

Dr Winters was opposed to abortion, for reasons related to his personal and religious beliefs. His moral dilemma, as he described it here, was how to respond sensitively and compassionately when women came to him requesting a termination of pregnancy, without compromising his own belief that any termination was wrong. In general terms, he "got around" his problem by referring patients to a partner who would be prepared to sign the referral letter.

To help me understand Dr Winters' reasons better, I asked him to give me some concrete examples of his dilemma.

> 3. *Can you give me an example of a typical case which would be a problem to you?*
> 4. In this context?
> 5. *Yes.*
> 6. I remember one young woman - it was in the recent past - who was on the oral contraceptive pill and I believe was using it correctly and still became pregnant. She came to speak to me about it and she was undecided. She was opposed to termination of pregnancy herself; at least she'd always thought she was before becoming pregnant and then now that she was, she wasn't sure. She had a lot of pressure from her then boyfriend; her parents didn't believe they were applying pressure. They said it was up to her, but they were saying they thought the best thing to do would be to terminate it, but the decision was ultimately hers. I spoke with her, and I said it was her decision, but my view was, my personal view was that she should go through with it, but that ultimately she had to terminate it and I tried to give her a balanced view in that the termination process is not without consequences, and neither is going on with pregnancy and having the child. That has attendant responsibilities as well. So there are no easy options, and that certainly termination in my view was not the easy option. Anyway, she decided after some deliberation to go through with it... So my current plan of dealing with this situation is, I just say, "personally I'm opposed, no, go and see someone else." But I'm still not completely happy with dealing with it that way and if you've got a better suggestion I'm waiting for it.
>
> Dr Winters

Dr Winters and I went on to discuss the nature of his religious beliefs and some rare circumstances in which he would consider supporting a patient's request for a termination of pregnancy. We then returned to the case he had been discussing previously:

> 18...What I tried to do was say, "look, it is your choice". And she already knew that I knew I wouldn't agree with it, so perhaps I tried not to apply any external pressure, but even the fact that she knew that I was opposed to it, which she did know, even though I would never say to her, "I don't think this is right so therefore I don't think you should do it". What I said to her was, "you know already that I'm opposed to this, but aside from that then is what you have to do is make your decision, not based on how you think I'll feel, and how you think your parents will feel, but how you'll feel", and then presented to her the potential consequences of both. If she had a termination that would be a big decision with possible medical complications. And likewise if she went through with the pregnancy she'd have permanent responsibility of child rearing at a relatively young age, etc etc. And then I just said, "well, I can't help more than that, you'll just have to decide for yourself", which she did.
>
> Dr Winters

The central tenet of Dr Winters' explanation here is that patients have to make their own decisions, based on their own reasons. In the discussion that followed, he identified two guidelines for action or, in bioethics language, specified two rules which followed from the principle that 'patients should make their own decisions'. First, he thought it important that, in his role as a doctor, he should not impose his own values and beliefs on his patients.

> 22. Yes, I think I'm non-directive, and because of my firm beliefs [and] anti-abortion stand personally I think more than average I have made a conscious effort not to be directive. Can you understand that? I really go to great lengths not to tell people directly what to do. But that's in that specific setting, whereas if I was having a conversation on a personal basis outside that therapeutic relationship then I would say, "no, I don't think you should have this, I don't think you should do that". It's a totally different relationship. If I had friends who'd asked me personally about a similar problem, I would say no and I wouldn't say, "oh, it's your choice".

The "therapeutic relationship" was a key concept for Dr Winters, and his comments about that relationship provided an insight into a second duty that followed from his principle that 'patients should make their own decisions' - the belief that he should provide a balanced account of things for his patients.

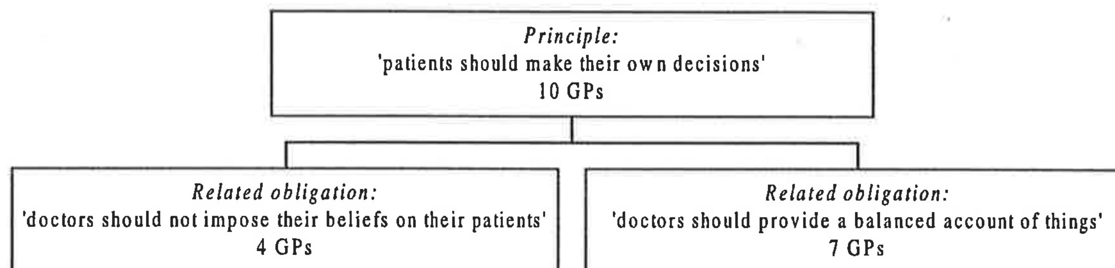
> *23. What's special about the therapeutic relationship?*
> 24. I think when an individual comes to see me with a problem, they're looking for a balanced view. They're not looking for someone to preach to them, and that maybe someone, some people deep down are looking for someone to tell them what to do, but ultimately the decision is their's, the responsibility is their's because the consequences will be their's, and it's unreasonable, and also foolish I believe, to make decision for people where it's - well, they're going to have to live with the consequences, and really the decision should be theirs once they have all the information...
>
> Dr Winters

This extended example from the interview with Dr Winters is helpful because it

introduces both the principle of respect for autonomy-in-use and the two rules or norms that the GPs identified as following from that principle. Figure 2 shows in schematic form how this principle and the two duties were related to each other, and gives an indication of the frequency with which the principle and duties were espoused.[25]

FIGURE 2

RESPECT FOR AUTONOMY-IN-USE BY THE GPS



* The total number of GPs using the two related rules is greater than 10, because Dr Winters mentioned both rules.

Ten GPs referred to the principle of respect for autonomy-in-use to justify their actions. For example, Dr Silverman offered the following version when he defined respect for autonomy near the end of his interview:

> 126. Respect for autonomy, I believe is allowing the patients to make their own decisions, even if you don't feel they're making the right decision. They have the right to make up their own mind based upon their beliefs given all the information available.
>
> Dr Silverman

Dr Stamos made similar comments when he was explaining paternalism:

> 85. I try to be as un-paternalistic as possible. People should be able to make up their own minds, given enough information, and whether or not they actually agree with what you think should be done, is really neither here nor there. I mean, it's their decision...
>
> Dr Stamos

These GPs were doing more than mouthing platitudes, as Dr Winters' interpretation of the principle showed. His development of the principle that 'patients should make their own decisions' into two rules – not to impose his own values and beliefs on patients and to provide a balanced accounts of things – was mirrored in the talk by other GPs.

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[25] Unless otherwise noted, the data used in this chapter and the three that follow relate only to those interviews for which I had complete transcripts. The 'denominator' is therefore 13 GPs. I have chosen, for the most part, to exclude the interviews with Dr Alderson and Dr Williams, from which only incomplete transcripts were made, because analysing the styles of moral deliberation required detail I did not have available in the notes from their interviews.

Four of the GPs connected respect for autonomy-in-use with the belief that doctors should not impose their own values or beliefs upon their patients. Instead, they believed that their job was to provide information in ways that encouraged rational decision-making. For example, Dr Silverman had described to me his attempts to "persuade" a patient to tell her boyfriend she had a sexually transmitted disease. I then asked him what he meant by persuasion:

> (72)...I think persuasion is presenting the information in such a way that the person is more likely to listen to it and respond in what I see as a rational and adult manner. Now they can behave in a rational and adult manner and still disagree with me. There's nothing wrong with that. But then I have to be mature enough to sit back and say "well, okay they've made their choice, and I've still got to be there to help out if something goes wrong." I mean, I can't force my own values on everyone I see, that's not right. I've seen what happens when that goes on, and I don't like the results.
> *73. Is this woman behaving in a rational and adult manner?*
> 74. She is behaving rationally given the way that she feels. I mean, you've got to understand how she's feeling, and she's responding to those feelings in what I see as an appropriate manner. I call that rational. The difficulty I have is that I feel that the way that she's actually feeling about it is perhaps immature, but then a lot of us do that anyway, and I can't sort of stand back and say "well I don't think she's being very adult about it", because whilst I might feel that way, it would be unfair for me to inflict my ideas of what adult behaviour is on someone else. Her lifestyle suits her.
>
> Dr Silverman

Seven GPs linked respect for autonomy-in-use to the norm that they should provide a balanced account of things. These GPs used a range of conversational tactics - describing treatment regimes, their nature and benefits, and the anticipated risks, inconvenience or discomfort - to provide patients with 'relevant' information so that they were in a good position to make their own decisions.[26] Dr Elwin, for example, offered a description of how he would talk about referrals with patients that emphasised the provision of explanations and information. In the section of the interview just before this excerpt, he had described a number of ethical dilemmas relating to referring patients on to specialists, focusing on how he related to the specialist. I then asked him to tell me about what he said to patients.

> *27. In each of those examples that you've given me, what do you say to the patient?*
> 28. In the example of the situation with asthma it's often prompted by the patient. They'll say, "oh, should I see a specialist?" and you say, "well, it's entirely up to you . I'm quite happy to look after your situation and I think that over time we'll get this under control. I'm quite happy with how things are going and I'm quite confident that we can get this situation nailed down ourselves. However, if you would like some opinion from a specialist in this particular area, then that's OK. I'm not going to say, 'no, you can't have that.' And I'll arrange for them to consult with you. Where would you like to go?" And some of them will say, "well, as long as

[26] Chapter Ten describes these conversational tactics in detail.

> you're happy, that's OK." Because they've perhaps got confidence in my abilities, but they were just wondering. And others often say, "well, yes, I would like to have a second opinion with regard to Johnny's asthma, because I have been knocked around with treatments and things". So I think in that sort of context I generally just sort of tell them how I feel about the management and ask them what they want to do.
>
> Dr Elwin

Dr Elwin's comments show how he tried to offer a balanced view to his patient in this situation. He indicated that both seeking an opinion from a specialist and not seeking an opinion were acceptable options, and his final comment reiterated again that 'patients should make their own decisions'.

The emphasis in all of these accounts of the principle of respect for autonomy-in-use and of the related rules is on the individual patient who takes responsibility for his or her own life, and makes sound and reasonable decisions using the information that general practitioners provide. At the end of the interviews I asked each GP to define 'respect for autonomy' and describe how it related to their work. Their definitions reflected the same orientation toward individualism and rationality I have described above, and also point to the GPs' lack of familiarity with the language of ethics. Five GPs' definitions suggested that respect for autonomy meant that patients made decisions, and two definitions focused on the individuality of each patient and the right to act as he or she wished. In addition, three GPs responded in ways which implied that they understood the term, but they did not define it in enough detail for me to be clear about their interpretation, two were not familiar with the term, and one thought I was asking about the independence of medical practitioners! (See Table 6.)

TABLE 6

GPS' DEFINITIONS OF 'RESPECT FOR AUTONOMY'

GPs' responses	Example – representative language	Which doctors
Decision-making	"I guess, to me it means respect that individual's own decision-making ability and, again, his rights or her rights to be that individual and be an autonomous..."	Dr Owen, Dr Silverman, Dr Elwin, Dr Masters, Dr Newton
Implied understanding	"That's what we were chatting [about] before. I think that is also extremely important. Autonomy, as in more the negative sense, in other words impinging people's autonomy as physical people, should be respected, absolutely."	Dr Stamos, Dr Dunt, Dr Little
Individualism	"That's, I mean, everybody's an individual. I suppose I respect them as individuals, and it depends, I mean, if you want autonomy, they've got a right to take or not take medication. I suppose that's autonomous, in terms of "take my answer or not", I mean, if they want a second opinion, by all means, go and get it. That's a bit of a silly term."	Dr Johnson, Dr Sing
Had not heard of term	" Respect for autonomy? I can't say it's a term I'd use very much...Elaborate..."	Dr Winters, Dr Kingsford
Independence of medical practitioners	" I think I've already touched on that a bit, talking about vocational registration where the government is, you know, has got us by the throat, really, we are not autonomous."	Dr Bright

These definitions and the ways in which the GPs used the principle 'patients should make their own decisions' revealed a great deal about the type of people the GPs assumed their patients were. They assumed that, all other things being equal, their patients wanted to make decisions. Furthermore, they seemed to think that there were really only two impediments to good decision-making by their patients - a lack of information and too much influence on the part of the general practitioner. The former could be dealt with by providing a 'balanced account of things'; this would ensure that decisions were rational. The latter problem was addressed by being careful not to overstep the value mark; this would ensure that patients were really making their own decisions.

The GPs could also derive some support for their interpretation of the principle of

respect for autonomy from the way in which the general practice literature invites general practitioners to place the individual patient at the centre of their work. The 'patient-centred approach' is important to the altruistic professional model of general practice. That approach encourages general practitioners to commit themselves to the patient's interpretation of their own problems, and to try to understand things from the patient's point of view. To achieve this, the professional altruistic model supports an open-ended approach to communication and counselling with patients. Dr Owen was very much aware of the way in which this aspect of his training in general practice had influenced his approach to dealing with moral problems. He suggested that many doctors would not have been as open-minded as he had been in dealing with the young woman he discussed with me.

> 85. No, unfortunately I don't. I think that a lot of doctors would approach that by saying - my training is to be very open minded about options and treatment for anything, and so I'm very aware of not closing down one or two options, in a situation. A lot of doctors are not so aware of their own ability to just choose one or two options and might have just gone ahead at the first operation, say, and said, "oh look, we'll do it, and we'll say nothing about it". If their own sort of feelings had been so strong, if they'd said, "look I think this is just terrible and I think that we can assume that she doesn't want to have any more children, or we can assume that we're acting in the best interests of the community, we should just do this, and we have a right to do this", and the same applies to when she came back with questioning of her tubal ligation. A lot of doctors would have just wanted her to go away and shut up and forget about it. They'd say it was a permanent decision, that was non-negotiable.
> *86. Are you saying that you don't think you are as paternalistic as some other doctors?*
> 87. No, certainly not.
> *88. Now, why do you think you're different?*
> 89. Probably because I've done general practice training.
> *90. What is it about the training?*
> 91. The training encourages you to think through different options rather than go for black and white options which is what your hospital training teaches you to do. Hospital training says to you there's a series of symptoms, you do an examination, you have some hypotheses, then you come to a decision. And you must always come to a decision. In general practice less than 50% of the time you have a decision at the end of seeing a patient and it tends not to be so structured and formal and didactic. Because we also do training and counselling in general practice training, we are aware of not closing off interviews and closing off options in interviews, and keeping options open and then keeping the patient very much at the front of decision-making because we counsel them to make their own decisions themselves, about themselves and finding the avenues of treatment themselves, and I think that helps you a great deal when you come into difficult situations where you maintain your perspective of different options. And that only comes through by doing adequate general practice training at a post-graduate level.
> *92. So that would differentiate you from other doctors who have not done general practice training.*
> 93. It helps. I think that a lot of GPs learn by mistake, by their mistakes over the years, that closing options is not the way to ultimately be giving a lot of solutions to deal with problems. By having the general practice training at least people get exposure to different theories of coping with this sort of problem and in managing interviews, and they can put them into practice much earlier, rather than take them ten years to learn them.
>
> Dr Owen

Dr Owen identified his training in general practice as central to both his patient-centred approach and to his interpretation of the principle that 'patients should make

their own decisions'. He noted, however, that many general practitioners arrived at an open-ended approach to the resolution of problems by dint of experience. For him, there was something in the nature of general practice that promoted the principle of respect for autonomy.

The individualist and rationalist framework that this understanding of autonomy assumed and imposed seemed to suggest a relatively minor part for the GPs in their patients' decisions. Yet, this explanation of the GPs' relationship with their patients sits oddly with the account I offer in Chapter Eight of the use of experience in moral deliberation. That account suggests that the GPs placed themselves at the centre of the moral world of doctor and patient. In a similar way, research in the sociology of doctor-patient communication suggests that doctors rarely play such a minor role in their patients' decisions.[27] Instead, difficulties beset and complicate communication between doctors and patients. Doctors unintentionally control the structure of their conversations with patients; they present their own interpretations of events as 'fact'; they treat patients from different cultural and socioeconomic groups in different ways. For their part, patients selectively absorb and interpret the information they receive; they understand information differently because of cultural and class barriers; they acquiesce in the consultation and then refuse to comply.

The evidence from the sociological literature and from the GPs' talk about the role of experience in their moral deliberation suggests that the principle that 'patients should make their own decisions', if used alone, does not offer a convincing account of principlism-in-use in the GPs' moral deliberation. Respect for autonomy-in-use was not, however, the only principle the GPs used. They also had a second principle to draw on that gave a very different perspective on their intervention in their patients' decision-making. That principle was beneficence-in-use.

[27] See Anspach, *Deciding Who Lives...*, 35-7, for a brief summary of research on doctor-patient communication and Chapter Three of this thesis, which summarises some of the many studies on doctor-patient communication in general practice.

7.4 BENEFICENCE

If the principle of respect for autonomy has been ascendant in bioethics over the last twenty years, then the principle of beneficence has been on the other end of the see-saw. The principle that doctors are morally required to act for the benefit of their patients has had a long and venerable history[28], but it has suffered considerably at the hands of those who suggest that, in any conflict between the moral obligation to respect autonomy and the moral obligation to act beneficently, autonomy must prevail.[29] In recent years, however, there have been attempts to revitalise debate about the balance between beneficence and autonomy.[30]

The GPs in this study seemed blissfully unaware of this debate about the meaning and moral value of beneficence. They made considerable use of their own version of the principle of beneficence; simply put, these GPs thought that doctors should 'do what's best for their patients'. For the most part, this principle was interpreted within the context of a particular encounter between doctor and patient. The meanings that it acquired in those specific contexts related both to the way in which the bioethics literature has interpreted beneficence and to the altruistic professional model of general practice.

7.4.1 Beneficence in the bioethics literature[31]

The principle of beneficence is premised on an obligation to benefit, or do good for, others. The form that doing good for others takes, and the meaning of 'good' may seem simple and obvious, but they are really complex concepts. Pellegrino and Thomasma note that "so beguiling is the idea of doing good for the patient that we

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[28] See Pellegrino ED & Thomasma DC. 1988 *For the Patient's Good: The Restoration of Beneficence in Health Care*. Oxford University Press, for a discussion of this tradition.
[29] Engelhardt TR. 1986 *The Foundations of Bioethics.* Oxford University Press.
[30] Pellegrino & Thomasma, *For the Patient's Good...*
[31] As with the section on respect for autonomy in the bioethics literature, this section provides only a very brief introduction to the literature on beneficence. I have chosen Pellegrino and Thomasma's work because it has a direct bearing on the GPs' beneficence-in-use. Beauchamp & Childress, *Principles* (4th edn)..., chapter 5; Childress, *Who Should Decide...*, chapter 2; and Engelhardt, *Foundations of Bioethics...*; and a number of the papers in Shelp EE. (ed.) 1982 *Beneficence in Health Care.* D Reidel Publishing Company, provide alternative introductions to this literature.

seldom examine closely which good, and whose good, we are serving".[32] One aspect of 'the good' for patients that *is* often examined relates to the common distinction made between benefitting and not harming. Some theorists distinguish between beneficence and nonmaleficence,[33] whereas others treat them as a single principle.[34] Theorists on both sides acknowledge that there are levels of beneficence, even if they treat these levels as shading into one another.[35] In the discussion which follows I sidestep this debate, because the GPs interviewed in this study nowhere made the distinction. I have chosen to treat their comments about not harming under the larger umbrella of beneficence.

Pellegrino and Thomasma's contribution to the examination of 'doing good' and 'the good' is to suggest that there are four related, but distinct, senses of 'the good' being used when the patient's good is invoked.[36] They preface their remarks by noting that, in accepting a patient, the physician is "obligated to act for the good conceived by the patient and to support the patient's goals".[37] For Pellegrino and Thomasma, this claim deals with the potential conflict between beneficence and respect for autonomy.

The highest of Pellegrino and Thomasma's four senses of 'the good' is the "ultimate good", or the standard that has the highest meaning for the patient and to which he or she appeals as a first and last resort. For some it will be God, for others some other driving force in their lives. A second sense of the good is the "biomedical good", that good which can be achieved by using technical medical knowledge; this good is often subsumed under the phrase "medically indicated". A commitment to the biomedical good of the patient requires that the physician use technical and scientific evidence, coupled to sound clinical judgement, to ascertain the likely consequences of a particular treatment for the patient under his or her care. Pellegrino and Thomasma note

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[32] Pellegrino & Thomasma, *For the Patient's Good...*, 73.
[33] Beauchamp & Childress, *Principles...*, chapters 4 & 5; Hart HLA. 1961 *The Concept of Law*. Clarendon Press, 190; Ross WD. 1930 *The Right and the Good*. Clarendon Press, 21-26.
[34] Frankena W. 1973 *Ethics*. (2nd edn) Prentice-Hall, 47.
[35] See, for example, Frankena, *Ethics...*
[36] Pellegrino & Thomasma, *For the Patient's Good....*,chapter 6.
[37] Pellegrino & Thomasma, *For the Patient's Good...*, 76.

that physicians have a tendency to take biomedical good as their only goal, and they argue against this conflation of biomedical good with good for the patient. They are clear that biomedical good is an essential, but not sufficient, component of good medicine. The third sense of the good is the "patient's perception of her own good at the particular time and circumstances of the clinical decision and how she prefers to advance her own life plan". Pellegrino and Thomasma equate this understanding of the patient's good with the patient's "best interests", those aims, plans and preferences that are unique to a patient and chosen by her at a particular time. The fourth sense of the good is "good of the patient as a human person", those things which preserve the patient's capacity to use reason to make choices, and this sense includes a number of bodily capacities as well. This sense of the good differs from the others in that its importance does not vary with particular circumstances in the way that the other senses of the good do. The capacity to use reason to choose for oneself what one will do is, according to Pellegrino and Thomasma, "a cherished and distinctive feature of human existence".[38]

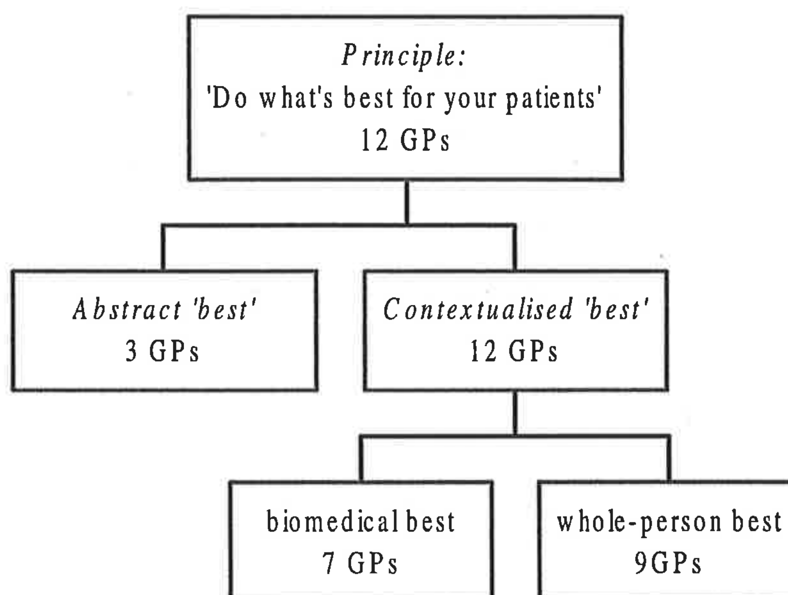
7.4.2 Beneficence-in-use: 'Do what's best for your patients'

Twelve of the thirteen GPs used the principle that you should 'do what's best for your patients' to justify their actions. However, whereas they used the principle that 'patients should make their own decisions' and its two related rules in a general sense, the principle of beneficence-in-use was rarely applied in a general fashion. More commonly, the GPs described situations in which doing the best for one's patients was explored in terms of that particular situation and that particular patient. This contextual interpretation of the best for one's patients took two forms - a biomedical best and a whole-person best. Figure 3 shows how the various forms of beneficence-in-use were related to each other, and gives an indication of the frequency with which the principle in its various forms was espoused.

[38] Pellegrino & Thomasma, *For the Patient's Good...*, 80.

FIGURE 3

BENEFICENCE-IN-USE BY THE GPS



Only three GPs talked of doing good for patients in an abstract or general sense. These GPs made general statements about acting for the good, benefit or welfare of their patients. For example, Dr Little spoke about beneficence:

> *(93)...do you think that there are general principles or any general guidelines that influence the way you respond in all of these kinds of situations from the sick certificate through to the working as the locum?*
> 94. I think the main thing you have to ask yourself is, "what's going to be best for this patient in this situation?" And if the patient really is stressed out and not coping then I think they deserve a day off. And as I said, they're mostly people down the bottom of a heap who don't have many coping skills. This is something else I learnt from [working as a medical officer in a gaol]. That most of the people in gaol are not there for criminal things, most of them are there for social incompetence. And they just don't know how to handle life and its situations and they just need a bit of time out now and then...
>
> Dr Little

In this quotation, Dr Little began with a general response and then went on to provide a particular example. It is the phrase "in this situation" which links Dr Little's abstract version of "best for this patient" to two other, more contextualised, ways in which the GPs talked about doing good. Twelve GPs offered a version of 'best for patients' that did not mention best in general or abstract terms. Instead, these GPs justified their judgments and actions in ways that assumed they were trying to achieve the best they could for their patients.

In these situations, the GPs drew on two understandings of what 'best for patients' might mean. First, seven GPs offered examples in which best was interpreted along the lines of Pellegrino and Thomasma's "biomedical good" in the sense that the GP's action could cure, contain or prevent disease; it could ameliorate symptoms; or it could prolong life. For example, Dr Elwin relayed the conversation he had with a patient about whether she should transfer to the major regional hospital down the road for care during her difficult pregnancy. He couched best interests in terms of the "safety" of mother and baby.

> 31. To her, I said, "well I'm prepared to look after you in this situation provided that, if I feel that the situation is getting out of hand and there's a chance of you delivering, that we organise admission to [the regional hopsital] under a different obstetrician straight away." And she was happy with that. Because I said, "my major concern in managing the pregnancy is safety and if I feel that it is not safe I'm not prepared to puddle along in a peripheral hospital and have a delivery go bad for the sake of a quick trip down the road and care taken over by another doctor." And she was fine when I put it in those sorts of terms. [When you] start talking about safety and loss of babies' lives most people come clear.
>
> Dr Elwin

In a similar way, Dr Johnson was guided by his patients' best biomedical interests: he said that he had to own up that he had made a mistake in not vaccinating a patient, because not to would have placed the child at risk of "serious life threatening illness" (6). Although Dr Bright's strong anti-abortion stance was grounded primarily in his belief that abortion was a form of murder, he also had biomedical best interest reasons for opposing it. He listed a number of "medical complications" that he thought were likely to occur when women had repeated abortions:

> 4...I do know a) that having an abortion is a bit more than taking an aspirin, even though there is now medication that will do this most of the time, and also doing a curette on somebody who's pregnant, to produce abortion is a bit different to doing a curette to tidy up somebody who's miscarried because in the one who's miscarried, the mouth of the uterus is open, and the one that isn't the mouth of the uterus is closed hanging on for dear life, if you like, and you have to stretch it harder. And so folk who have had a few abortions get an incompetent cervix. If they get pregnant, they've got the fool thing sewn up. And also, more folk who have abortions get blood transfusions and other complications than folk who have normal pregnancy, or even folk who miscarry. So, in spite of what folk say, doing abortions has medical complications, and psychological and social complications that people are not generally aware of and basically, I think, they don't want to be told, they want to get rid of it, and that's it.
>
> Dr Bright

These examples all presume that the good for the patient could be equated with "medically indicated". Yet, there is a twist here that Pellegrino and Thomasma do not

take into account in their taxonomy. Pellegrino and Thomasma's notion of biomedical good is premised on the understanding that doctors deal with the treatment of disease in a patho-physiological sense. Yet, in most of the situations these GPs described the focus was not on a disease to be cured, prevented or contained, on physical symptoms to be ameliorated, or on a life to be prolonged. Instead, the GPs' attentions were focused on the good of the 'whole-person' through an emphasis on social, emotional and relational issues.

This focus on 'whole-person best' constituted the second interpretation of 'best for patients' offered by the GPs. Nine GPs provided examples of moral deliberation in which actions or judgements were justified in terms of doing what was best for the whole patient. For example, Dr Owen had a range of interests in mind - mainly social and psychological - when he talked about doing 'good' for his patient and others:

> 23. Well, I must say that I thought that if she was not able to have any more children that would be a good thing, and I don't think that she would care whether she had, if she didn't have any more children...
> *24. Who would it have been a good thing for?*
> 25. It would have been a good thing for, probably for her, it would have been a good thing for her daughter. It would have been a good thing for any child that she had, probably, based on her past behaviour. It would have been a good thing for me, because I wouldn't have to look after her pregnancy and any other problems that would arise out of that. And, I guess in a community sense it would have been good because of the problems that would have been prevented.
> *26. Why would it have been a good thing for her?*
> 27. Well, I, it makes assumptions that she wasn't fully in control of what she was doing. I guess that she didn't understand the implications in a lot of her behaviour, her drug and alcohol behaviour, and her promiscuity, that she didn't understand all the implications from that, and we were trying protect her from herself, which is certainly an unwise assumption, but many of us are inclined to do that, especially if we have people that are, how do I say, poor background, poor education, people who don't really want a, or don't show behaviour, I suppose, that we find acceptable as a community standard. But, whether our assumptions are correct or not is another thing.
>
> Dr Owen

Dr Newton also focused on the need to do what was best for her patients in a holistic sense when she talked about her dilemma concerning how far to pursue patients who had decided to change doctors. She had noted earlier in the interview that she thought it important when dealing with old people, as she was in this instance, that the doctor should not "hassle" them, because this was likely to cause the patients distress.

> 54. I could have consulted them - all three of them - much more personally. And said - probably I should have, I guess, and found out exactly why. But, I felt embarrassed about the thought of doing that. Embarrassed and hurt, so I didn't really know whether I wished to involve myself in that. It's always easier to turn your back and walk away. And also, I'm not sure that that's fair to an elderly patient. I mean, if they'd made the decision to change then I don't think you should

pressure them, and I don't think you should ... I'm not sure about this. I had an ethical dilemma there, as to how far I should go. But, I felt confident with what I did. It's made me feel much more cynical about the way I look after my patients.
55. It's a difficult situation. Why do you feel it would be putting them under pressure to confront them?
56. I guess I think they have the right to change without having to explain to me why. And I think the wife of the couple would have been very upset about the whole thing, and quite distraught, and I didn't want to add to that. I thought that it was better for me to buy out. I don't think he'd have been upset at all. I don't know what his reason, to would have been. They were all very elderly , they were all ... a touch of dementia. They were all personality problems, none of them were easy straight forward patients. I knew what I was going to be buying into if I tried to do that. Now I didn't think it was going to be helpful. I thought it would actually be helpful. It was better to ensure a smooth transition.

Dr Newton

Dr Newton's reasons for not 'pressuring' her patients related partly to her own feelings of embarrassment and hurt. In addition, she was concerned that the patients' best interests be served by minimising the harm for them. Her concept of harm, however, was not a medical one; rather, it was focused on the emotional and psychological distress and agitation that she would create if she pursued the issue further. Her concern was for her patients' emotional and psychological well being.

Dr Kingsford also used the notion of emotional well being to explain why he kept a patient who had been assaulted by her father in hospital for 48 hours.

66... when I put this particular patient in I felt that she was very emotionally disturbed, very upset, and she needed a break from the environment, which I think, in retrospect was the right thing, because she was in for a couple of days, it gave her time to relax, gave her time to communicate well with her boyfriend. That situation may not always be available in the city, I think. It's a case of restriction of hospital access by GPs. So I think that was a factor, that it was good to be in the country. She needed counselling by an older person at that stage, someone that she could trust.
67. Did you keep her in hospital, partially because you just wanted her to have that time, or did she need two days of observation?
68. Yes. Well, she did need at least 24 hours observation, and then the second day, I think, I got the feeling that she really needed a little bit more time to settle down. The second 24 hours in hospital was probably more related to getting over the emotional trauma I think, rather than the physical side of it, although she still did have a headache after the first day or so.

Dr Kingsford

Dr Kingsford made a clear distinction in his comments between his patient's "physical" needs, which might be equated to her biomedical good, and her emotional needs. It was not the "physical side of it" which determined how he saw her best interests being served, but rather how he judged her emotional needs. Dr Kingsford regarded this judgment as much an exercise of his 'technical' knowledge and skill as a general practitioner as decisions he made regarding her physical well being. Dr Kingsford was typical of all the GPs in this study in his facility for moving between physical,

emotional, social and relational criteria for judging what would be best for the patient.

The GPs' concern to seek the 'whole-person best' for their patients is not surprising when we are reminded of the ideological context of general practice. The altruistic professional model of general practice discussed in Chapter Five encourages general practitioners to provide 'comprehensive' and 'whole-person care'. Care under this rubric incorporates the "psychosocial hallmarks" of the patient, taking into account the patient's emotional state and his or her social, psychological, family and financial circumstances.[39] The altruistic professional model of general practice invites general practitioners to step beyond a narrowly biomedical understanding of their work and exhorts them to include a focus on the full range of patient needs.

In summary, the GPs in this study rarely gave an abstracted or generalised version of beneficence. In that respect, their version of the principle of beneficence could be said to be hardly a principle at all. Yet, some notion of working for the good of their patients, expressed either as biomedical best or as the best for the 'whole-person', was implicit in many of their explanations. Unlike respect for autonomy-in-use, beneficence-in-use reared its head principally in situated and contextualised circumstances.

7.5 DEALING WITH CONFLICTS BETWEEN PRINCIPLES

The account so far has suggested that the GPs used versions of both a principle of respect for autonomy and a principle of beneficence in their moral deliberation. It is almost a truism in bioethics to say that there is an inevitable tension between these two principles.[40] Yet, the GPs did not talk in ways which suggested that any such conflict existed. On closer examination, the GPs had two main strategies to deal with the potential conflict between respect for autonomy and beneficence.

[39] See, for example, Murtagh J. 1994 *General Practice.* McGraw-Hill, 71-76, on the nature of the "whole-person approach to management".
[40] Engelhardt, *The Foundations of Bioethics...*

The GPs' first strategy was to carry out a form of specification that did away with the conflict. For example, Dr Dunt described very succinctly how he combined his principle of respect for autonomy with the principle of beneficence. He began by saying that the guiding precept for his practice of medicine was that one should act in one's patients' interests.

> 50. [It's] a feeling that I've always had that if you practise medicine, you do so completely. That you do so with your patients' interests. And that's why I'm in medicine to start with, and I believe very strongly in what I do, and if that means risk to me I'm prepared to take it.

When I asked him to explain what acting in his patient's interests meant, he defined it as following the patient's wishes.

> *51. So, why was the course of action that played itself out in Pam's interest?*
> 52. Because of the way Pam saw it. No-one else. It was her body. It was her decision to make. It was no-one else's in my opinion. It is not up to me to tell someone where they'll be delivered. It's for me to advise and to advise the risks, for the person to decide.
>
> Dr Dunt

Dr Dunt's beneficence-in-use was expressed in terms of respect for autonomy-in-use. The way that he specified the principle of beneficence, taking it to mean 'patients should make their own choices', left no room for conflict.

Dr Silverman used the same approach, but in reverse. We had been discussing whether it was ever appropriate to carry out a blood test without telling the patient why. He was vehement that doctors should never do any tests to patients without telling them what they were doing. Such a view seemed to fit with his earlier and later statements that patients must always be the ones to decide what happened to them. However, when I asked Dr Silverman to explain why doctors should tell patients what they were doing, his reasons revealed rather more concern for the patient's welfare than they did for the patient's right to self-determination.

> 56. No, I don't believe you should do any test to anybody without telling them what you're doing.
> *57. How come?*
> 58. Because, an HIV test has an enormous emotion impact on people, whether it's positive or negative. If they don't know what happening and they just ring and ask for results, and the staff recognise the voice, then they're going to tell them the results. If they don't recognise the voice they put them through to me. If I don't recognise the voice I'll ask them to come in so I can see who it is I'm talking to. But if I recognize the voice I'll give them the test results. It's a simple method of doing it. But, I wouldn't want that to happen.
> *59. For what reason?*
> 60. If suddenly somebody found out they'd had an HIV screen and didn't know about having it done and, giving that she appears to be doing her darndest to ignore any information about such a transmissible disease, I think that certainly she would be very very upset, firstly. Secondly, she'd start to wonder that perhaps I thought she was in a high risk group and start to panic that maybe that the test was negative and it was in the window period, and maybe she does have

something nasty and it's been missed. You can induce all sorts of anxieties that way, and I don't think that's a reasonable thing to do. Better for me to persuade her to accept that based upon good sound knowledge of knowing what she's getting into. Then when she gets a negative test result back she'll be much more happy with it.[41]

Dr Silverman

Despite his tendency to wander around the point here, Dr Silverman was clearly interpreting the principle of respect for autonomy in a way which made it consistent with his commitment to acting for the best for his patients. He repeated that interpretation in his next comments in the interview.

61. Would you use the same approach for all types of tests, even ones that don't have quite the same seriousness?
62. Yes, I do actually, because I feel very strongly that people should know what's happening. I don't believe that any treatment or investigation the patient should be done without people knowing why.
63. Now, why's that?
64. A friend of mine died early last year of bowel cancer. He was initially sent for a Barium, enema, without really knowing what was going on. He complained, of bleeding - he knew he had piles, but his doctor sent him for a Barium enema without telling him why. He just said, "oh I think we ought to do this, just to make sure there's nothing else going on". That was it. And when the result came back that there was an obvious tumour there, he was extremely upset and angry because he hadn't been told. He felt that he should have at least been told that that was a possibility, and that that was what was being checked for. The other reason he was angry was because, in addition to this diagnostic test that was being done, he was also sent for faecal occult bloods and he found out later that you sort of, well you already know you've got bleeding piles and when you know that you're in a risk group that should be checked diagnostically, a screening test isn't appropriate, and he, of course, he paid for that. And he was very angry about that, too. He felt that the doctor was dishonest with him, and that undermines the relationship and without a good trusting doctor-patient relationship you're not going to be able to achieve other things later.
65. Like what?
66. Like persuade people to go for other tests or investigations where you're not really certain of what's going on but the diagnosis is in doubt, that it may be something serious, but you want them to trust you, to go through it to make sure. If they say, "well, if you're not really sure", or "doesn't seem that right, then why should I do it?" But if they trust you, they do it anyway. I know that sounds odd. Trust is very important for the long-term management of patients. It is not in interim care, but in general practice it is continuity of care over a long period of time, and that means you've got to built up a relationship. If you start off by deceiving somebody, or you undermine their confidence in you in any way, then they've two choices, they can change doctor, which breaks up the continuity of care and decreases the quality of care generally, usually. Or, they will question everything you do, which means that the consultations will take a lot longer to achieve the same ends. Or, they just won't do it, which can have disastrous consequences.

Dr Silverman

The central tenet of Dr Silverman's argument was that honesty and providing information for patients were important values mainly because they enhance the general practitioner's ability to act in the best interests of his patient. According to Dr Silverman, doctors who deceived their patients were at risk of providing poor quality care for two reasons: patients could leave, and this impaired continuity; or patients would not do what was in their best (medical) interests. His third reason, that the

[41] Indeed, South Australian Health Commission Policy is that counselling should always be provided when testing is contemplated.

patient would question everything and take up valuable time, was a reflection on the time constraints under which he (and his colleagues) worked.[42]

The GPs' first strategy for managing conflict between principles was to specify the conflict out of existence. Their second strategy for managing conflict between principles was more confusing. It involved ignoring the rules of ethical engagement that those of us trained in ethics seem to accept as necessary. The standard methods for moral argument - consistency, logic, coherence - occasionally disappeared completely from these GPs' talk. Across the thirteen interviews, there were six examples in which the GPs either applied the same principle to very similar situations and came up with opposing judgments, or they identified a decision as right because it upheld a principle they valued, and then, in another situation, suggested that a completely different decision would be correct.

Dr Winters provides perhaps the best example of this approach. As I noted earlier, he had specified the principle that 'patients should make their own decisions' to mean that his role was to provide a "balanced account" of things:

> 24. I think when an individual comes to see me with a problem, they're looking for a balanced view. They're not looking for someone to preach to them... really the decision should be theirs once they have all the information.
>
> Dr Winters

At this point in the interview he was talking about the way he counselled women who sought abortion, given that he was strongly opposed to abortion on religious grounds. Immediately after this, though, he began to talk about how doctors sometimes had to:

> 24... make the decision for the patient, because it's impossible to present - all the facts can be presented, but then the patient can be so overwhelmed by the possibilities of potential consequences that they, in fact, won't make the right decision because the judgement is not based on - I'm trying to explain this and not doing very well....
> *25. Can you give me an example? That would help me.*
> 26. This is just a small example. I have a number of patients come in and they're concerned about vaccination of children against haemophilus and they're concerned about the risks of their children getting meningitis and things like that. And I explain to them it's not a vaccination against meningitis, it's a vaccination against a specific bug that can cause specific type of meningitis, which is particularly serious and which can lead to some fairly serious sequelae, including death. And they're worried about what are the risks between having the vaccination and getting meningitis. And I try to explain to them that even though the risk of getting this sort of meningitis is small, the risk of getting any sort of meningitis, relatively speaking on a population basis, is small, and then getting this one particular type is even smaller. Nevertheless there is a risk and the consequences can be devastating. And then they talk about the risks from

[42] The impact of time constraints on practice is explored in Chapter Ten.

having the vaccination. Well, there are risks from having a vaccination, as well, albeit small. And they're left with a decision of small risk if I don't have it and small risk if I do have it, and essentially then I just tell them "Look, have the vaccination" and I say, well they often ask me, "well, what would you do?" And I say, "if I had a child less than 5 years old, I would - if it was one of my children, I would have the vaccination". And then they say, "well, if you'd do it, I'll do it then". So that's the sort of situation where I don't think it's fair to ask people to make a decision because the risks of having the vaccination are small, but also the risks of contracting that illness, and the sequelae can be very very serious, so out of two small risks, I think the way to go is have the vaccination.

Dr Winters

Apparently Dr Winters found it more acceptable to "make the decision for the patient" when vaccination was the issue than when an abortion was involved. He seemed to shift ground here to adopt a principle that 'doctors should do what's in their patients' best interests'. I tried to tease out how he could hold these different approaches together by asking him to distinguish between situations in which he thought he might be biased and situations in which he thought he was impartial. Despite his earlier comments that, when dealing with abortion counselling, he thought that "more than average" he tried to be non-directive, he could still say that:

34... I think in [the] situation [of abortion] I would be biased. I don't think in a situation talking about immunization that I'm biased at all. It really is very much up to you, and I think ... that's a good question. I guess the risks ... I'm trying to think why, it's not simple. Guide me!

Dr Winters

Dr Winters was using principlism in a way that few bioethicists would find acceptable. He shifted position as it seemed to suit him, and adopted whatever principles seemed to apply at that moment. Dr Winters, perhaps, was not unaware of the contradictions in his views - the remarks he made at the end of the interview indicate how hard he had found this business of 'doing ethics':

113. Respect for autonomy? I can't say it's a term I'd use very much...Elaborate...
114. When people talk about autonomy, they usually mean people's right to be self-determining, to decide for themselves.
115. Yes, I understand from that point of view, but I've never phrased it like that. I guess, as we've had this conversation this morning that's essentially what I've been saying. They have their rights - yes, they have their right to autonomy. I decline to make decisions that I think they should be making, but then having made that decision then I am deciding what they have the ability to make the decision on. That's why I don't do ethics - it's too hard!

Dr Winters.

Dr Winters' interview provides the clearest example of a GP whose moral deliberation contained inherent contradictions and confusion. Dr Silverman and Dr Sing, particularly, also appeared to shift moral ground as they developed their stories, but in these cases, and three others, the contradictions were scattered more loosely

throughout the interviews.

One GP differed significantly from the others in his approach to managing the conflict between beneficence and respect for autonomy. Dr Owen was the only GP to talk about a conflict between autonomy and doing no harm:

> 73. Yeah. The balance is always between patient autonomy and doing no harm. Well, it's always that difficult balance in medical ethics and I think that, unfortunately there's a little bit of paternalism involved in this because we are not giving her, we're making some of the decisions for her, based on assumptions, based on her past behaviour, I guess, those decisions are made. I think that her autonomy has been respected as best it can be without creating a situation that's too difficult, I guess.
>
> Dr Owen

Dr Owen was also one of only two GPs to recognise the term 'beneficence' and to define it correctly. He also reported some informal education in bioethics (through his reading of a well-known Australian text on bioethics for medical students). One might speculate that Dr Owen's exposure to bioethics had primed him to see conflict between beneficence- and respect for autonomy-in-use where his GP colleagues found other ways to get around or ignore the conflict.

7.6 CONCLUSION

Why did the GPs approach the conflict between beneficence and respect for autonomy as they did? One possible explanation is that the nature of general practice work is such that it rarely requires the type of thinking that the GPs were invited to do in this study. General practitioners in Australia work primarily in private practices, providing medical services to patients on a fee-for-service basis. Their consultation time is carved up into many short consultations with many patients each day. They become experts in speedy problem resolution: they collect information, make a diagnosis, explain the situation to the patient, and proffer a treatment, all in a matter of minutes. Then they repeat the process with a completely new problem. In their daily work as problem solvers, GPs have little opportunity to practise the sorts of skills that seem so valued in principlist reasoning - skills in developing arguments carefully, articulating unacknowledged values, following the implications of a thought right through to its end, or even being consistent. One of my general practice colleagues

described it this way:

> Docs like neurologists, or even psychiatrists, get time to think. For a neurologist most of the fun is in the chase. You spend the time with the patient pinpointing the bit of the brain that isn't working. Then you can't do much about it anyhow. But it's not like that in general practice. We have to solve patients' problems, and do it quickly.

Practice at work aside, general practitioners have had little formal opportunity to learn ethics from others. The GPs in this study were unusual because they were *interested* in ethics, but even they had relatively little ethics education - one had a degree in philosophy, and two had educated themselves to some degree. They had had little or no exposure to ethics during their medical education.

In dealing with moral issues in a spur-of-the-moment way, the GPs were perhaps only mirroring the experience of other lay people doing ethics. Every-day moral reasoning seldom affords its practitioners the time and opportunity to apply rules in the logical, coherent and consistent fashion so valued by principlist bioethicists.

Despite their contradictions and inconsistencies, it is important to remember that the GPs did have and use moral principles. Their two principles - doing what's best for patients and letting them make their own decisions - were both important, but they clearly weren't the whole of the picture. On this point, I would agree with Johnson:

> My view, then, is not that we don't have moral principles, but rather that such meaning, relevance, and guidance as they offer depends ultimately (though perhaps not always immediately) upon the narrative settings in which they have emerged and to which they are being applied.[43]

Johnson's point is that we need to understand the use to which moral principles are put, in the light of the experiences that those who use them have. In the next chapter I explore how the GPs in this study used their experiences in their moral deliberation.

[43] Johnson, *Moral Imagination...*, 160.

8 THE ROLE OF STORIES: CASUISTRY-IN-USE

8.1 INTRODUCTION

The previous chapter discussed the role of principles in the GPs' moral deliberation. This chapter explores the ways in which the GPs used their life experiences, expressed as stories and anecdotes, to shape their thinking and talking about moral problems.

There are a number of ways to approach the question 'How has your experience over a lifetime influenced the way you deal with difficult issues?' Expressed in this abstract way, the question is difficult for many people to interpret. Indeed, the GPs in this study struggled to answer this question when I formulated it as a general inquiry about their lives and backgrounds. Yet, although they found the general and abstract concept of experience difficult, the GPs clearly had a wealth of experience that shaped the form and outcome of their moral deliberations. That richness of experience surfaced as stories – brief anecdotes and vignettes drawn from their lives that they compared and contrasted with the moral problems they were discussing. The GPs' stories represented their accumulated experience.

Experience presented in this form posed something of a paradox for me, because the GPs believed both that each encounter with a patient was different, and that experiences collected over a lifetime had an important influence on how one dealt with morally problematic situations. Dr Kingsford was speaking for all of his colleagues when he commented that:

> 62...I think as you get older you tend to - I've had over 30 years in general practice - you tend to get to know how to handle these situations, and I think this just comes with experience, you know it's the science and art of medicine, and it's - you only pick up the art of medicine with experience.
>
> Dr Kingsford

Yet, just as strongly, the GPs believed that every experience was unique, offering new challenges:

> 8. Yes, I think each case would have to be thought about individually.
>
> Dr Winters
>
> 46...Well, you have to take every case on its merits...
>
> Dr Sing

The tension between an experience of particular events and generalisation from those events is a puzzle. How is ethical expertise accumulated through experience? If every case is unique, how do experiences influence thought processes and decisions?

Lauritzen's paper in the *Hastings Center Report* on the relationship between ethical judgment and experience suggests one answer to these questions when he notes that, for himself, the appeal to experience has seemed to function like some kind of trump on moral talk.[1] Complex and vigorous debates about the morality of actions and situations are often silenced when people throw their own experience into the moral ring. It is as if they are saying "This is what happened to me. Top that!" Lauritzen puzzles over why this should be so, and concludes that the authority we ascribe to these appeals to experience appears to rest on a distinction made between 'facts' - real events that happen to real people - and 'fiction' - interpretation or discussion of those events. Yet, although the events related in an appeal to experience can be said to have occurred, it is the meaning we ascribe to those events that matters when people talk about their experiences. The line between 'fact' and 'fiction' as far as the meaning of events goes is thin indeed for, in practice, the things we experience and our interpretations of them are so intertwined that often we can not distinguish them.

If, as Lauritzen suggests, "an experiential report does not map reality but an interpretation of reality"[2], then the authority of these reports can not rest on their status as 'fact'. We need another way to regard appeals to experience and Lauritzen suggests that we treat appeals to experience as a sort of story-telling, and use the criteria that are readily available to evaluate narratives. He notes a number of writers who have sought to demonstrate that human experience is narratively structured,[3] not least because it is

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[1] Paul Lauritzen (1996) takes this issue as his central question in "Ethics and experience: the case of the curious response" (*Hastings Center Report* 26: 6-15).

[2] Lauritzen, Ethics and experience…, 8.

[3] Crites S. 1971 The narrative quality of experience. *Journal of the American Academy of Religion* 39: 291-311; Taylor C. 1989 *Sources of the Self.* Harvard University Press; Ricouer P. 1992 *Oneself as Another.* University of Chicago Press. To his list, I would add Johnson M. 1993 *Moral Imagination.*

impossible to conceive of experience without the ordering brought about by a time dimension. Recounting an experience is much like the task any storyteller faces: what is included? what is left out? how is interest sustained? and, most importantly, all for what purpose? Furthermore, there can be no divide between the 'events' being recounted and the interpretation of them, since, in practice, our experience is our narrative and *vice versa*.

My interest here is not in how we *ought* to regard appeals to experience, but in how those appeals work for the people who use them. However, Lauritzen's approach does offer a strategy to explore how experience functions in moral deliberation by suggesting that the questions we might address to an appeal to experience in moral debate are the same as the questions we would ask of any narrative. As I noted in Chapter One, the central element in narrative scholarship is the story. Scholars working within a narrative framework employ the methods and techniques of literary criticism, focusing on the features of narratives (for example, narrative frame, time, plot and desire) and on the ways in which stories are recognised, formulated, interpreted and validated.[4] The force of a narrative then depends on literary elements such as the development of plot, attention to detail, or use of symbolism, as well as "consistency with certain background theories".[5] If we take this narrative approach to ethics, we can treat moral argument as a matter of rhetorical persuasion. This requires attention to narration, description, detail and contemplation. In other words, we can evaluate an appeal to experience by using the criteria with which one evaluates a story.

Implications of Cognitive Science for Ethics. University of Chicago Press.
Kathryn Montgomery Hunter has written specifically on the role of narrative in clinicians' reasoning. See, for example, Hunter KM. 1986 "There was this one guy..." The uses of anecdote in medicine. *Perspectives in Biology and Medicine* 29: 619-630, and Hunter KM. 1996 Narrative, literature, and the clinical exercise of practical reason. *The Journal of Medicine and Philosophy* 21: 303-320.

[4] See, for example, Charon R *et al.* 1996 Literature and ethical medicine: five cases from common practice. *Journal of Medicine and Philosophy* 21: 243-265, and Charon R. 1994 Narrative contributions to medical ethics : recognition, formulation, interpretation, and validation in the practice of the ethicist. in DuBose ER, Hamel RP & O'Connell LJ. (eds) *A Matter of Principles? Ferment in US Bioethics.* Trinity Press International, 260-283. See also Riessman CK. 1993 *Narrative Analysis.* Sage Publications, for a helpful introduction to the literature on narrative analysis.

[5] Lauritzen, Ethics and experience...

The approach taken in this chapter uses in a simple way the tools of narrative analysis to construct an account of the way in which the GPs used stories to assist their moral deliberation. I show that the GPs introduced a wide range of stories, chiefly set in medical environments and about themselves, to their moral deliberation. These stories – about 'every-day', 'anomalous' and 'disastrous' events in their lives – were put to use in ways consistent with Lauritzen's notion of the trump on moral talk. The GPs' moral trumps were of two types – a 'consequence' trump, in which the focus was on outcomes; and a 'deontological' trump, in which the emphasis was on the illustration of a rule of thumb or maxim. There were also a small group of stories that seemed to have no trump; these stories were descriptive only.

The narrative approach taken to the analysis of these stories does not provide the only means by which to acknowledge the importance of events and occurrences in moral deliberation. Casuistry also takes the 'story' seriously, through its focus on the role of cases in moral analysis. The final sections of this chapter compare the GPs' use of stories in their moral deliberation with casuistic methodology. I argue that there are similarities between the two approaches but that the GPs' casuistry-in-use did not display the careful and rigorous use of logic and rhetoric that casuistry requires. The GPs' casuistry-in-use could also be criticised for some of the same reasons that contemporary casuistry has been criticised. In particular, the emphasis in the GPs' use of stories on individual medical encounters with doctors as central characters mirrors casuistry's emphasis on the particular, the personal and the specific, sometimes to the exclusion of the general and the social.

This emphasis on the particular in the GPs' casuistry-in-use was related to more than the similarities with casuistry. It also reflected the organisation of work in general practice, for general practitioners work in an environment that is oriented around individuals. Such an environment makes it difficult for patterns of illness to become apparent or for general practitioners to see associations between the problems patients

bring and the environment outside the consulting room. In this way, the organisation of general practice work supported and influenced the GPs' casuistry-in-use.

8.2 METHODOLOGICAL CONSIDERATIONS

The narratives I use here are the stories and anecdotes the GPs told as they discussed the ethical problems in their work. I use terms 'story' and 'anecdote' interchangeably. Following Hunter's lead, both designate:

> ...a more or less coherent...spoken or (by extension) enacted account of occurrences, whether historical or fictional...used, especially informally, to denote spoken and fictional accounts, where there is a strong sense of the story-teller.[6]

To provide some structure for the analysis I initially used the summary sheets I had made of each GP's moral decisions and moral reasoning. My review of those sheets suggested a set of questions that I might apply to my original interviews. I returned to the transcripts of the interviews to find those instances in which the GPs retold a life experience in the context of moral decisions and reflection.[7] I asked of each of these stories in each interview the questions: What type of event is being recounted? Who is the narrative about? What is the setting? What is the point of the narrative? In this case, how is it used to support a moral argument? These five questions formed the background for the analysis presented below.

The GPs made considerable use of stories and anecdotes in their moral deliberation. There were 84 discrete anecdotes scattered through the 13 interviews, or an average of 6.5 stories per interview.[8] Dr Newton made the least use of this type of experience, for she mentioned only two stories in her interview. At the other end of the extreme, Dr Sing really 'did ethics' by anecdote, relating 14 different stories drawn

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[6] Hunter, Narrative, literature, and the exercise of clinical reason..., 306. See also Hunter KM. 1995 Narrative. In Reich WT. (ed.) *Encyclopedia of Bioethics.* (2nd edn) Simon and Schuster Macmillan, 1789-1794.

[7] The only 'stories' I excluded with this approach were: a) the GPs' brief autobiographies at the end of the interviews in response to my questions about their background, educational and professional experience; and b) the stories with which the GPs had responded to my opening question: "Tell me about an ethical problem in your work as a general practitioner", for my intention was not to analyse how the GPs described these theme-setting stories, but how they pulled other experiences into their moral deliberation.

[8] As with the previous chapter and the two that follow, the data used in this chapter relate only to the 13

from his experiences. Table 7 shows the how many stories each GP recounted in his or her interviews.

TABLE 7

NUMBER OF STORIES EACH GP RECOUNTED DURING INTERVIEWS*

GP	Number of stories related during interview
Dr Sing	14
Dr Silverman	10
Dr Bright	8
Dr Little	8
Dr Winters	7
Dr Johnson	7
Dr Owen	6
Dr Masters	6
Dr Elwin	5
Dr Kingsford	4
Dr Dunt	4
Dr Stamos	3
Dr Newton	2
TOTAL	84

* Excluding incidents related at beginning of interview

8.3 SETTING AND ACTORS – MEDICAL SETTINGS, MEDICAL SELVES

Overwhelmingly, the GPs drew on their medical experience and medical events when describing stories that illuminated their moral discussion, and they did this in two ways. First, the setting was almost always medical. Seventy-nine of the 84 stories that the GPs related were set in either the clinic or the hospital. Only five stories related to events that occurred outside a medical environment, and even three of these stories were set in a mix of the GPs' social and medical worlds. Dr Silverman, for example, mixed the medical and the social when he launched into a description of the illness of a friend in the context of a discussion about confidentiality.

> 62... I feel very strongly that people should know what's happening. I don't believe that any treatment or investigation of the patient should be done without people knowing why.

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interviews for which I had complete transcripts.

63. *Why's that?*
64. A friend of mine died early last year of bowel cancer. He was initially sent for a Barium enema, without really knowing what was going on. He complained of bleeding - he knew he had piles, but his doctor sent him for a Barium enema without telling him why. He just said, "oh I think we ought to do this, just to make sure there's nothing else going on". That was it. And when the result came back that there was an obvious tumour there, he was extremely upset and angry because he hadn't been told. He felt that he should have at least been told that that was a possibility, and that that was what was being checked for...

Dr Silverman

Second, just as the GPs drew on their medical worlds for significant events, so they also placed themselves, almost always as clinicians, at the centre of the stories they recounted. Table 8 shows who played the major roles in each of the anecdotes the GPs mentioned. In half of these stories, the GP was the principal actor or the only actor, and in a further 29 the GP and a patient were the central characters in the story. In the remaining small number of incidents, the patient, another doctor or a friend carried the central roles in the stories.

TABLE 8

PRINCIPAL ACTOR IN EACH STORY MENTIONED IN INTERVIEWS

Principal actor					
GP only	GP and Patient	Patient only	Other doctor	Friend	TOTAL
42	29	4	7	2	84

In the 42 stories in which the GP was the principal figure, there were usually other characters, but they were introduced only to support the central role of the GP. Dr Bright's description below of an incident in which he was involved earlier in his career exemplifies this very well. I had asked him to define informed consent and its role in his practice. Dr Bright said that you can't always inform patients of the risks. He went on:

73...I remember that I, at one Hospital many moons ago, opened up this patient to do an appendix. And I had a bit of a poke around as I was doing it. There was this funny little yellowy-orange blob on the small bowel. "I don't like the look of that", says I to myself and to the assistant, "we will see if there's a surgeon in the hospital". And for once in it's life there was no surgeon in the Hospital. A senior GP sort of wandered in and said, "yes, John, I think I'd take that out, if I were you", and wandered out again. Now you can't wake the patient up, nor should you and give them 24 hours to recover from the anaesthetic so they'd know what they're doing, and say, "I've got to open you up and take this out". And I did take it out, and it was a carcinoid

which potentially is a nasty thing. She had a hysterectomy some years later and I got the gynaecologist to look along the bowel. You couldn't even see where I'd taken it out, let alone a lump.

Dr Bright

Dr Bright's anecdote includes a patient, an assistant, a senior general practitioner, and a gynaecologist, but these characters exist only to confirm Dr Bright's views. Were it not for his presence, they would have no role to play at all.

In 29 stories, the GP and a patient shared the main roles. In some of these situations, there was more emphasis on the GP and his or her decisions and actions. Dr Little, for example, told the following story from the perspective of his own thoughts and actions, but the patient also had a significant role to play:

49...Those sorts of practices tend to be problems in various ways. And I didn't go back to them as a locum.
50. *What problems?*
51. Well, they tend to be, sort of, keeping their business up with their drug prescribing patterns or their management patterns. I guess the first time I twigged to this pattern was for a fellow that came in for a blood pressure check which was about a monthly blood pressure check and his blood pressure never had been very high and I really couldn't see why he was on much treatment anyway and such a regular follow up. And he said, "oh, and I need some more pills, Doctor." And I said, "Righto, and that's...", (Aldomet I think it was that he was on) 'and that's a hundred tablets and two repeats, isn't it?" And he said, "oh, can you get repeats now, Doctor?" And I thought, "Hello!" They're just writing out the one amount and every time they run out the fellow has to come back and have his blood pressure measured...

Dr Little

This anecdote is primarily about Dr Little's management; his role in the story is more important than that of his patient. We learn relatively little about the patient, beyond that he actively seeks out the treatments he thinks he needs. Yet, the patient's involvement is pivotal; the account turns on his question "oh, can you get repeats now, Doctor?" In the way that Dr Little tells this story, the patient's question is the punch line, even though the patient himself has been on the sidelines for most of the account.

In other scenarios the patient had a more significant role to play. For example, Dr Kingsford explained why he would never predict for his patients how long they had to live and he used the following anecdote to explain his reasons.

52...I've got a patient in hospital now with cancer of the lung that's virtually been told by someone at the [main metropolitan] Hospital, two and a half years ago that she only had a few months to live. Well she's just come into hospital now, having spent most of the time at home and she will be going home from hospital again and she's still going on quite satisfactorily. She's on MS Contin for pain, and she's needed a lot of counselling because she gets very frightened.

> But it all boils back to the fact the she was told she had a few months to live, but not to bother to make another appointment in fact. That was one of the things, she said, "oh, why didn't they ask me to come back for another appointment?", at the Hospital because they didn't expect her to live, you see. But now two and a half years down the track she's still going on quite satisfactorily. It's just a very, very slow growing cancer. And I don't think any doctor can accurately say that you've got so much time to live, because, in fact, I get very annoyed when people come and say, "oh, I've been to a specialist, and he said I've got six months to live." You can never say that in medicine. It's very fool-hardy to do that.
>
> Dr Kingsford

In this story the focus moves from doctor, to patient, to doctor again. Dr Kingsford begins by characterising the patient as 'his' patient. From here on, the patient is at the centre of the account. Her history and her feelings are recounted and it is her experience of being dismissed as dying, and therefore of no interest, which constitutes the point of the story. With his concluding remarks, Dr Kingsford returns our attention to his own role in this story as he draws a general conclusion about what doctors should not do in situations like these.

To discover that doctors tell medical stories about themselves is hardly new. Hunter's work on the uses of anecdotes in medical talk suggests something a little similar. The anecdotes she analysed were spoken in the "in-group" activities of ward rounds and case conferences, generally told by senior clinicians to more junior staff, and often about themselves.[9] The GPs in my study were asked to describe an ethical problem which they had faced personally in their work as general practitioners, and it is only a short step from the recounting of that story to other autobiographical and medical stories. Nevertheless, their story choices do indicate that they thought that the most illuminating experiences of their lives, for the purposes of solving moral problems, were their work experiences. They aligned their ethical deliberation with what David Landis describes as their "medical selves", rather than their "everyday selves".[10]

There is a fair debate to be had about whether such an alignment is helpful. On the one hand, we might say that the GPs' preoccupation with the medical world privileged medical constructions of morality over other ways of thinking about moral

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[9] Hunter, "There was this one guy…"

[10] Landis D. 1993 Physician distinguish thyself: Conflict and covenant in a physician's moral development. *Perspectives in Biology and Medicine* 36: 628-641. Landis is not arguing that there are two

problems. On the other, (and this is the line Landis takes), there are distinctive ethical obligations attached to specific roles; every doctor will be, at least, a doctor *and* a private person, with the quite different duties those two roles imply. If doctors use their personal 'non-medical' experiences to illuminate the moral decisions they make in their work, they run the risk of conflating duties which ought not to be conflated. Entering this debate is essentially a question of 'oughts' again, and one which I have chosen to sidestep. Whichever side one takes, however, the question still remains: how were these medical and self-centred stories functioning in the GPs' moral deliberation? What role did these anecdotes play in ethical reasoning? What were they doing, ethically speaking? In order to tackle those questions, it is necessary to say something first about the types of stories these GPs recounted.

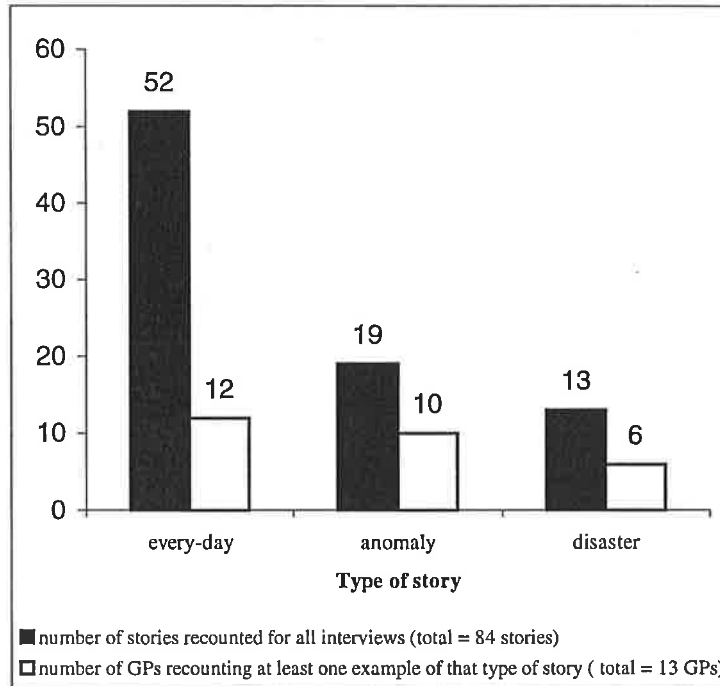
8.4 TYPES OF STORIES – THE EVERY-DAY, THE ANOMALY AND THE DISASTER

The stories that the GPs were of three types: the 'every-day' story, the 'anomaly' story and the 'disaster' story. 'Every-day' stories were stories about typical, ordinary or predictable events in medical work. 'Anomaly' stories, by contrast, focused on the atypical or exceptional event. The third type of story, the 'disaster' story, dealt with events that, in the GPs' terms, were "awful" or "horrendous". Over half of all the stories that the GPs related were 'every-day' stories and 12 of the 13 GPs told at least one 'every-day story'. Figure 4 indicates this in graphical form. It shows the number of GPs who related at least one example of each type of story and the total number of stories of each type.

persons in the one doctor, but rather "two human interactional entities".

FIGURE 4

TYPES OF STORIES RECOUNTED



8.4.1 'Every-day' stories

'Every-day' stories were about events that the GPs expected to encounter in their work on a regular basis. Events of this type did not occur literally every day, but they happened often enough that the GPs constructed them as familiar. Dr Owen's anecdote about how he dealt with a colleague who was drunk at work was an 'every-day' story. He described the situation as like others that he had met before, including during his time as a general practice trainee overseas:

> 137...The situation that occurred, and I've seen it in several other situations, unfortunately, even overseas, is that - an older doctor who had been known to have a drinking problem anyhow, was on call for casualty - was in casualty - and smelt really strongly of alcohol. Unfortunately, you can't really say whether they've been drunk or not. He certainly stank of alcohol and a patient complained to the Sister on duty, and I happened to be there because I was delivering a baby...
>
> Dr Owen

Dr Elwin also provided an example of an 'every-day' story when he was talking about how he dealt with situations in which he was a locum, filling in for the regular general practitioner. He referred explicitly to the common nature of the problem right at the end:

64...So if someone's got an acute episode of asthma and during my history taking I notice that they've had asthma symptoms for two months and have been using their Ventolin Inhaler six times a day for the last two months and haven't been on any inhaled steroids then I would not only give them the acute care and would put them on whatever if they were particularly bad, but I would also start off some kind of steroid plan. Document the reasons for doing that in the case notes so that the GP understood my thinking and I think in that circumstance,...if you're doing it for reasonable grounds, then they're fairly happy. I think when they get a bit annoyed is if you're changing from one drug to another for really no good reason apart from the fact that you prefer to use them that way. You see it quite a lot with locums...

Dr Elwin

Not all of the 'every-day' stories were about actual events from the GPs' pasts. The GPs also talked about 'hypothetical' cases that were representative of their practice, to make points about how they usually dealt with particular situations. Dr Silverman, for example, introduced this variant of an 'every-day' story to help him explain why the ethical problem he discussed with me was indeed a dilemma for him. He was exploring how to deal with a patient who wouldn't tell her ex-boyfriend that she had a sexually transmitted disease.

37. *Go back to the other problem, the one about telling the boyfriend. Have you thought about any other options, any other ways of dealing with it?*
38. Well, it's a bit difficult. It's not somebody that she's seeing at the time. If she was still seeing him it would have been somewhat easier, because I don't seem to have any trouble in persuading young ladies to bring their boyfriends with them to consultations. Usually, I can persuade them to sort of allow the boyfriend into the consulting room near the end so we can have a talk about the issue and discuss things such as the modes of spread, other sexual partners and protection, and in this situation, of course, you can't do that because he is no longer being seen. I can't really tell his doctor, because that would be a breach of confidentiality too.

Dr Silverman

Dr Newton was doing something similar when she contrasted the way she behaved with elderly patients with what she might have done, had they been younger:

58. I would have consulted, even just to say, "can you give me an explanation as to why you've done this? Have you had a problem with me?" And I think that would be reasonable, and I would usually do that with a younger patient.

Dr Newton

In both of these quotes, Dr Silverman's and Dr Newton's mention of how they usually dealt with particular situations in their work is almost an aside. Dr Silverman suggested that "usually" he persuaded his female patients to bring their boyfriends with them. Dr Newton noted that it would be "reasonable" with younger patients to pursue issues further, and that she would ("usually", again!) do that. Both of these statements hardly qualify as 'stories'. Even so, the wealth of experience that they represented played into the decisions that these GPs took. They point just as surely as the more detailed

anecdotes do to the role that experience plays here in moral deliberation.

8.4.2 'Anomaly' stories

The second type of story was the 'anomaly' story. Ten of the GPs mentioned at least one 'anomaly' story when relating incidents from their lives, and these anecdotes accounted for 19 of all stories mentioned. (See Figure 4.) With 'anomaly' stories the GPs described situations in their lives that were quite exceptional, unusual or abnormal, situations which were outside of the expected pattern of things. These stories were the aberrations in medical practice, the variants from the norm. The GP relating an 'anomaly' story said of it "This doesn't happen often, but...". Dr Newton, for example, was relating how she had cared for her elderly patients and she used two examples to indicate the lengths to which she had gone to ensure that they were appropriately treated.

> 50... And at times I'd put myself out a lot - not just a little bit - but a lot, on individual instances, and that had always been appreciated, or seemed to have been appreciated. And yes, I'll give you some beautiful examples... And with the other lady there was an instance where I went to see her at home early one evening, I suppose, when I happened to have my two children with me in the car to do this home visit. And again called out because she was unwell and my children at that stage were very small and her blood pressure was extremely high, and I decided to hospitalise her, and I could not contact any member of her family - or I could contact the family, but no-one was willing to come and wait with her or pack her up to go to hospital or wait for the ambulance to come and I - because I was there and I was the doctor I actually felt I couldn't leave, from a medical point of view. Because if I'd left and she'd had a stroke, or something had happened before the ambulance came, I was the one responsible. But I had two young children which I brought into the place who managed to rampage around while I tried to calm things down, and try and find a relative to even notify that she was going into hospital. The only one I could find was a poor grand-daughter who was many miles away with a new baby and no car. And so at least I found somebody to let them know that I was moving her into hospital, and I waited there until the ambulance came, which was some time. That's going beyond the call of duty, on the whole.
>
> Dr Newton

The key to Dr Newton's story here was her last comment "beyond the call of duty". She didn't usually behave this way with her patients, and she would not have wished to extend this level of care to all her patients.

Dr Winters also told an 'anomaly' story. He wanted to show that he took confidentiality very seriously, and that he would always respect a patient's right to confidentiality, even in extreme or extraordinary circumstances.

> 103... I do not discuss anything with anyone else without that patient's permission. I don't want

to labour the point but, there was one case in which a very close friend of my wife's who, her child was hit by a car, and I saw the child, and it was really very serious injuries. At the time I thought he was dying. But, I knew that my wife would want to know about it, and I asked that individual at that time if they would mind if I told her. And they said they didn't, they said, no, that's fine. But I would not have even done that without - I think the rules of confidentiality have to be observed very stringently, I wouldn't even compromise on it.

Dr Winters

8.4.3 'Disaster' stories

The two types of stories discussed thus far are, in some ways, opposites of each other. In telling them, the GPs were offering glimpses of both the usual and every-day aspects of their work and of the atypical and rare. The third type of story – the 'disaster' story - was different in character. In telling these stories, the GPs focused not on similarity to or difference from usual medical work, but on the disastrous nature of the events they recounted. Only six of the GPs had a 'disaster' story to tell (see Figure 4), and 5 of the 13 'disaster' stories mentioned came from one GP, Dr Johnson.

'Disaster' stories revolved around events that were unpleasant, painful and hurtful and in which the outcome was always poor. The GP telling a 'disaster' story began with a phrase like "This awful thing happened...". For example, Dr Sing talked about an incident that he had been involved in as a gynaecology registrar, which still seemed to have a significant influence on his beliefs.

106... one thing I hate is a Jehovah's Witness. I've got no time for them at all. Again, that view is tainted because when I, when I'd just qualified a lady died in front of me. One of my first gynae terms. She died - she bled and she died. We had the blood ready, we had the drip running, we had normal saline but the bloody hospital won't allow us to give blood. And she became unconscious. I said, "yes, but she's going to die." And she left it to her husband. So she said, "well, God will decide." But she left it to the husband. The husband said, "no". I said, "you're not dying. She's the one who's dying." He wouldn't, so I've got no time for it...

Dr Sing

Dr Johnson's "horrendous" experience with a patient who came to his practice following surgery elsewhere was also a 'disaster' story.

38... We had a patient here, for example, who had a horrendous experience. He had surgery done, and as a result of the surgery there was complication which the surgeon made, and wouldn't admit to, or he just would not concede that this person had come back to him again, and as a consequence he almost died. But even in the end he just swore black and blue that this person hadn't presented back to him...

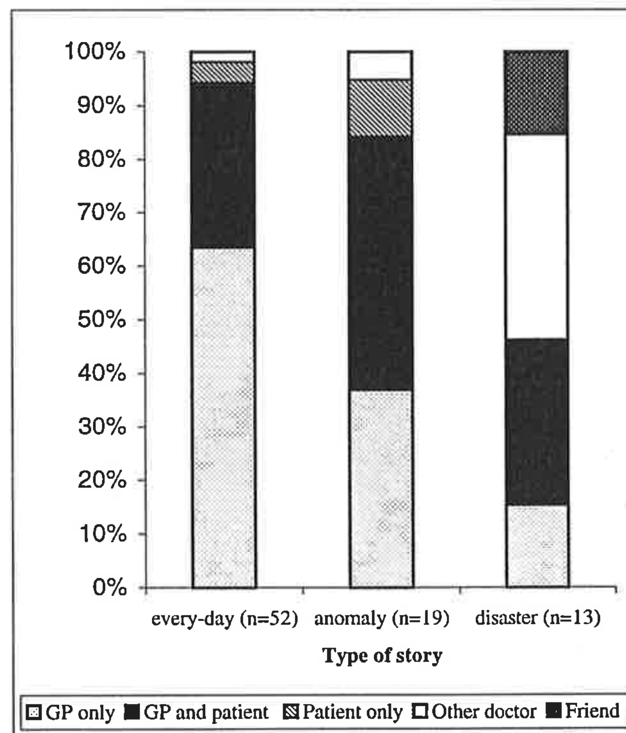
Dr Johnson

In this story as Dr Johnson tells it, the GP is not a key player; instead the protagonist is a dishonest surgeon. The movement of the GP to the sidelines was

characteristic of many 'disaster' stories. In over half of their 'disaster' stories, the GPs identified themselves as mere onlookers. This stands in stark contrast to their egocentrism in all other types of story. Figure 5 shows this in graphical form. In 'every-day' stories the GPs, alone or with their patients, were the principal actors in over 90% of the stories. In 'anomaly' stories the GPs, alone or with their patients, were protagonists in over 80% of the stories. By contrast, in 'disaster' stories other doctors or friends were the main characters in just over 50% of stories.

FIGURE 5

PRINCIPAL ACTOR IN EACH TYPE OF STORY



A brief summary seems in order at this point. The analysis above – of setting, character and story type – shows that the GPs in this study introduced experience to their moral deliberation with stories almost always about themselves and set in the clinic. They told three types of stories - 'every-day, 'anomaly' and 'disaster' stories – of which 'every-day' stories were by far the most common. Only in the case of disaster stories did other characters enter the narrative as significant players.

The predominance of every-day and routine events in the GPs' stories stands in contrast to findings in a number of other studies on like matters. In Hunter's research on anecdotes in medicine, the doctors' stories were usually about aberrations or variants from the norm.[11] Guilleman and Holstrom's account of the social context of decision-making in neonatal intensive care similarly suggests that, in the neonatal intensive care unit they studied, a small group of "borderline" cases around which staff had "agonizing" discussions had a "disproportionate impact on the staff's attention, energy, and emotions". Even after these babies left the unit, they continued to have a significant effect on the decisions that staff made.[12]

Why did the GPs I interviewed focus on the relatively routine and mundane, rather than the aberrant and unique? One possible explanation is that the relatively brief contact I had with them did not allow the development of the kind of relationship that is needed if people are to talk about their work 'warts and all'. Against this, I formed the impression during interviews that the GPs generally were quite candid about their work, and I was given no indication that they were choosing their words carefully to present a positive picture of medical practice. On the contrary, Dr Stamos and Dr Johnson particularly were very open about their dissatisfaction with general practice.

A second explanation for the dominance of 'every-day' stories is that these relatively routine events and experiences were in fact the most helpful ones for the GPs as they tried to deal with difficult moral problems. In order to assess this claim, we need to turn to the question of the moral purpose of the GPs' stories. What roles did these anecdotes play in the GPs' ethical reasoning? What moral points were the GPs making as they told their stories? These questions are considered in the next section.

[11] Hunter, "There was this one guy…"
[12] Guillemin JH & Holmstrom LL. 1986 *Mixed Blessings. Intensive Care for Newborns.* Oxford University Press, particularly 116-118. See also Rosenthal MM. 1995 *The Incompetent Doctor. Behind Closed Doors.* Open University Press, for a study of 'disaster' stories involving medical incompetence.

8.5 USING STORIES IN MORAL DELIBERATION

The question of how the GPs used stories in their moral deliberation returns us to the beginning of this chapter and Lauritzen's notion that experience tends to function as a trump on moral talk. It should be apparent from the foregoing examples that this was frequently the case for the GPs. Often they offered a story to provide the last word on the issue they were discussing. However, the way in which they used these anecdotes to trump moral discussion was somewhat more complicated than Lauritzen implies.

The GPs' moral trumps were of two kinds – a consequence trump and a deontological trump. Stories with consequence trumps focused on outcomes and consequences, whereas stories with deontological trumps emphasised a maxim or rule-of-thumb related to a particular event or set of circumstances. In both types of accounts telling the story more or less brought to an end the GPs' ethical deliberation. The consequence trump did this with the aid of the considerable force that knowing the outcome offers. The deontological trump drew moral authority from associating experience with rules-of-thumb.

In over half of the stories, the GPs invoked deontological trumps. Ten GPs mentioned stories with a deontological trump at least once, and trumps of this type appeared in 49 of the 84 stories. Ten GPs also told at least one story with a consequence trump, but trumps of this type were present in only 25 of the 84 stories. In addition, there were a group of anecdotes with no obvious trump; these stories seemed to be simply descriptive, told to illustrate the nature of work in general practice. Nine GPs told stories of this type, and they accounted for 16 stories in all. These stories that merely described moral events are probably the least important for a discussion of moral argument, but I suggest below that even this role carries some moral weight. (Table 9 shows the moral purpose to which the stories were put and their frequency in diagrammatic form.)

TABLE 9

MORAL PURPOSE OF STORIES

Roles	Number of GPs relating a story with this role at least once (13 GPs)	Number of stories with this role for all interviews (84 incidents)*
consequence trump	10	25
deontological trump	10	49
description only	9	16

* A small number of stories appeared to have more than one purpose.

Most of the GPs did not have clear preferences for particular ways of using stories in their moral deliberation. Only Dr Johnson and Dr Bright relied heavily on a particular approach - the consequence trump - to give purpose to their anecdotes. Generally though, as with their approach to moral deliberation more generally, the way the GPs used their stories to make moral points was rather eclectic.

For stories that fulfilled the two trumping roles described above, there was an obvious sense in which experience was being used as the moral trump to which Lauritzen refers. The picture is complicated, however, by the relationship between the type of story being told and the type of trump the GPs invoked. When the GPs told 'every-day' stories, the trump was used to affirm the GPs' decisions, choices, actions, behaviour and, in the case of deontological trumps, the maxim or rule-of-thumb invoked. In 'anomaly' and 'disaster' stories, the deontological trump seemed to work by defining the exceptions to the rule, and thereby justifying the rule. The deontological trump here also displayed the complexity and inherent ambiguity of the moral life. Consequence trumps, by contrast, functioned in 'anomaly' and 'disaster' stories to justify an alternative or different choice, decision, action or behaviour. (Table 10 shows these relationships in diagrammatic form.) The trumps and their relationship to story type are discussed below in more detail.

TABLE 10

MORAL PURPOSES OF STORIES AND THEIR RELATIONSHIP TO STORIES' TYPE AND TRUMP

Type of trump	**Type of story**	
	'Every-day'	*'Anomaly' or 'Disaster'*
Deontological	Affirm decisions, choices, actions, behaviour and maxims invoked.	Clarify exceptions to maxims thereby supporting maxim; Show the complex and ambiguous nature of moral reasoning.
Consequence	Affirm decisions, choices, actions and behaviour	Justify a different decision, choice, action or behaviour.

8.5.1 The deontological trump

The first way in which the GPs used stories in their moral talk was to illustrate a rule of thumb or a guideline for dealing with situations. These stories had two characteristics: a maxim or rule was stated and an example to illustrate it was provided. They therefore resembled deontological approaches to moral reasoning, because the rule or maxim provided the standard according to which a judgment of right or wrong was made, independent of the outcome. The moral force in a story with a deontological trump lay in the rule or maxim and the way in which the GP fitted it to the events he or she was relating.

Deontological trumps tended to work in either of two ways, related to the type of story the GPs were telling. First, when the GPs told 'every-day' stories, the deontological trump affirmed the GPs' general way of behaving or the rule-of-thumb they usually accepted. Dr Winters' definition of confidentiality and one example he gave of the role it played in his work provided an excellent illustration of the deontological trump.

103. Define confidentiality? To me that just means that the relationship that I have with the patient is - there's assumed confidentiality there. It's just, it almost goes without saying. I do not discuss anything with anyone else without that patient's permission... I just don't find it, it's not

> reasonable for me to divulge any information without permission, even for friends who've had babies, I won't even do that. "Have they had their baby yet?". I might tell them that they've had their baby. Then I say, "if you want to know more about it, call her". I just don't to be involved because if you start, it can be like a wedge, once you start with the little things, in my mind, it potentially grows up to before you know it, talking about everything...
>
> Dr Winters

Dr Winters' point of departure here was the maxim that "I do not discuss anything with anyone else without that patient's permission". He described a situation that was not uncommon in his rural practice – whether to reveal information about the birth of friends' children – in order to illustrate the importance of the principle of confidentiality.

Deontological trumps also worked in a second way. When the GPs related 'anomaly' and 'disaster' stories the deontological trump functioned to clarify the limits to moral rules. The GPs took examples of incidents in their lives that were either unusual or awful and used these experiences to indicate that there were always limits to any rule-of-thumb and exceptions to any maxim. Yet, while these stories focused attention on the exceptions to generally accepted norms and maxims, they did so in ways that did not undermine the maxims themselves. In fact, making it clear that most rules-of-thumb admitted of some exceptions seemed to strengthen the place of these rules in the GPs' moral reasoning, because the anomalies and disasters the GPs described were so unusual or so perverse.

Dr Masters and Dr Bright used deontological trumps to explain the exceptions to their opposition to abortion. Dr Bright, for instance, made it quite clear at the beginning of his interview that he was opposed to abortion under almost all circumstances. He then went on to illustrate the exceptions to his rule with three examples from his own practice: the first concerning a woman whose life was endangered by her pregnancy, the second a woman he referred for a second opinion whose gynaecologist then deemed it appropriate to perform an abortion, and the third a young girl raped "one Sunday night on her way home from church". He used each case to illustrate how his principled opposition to abortion was not weakened by these anomalies, even though he had concurred in the three particular instances.

Dr Silverman took a very similar line with respect to his attitude to confidentiality. He laid out very forcefully his views on the inviolability of patient confidentiality at a number of points in his interview, and I asked him whether there were any exceptions to his rule. He couched his response not in abstract, general or hypothetical terms, but in terms of the one experience he had as a general practitioner that might qualify as an exception:

> 77. *Are there any exceptions to that?*
> 78. I can't think of making any in the last few years, that's for sure...
> 80. Yes, there has been an exception. The man had to be certified.
> 81. *Go on, tell me a bit more.*
> 82. His wife was very upset. She basically knew the score and was fully committed with what had been going on anyway. And so I did explain the situation to her. In actual fact I suppose I probably shouldn't have actually certified him but it was the only way I could get him to accept treatment for a frontal lobe tumour.
> 83. *Why did you act that way, in that situation, when you said you wouldn't do it in any other?*
> 84. The tumour was life-threatening. He was not able to think rationally about it because of the illness itself. He was not a responsible adult. His wife is a responsible adult, and a responsible adult had to take some knowledge and care about his treatment and management. Not having another legal guardian, his wife was next of kin. I feel it was reasonable to look after his affairs until he got better. He's back home now, anyway. That was a couple of years ago.
>
> Dr Silverman

Dr Silverman had no other experience that paralleled this example of certifying as incompetent a patient who would not accept necessary treatment. He seemed convinced that only the unique circumstances that this situation created could justify violating confidentiality and even then he had lingering doubts about whether he should have certified the patient. The exception clearly did nothing to shake his faith in his maxim. The exception was so unusual that it seemed to justify his rule.

The GPs also used their stories about exceptions to the rules to convey what anyone thinking about ethical issues knows - that these issues are never cut and dried, never either black or white. Even Dr Bright, as passionately opposed to abortion as he was, understood this, for he could recall three situations in which he had violated his own principles. It was through incidents like these that the GPs articulated their own experience of the inherent ambiguity of moral decision-making. It was a way of voicing Dr Stamos' belief, discussed below, that those who are not "at the coal face" just can not appreciate the complexity and uncertainty of medical work.

Stories with deontological trumps, whatever their type, shared two common features. First, there was movement back and forward between the general and the particular, between abstract principle and concrete example, between generalities and detail. For example, Dr Elwin's discussion of how he saw his relationship with his patients began with the maxim that "the general practitioner is ultimately responsible for the patient's care"(62). He explained that this meant that any specialist involved in the patient's care had an advisory role. Yet, he noted that there were "special situations" at times that might warrant a more interventionist approach for the specialist.

> 62... If you've got patients that need surgery obviously if the surgeon's doing the operation in town and so forth then he's responsible for the surgery and responsible for the post-operative care and so forth, but I think as soon as they're sort of over that then the responsibility for their care comes back to the GP...
> ... in terms of things like Gold Therapy or anti-cancer therapy and those sorts of things which are just way out of my area of understanding, the decisions about those - I mean, again, I still sort of have the idea, I think, in my mind, that he is providing advice but I'm sort of more, much more prepared to accept his advice because it's in an area that I don't know a great deal about. I'm sending a patient with his rheumatoid arthritis to a fellow who suggested Gold Therapy. You might have three, four patients in the practice with rheumatoid arthritis. Maybe two of them are on Gold Therapy so you really don't have a huge amount of experience in that sort of area.
>
> Dr Elwin

As he described these situations, Dr Elwin moderated his original dictum to account for the out-of-the-ordinary. He still regarded himself as responsible for his patients, but in those situations in which he lacked experience, "I'm much more prepared to accept his advice because I don't know anything about it myself".

A second feature of these stories was the way in which they lent moral weight to the maxims they illustrated. Rather than relying on the story's outcome for moral authority (as the GPs did with the consequence trumps discussed below) stories with deontological trumps acquired moral weight merely through being linked to the GPs' experiences. Simply recounting a story in relation to a rule-of-thumb seemed to imply that the rule was valid, or at least to be considered very seriously. How valid it was depended on how good the GP was at establishing and sustaining the links between the rule and the particular case. In other words, the moral weight of the rule-of-thumb turned on the GP's rhetorical skill.

8.5.2 The consequence trump

The second way in which the GPs used many of the anecdotes they related bore a family resemblance to consequentialist approaches to moral reasoning. Consequentialist theories direct our attention to the outcomes and consequences of events; they provide a canon for judgment about whether actions are right or wrong on the balance of good and bad consequences. In a similar fashion, the GPs used the outcomes of their stories to justify their choices and behaviour. Consequence trumps provided a way of saying "This is what happened in that incident. Be extrapolation, I think this is the right way to behave." Put another way, the moral force in a story with a consequence trump lay in the story's outcomes.

The particular conclusion that the GPs drew from their experiences depended on the type of story they were recounting. When a GP told an 'every-day' story, the outcome to the story provided a justification for behaving the same way in other situations. Here their experience provided confirmation of usual choices of action or approach. Dr Dunt argued in this way when he explained why he had felt he should support his patient's decision to have a home birth. His reasons revolved around his own experience in obstetric practice. Early in his interview he stated that he had "done a lot of obstetrics" (26) and this had led him to believe that home could be a safe place to deliver. When I suggested that the medical profession did not uniformly support his opinion, he responded initially by emphasising his own experience:

> 65. *Some medical people would say there is always a safer place for a delivery than at home.*
> 66. Well, I know that, but I don't believe that's true for normal deliveries. I have seen excellent obstetrics carried out at home. My own experience tells me, plus the figures, the excellent figures that came out of English districts and the situation that still occurs in Holland today, indicate that properly conducted home deliveries can be very successful providing you exclude those in need of more intensive care. And, we did that.
>
> Dr Dunt

Dr Dunt's rationale relied heavily on his experience of good outcomes; he proffered his experience as a consequence trump.

Dr Stamos used a similar approach when he talked about why he thought abortions were morally acceptable. He framed his defence of abortion in terms of his

own experience "at the coal face". He argued that people who opposed abortion did not know what it was really like. The opponents of abortion...

> (98)...sort of see a 23 year old woman who gets pregnant and goes off and has an abortion for a purely convenient sake...

His experience as a GP was quite different.

> ...At the coal face, I think you see 14 and 15 year old girls, who are still children themselves, who have no real understanding of how to take care of themselves, let alone how to take care of a child, probably... You see these sort of... If you actually ever bothered to go into some of these housing-trust places, and I'm not being paternalistic, they are real disasters. There are some superb ones as well. And there are lots of these young girls who have elected not to have abortions who are single mothers, who really just spend the whole of their lives, taking care of a child. Some people say that's great, but I don't know, at 15 years of age, I don't know whether you should be having children. I think if you look at those sorts of things, there are things like rape, things like a family of three, and mum get pregnant, you can hardly afford to keep three children going, let alone a fourth one. And I think that's what the different things at the coal face mean.
>
> Dr Stamos

Dr Stamos' beliefs about the rightness of abortion was contingent here on outcomes – in the situations he saw every day, when women were denied abortions, they (and their children) suffered. For him, therefore, abortion was morally acceptable.

When the GPs recounted 'disaster' or 'anomaly' stories the consequence trump worked differently. Here the story's outcome provided a lesson in how things should not be handled. Dr Silverman provided a good example of this type of reasoning when he talked about an incident during his medical training that had influenced his views on confidentiality. In the latter part of his training a fellow student and friend developed a peri-anal abscess when they were on a surgical ward together.

> 106...the consultant surgeon drained it for him and it was sent to the lab, and of course [it] grew tuberculosis...he wasn't allowed back on the wards until he completed another year of treatment. That meant he was put back a year in his medical course purely because he caught something. What a disaster for him! And again, that's only because of the unreasonable fear, I mean, as soon as he'd started treatment he was no longer infectious. None of the people who worked closely with him for that time managed to catch it, and we were certainly a lot closer to him than any of his patients were. We were sharing rooms. We were sharing drinks. We were sharing meals. And yet none of us caught it. So I thought that was unreasonable too.
> 107. *And did that have an impact on the way in which you now work with patients?*
> 108...that was a notifiable disease. It's just the way it was handled was very poor. The laboratory rang up the ward and told the staff. And so, everybody was talking about him before he was even told what was going on. I find that distinctly unreasonable, especially considering he was in a position to fully understand it. And then the subsequent discrimination which was outrageous.
>
> Dr Silverman

Beneath this somewhat confusing and temporally disordered account lies the conviction that confidentiality is immensely important. It was important there because not

attending to it led to "outrageous" discrimination and a "disaster" for Dr Silverman's student colleague. By inference, confidentiality is always important because, if you don't attend to it, people suffer, and unfairly so. It was not the only time at which Dr Silverman played a consequence trump. He used this story of a friend who died of bowel cancer in a similar way to show that when doctors are not honest with their patients, the patients are harmed. He extended his consequentialist thinking in that incident to argue that dishonesty undermined the doctor-patient relationship and "without a good doctor-patient relationship you're not going to be able to achieve other things later on". (64)

8.5.3 Descriptions only

The final way in which the GPs used experience in their moral deliberation was merely to provide a description of events. Stories that were simply descriptive provided information in the same way as other kinds of stories. There was more or less detail about time, place and person, but there was no attempt use the story's outcome to make a moral point, to explain a moral dictum by way of examples or to define the edges of moral conduct. Instead, there was just an account of what happened.

No criticism is intended here. When we tell stories we are not always doing it to make a moral point or justify a position. Much, and perhaps even most, of the time our stories do not have a moral. Some stories are just space fillers, designed to keep conversation flowing. Other stories are attempts to respond to questions, to provide the kinds of answers we think we are being asked for. Some of the stories the GPs told in these interviews probably were of these types. I was certainly aware that the GPs were struggling at times to respond to my questions. They wanted to be helpful, though, because they knew that I was interested in their working lives and neither of us wanted me to go away empty-handed. Some of their stories were essentially a way of being polite.

Carried within these strategies to maintain polite conversation was nonetheless something more substantial. In telling me stories, they were conveying what it was like to be a general practitioner. In a most effective manner, they were showing me what it was like to be them. This is another important role for story telling – to tell others what it is like to be us.

Dr Little provided a number of examples of what it was like to "be him". He had a long and varied career as a general practitioner, working in a number of settings, some of which were rather unique. One more ordinary aspect of his career was his time spent working as a "day-time fill-in locum" for other general practitioners. He began his account of the moral problems associated with that type of work by illustrating his rule-of-thumb – "you're not employed by the doctor who's paying you to destroy their practice" – with an 'every-day' story. I asked him a couple of questions about the particular moral problems that arose in that setting. His response was an incident I presented earlier in this chapter: the patient whose regular visits to the practice in which Dr Little was a locum were perhaps too frequent. This contrast - between busy, lucrative rural practice and leisurely, but less profitable, urban practice - gave valuable detail about the moral dilemmas in his working life, but little else.

The analysis presented in this chapter thus far has focused on the characters, setting, type and purpose of the GPs' stories. My account has been essentially descriptive, rather than evaluative. I have not attempted to assess the extent to which these stories assisted and illuminated moral deliberation. Nor have I addressed the issue of the fit, if any, between the GPs' moral deliberation using stories and mainstream bioethics approaches to moral reasoning. The section that follows takes up these issues.

8.6 STORY-TELLING AS A FORM OF CASUISTRY: CASUISTRY-IN-USE

8.6.1 Casuistry in the bioethics literature

The approach I have taken to the analysis of the GPs' anecdotes and stories shares similarities with narrative ethics, in so far as I have used in a simple way the tools of narrative analysis.[13] However, narrative analysis and narrative ethics are not the only disciplines that explore the role of the story in moral reasoning. There is also within bioethics a significant body of theory in casuistic approaches to moral reasoning that relates particular experiences and events to others to arrive at moral resolution. At the most basic level, both casuistic and narrative approaches to ethics are concerned with discrete events, incidents and happenings.[14]

A number of scholars have noted the link between narrative ethics and casuistry, but they have not pursued the connections in any detail. Hunter, for example, invokes Jonsen and Toulmin's casuistry in her discussion of narrative ethics, but does not discuss the similarities between her model of narrative ethics and casuistry in any depth.[15] Other narrative scholars use the language and forms of reasoning of casuistry but do not seem to acknowledge a connection. Widdershoven and Smits, for example, claim an interest in stories in all their detail, complexity and ambiguity, and suggest that a focus on the particularity of stories can illuminate general practices. This is very similar to the casuists' emphasis on detailed cases and their concern to show how the evaluation of particular circumstances sheds light on maxims and principles.[16]

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[13] See footnotes 3 and 4 for a brief introduction to the literature on narrative ethics and narrative analysis.
[14] Jonsen defines a 'case' – the linchpin of casuistic reasoning - as an event or happening. See Jonsen AR. 1991 Casuistry as methodology in clinical ethics. *Theoretical Medicine* 12:298.
[15] Hunter, Narrative, literature, and the exercise of clinical reason…; See also Zaner RM. 1993 Voices and time: The venture of clinical ethics. *Journal of Medicine and Philosophy* 18: 9-31 whose concern to present a multiplicity of voices in all their complexity seems to place him also in the narrative stable. An alternative view on the relationship between casuistry and narrative accounts is put by Benner, who suggests a sharp contrast between the two: "casuistry uses case studies to exemplify a particular ethical principle, whereas a narrative approach is inductive and uses naturally occurring situations to explicate ethical concerns and the good and worthwhile in relation to particular persons, communities and situations". Benner P. 1991 The role of experience, narrative and community in skilled ethical comportment. *Advances in Nursing Science* 14: 3. Benner's description of the nature of casuistry would not be shared universally by casuists.
[16] Widdershoven GAM & Smits M-J. 1996 Ethics and narrative. In Josselson R. (ed.) *Ethics and Process*

This section evaluates how well the GPs' stories worked as a form of moral argument by comparing their use of stories with the way in which casuistic reasoning works in moral deliberation. I discussed the nature and methodology of casuistry in Chapter Two and at this point I merely summarise the main points from that account.[17] I argued in Chapter Two that modern casuistry, as articulated by Jonsen and Toulmin, has changed over time. In particular, later versions of modern casuistry emphasise methodology and impose an order on the process of reasoning not apparent in earlier versions. In addition, Jonsen seems to move over time toward a weaker interpretation of the relationship between cases and principles. In the analysis that follows I have tended to draw on the earlier versions of modern casuistry. My rationale is that Jonsen and Toulmin's early work in *The Abuse of Casuistry* displays the method of casuistry as used by others, particularly the medieval and renaissance casuists, and in that sense it is a description of moral reasoning. Jonsen's later writing, in its concern to articulate an ordered methodology for casuistry, is more an account of how casuistry *ought* to look. Since my own interest is in what moral reasoning does look like rather than what it ought to look like, earlier versions of casuistry offer a fairer basis for comparison. Either way, the difference is one of degree only, since the principal characteristics of modern casuistry, for the purposes of comparison with lay moral reasoning, are present in both earlier and later versions.

Modern casuistry, as articulated by Jonsen and Toulmin, is a variant of medieval and renaissance casuistry, resembling its earlier counterparts in a number of ways.[18] Casuists reason by analogy, using "paradigm cases" around which there is clear agreement about the rightness or wrongness of actions. They rely on the maxims or rules-of-thumb that are embedded within cases as a basis for comparison, and move out from the paradigm case to others by adding detail (who, what, when, where, how and by what means). While casuists offer a resolution for each case, they rarely express their conclusions in black and white terms; rather, they emphasise the uncertain nature of

in the Narrative Study of Lives. Sage Publications, 275-287.
[17] See section 2.3 in Chapter Two.
[18] Jonsen AR & Toulmin S. 1988 *The Abuse of Casuistry. A History of Moral Reasoning.* University of

moral reasoning and phrase their resolutions as more or less likely. The strength of a casuistic argument depends less on internal logic than on the weight of examples and reasons.

Rhetoric – the art of making a persuasive argument - is central to casuistry.[19] With it, the casuist establishes connections between cases and identifies those aspects of paradigm cases that can inform moral debate. In using rhetorical analysis, the casuist deals with the difficulties created by partially fitting or confusing paradigms by attending closely to the detail of cases, rathe than by emphasising abstract principles, rules or maxims.

8.6.2 The GP's casuistry-in-use

In the analysis that follows, I suggest that the GPs' use of stories in their moral deliberation had some of the features of casuistry. However, the GPs' casuistry-in-use was less rigorous and disciplined than that of the 'professional' casuist. In particular, they lacked clear paradigm cases on which to base the comparison of cases and their use of rhetorical technique was poor. In addition, some of the negative features of casuistry could be seen, writ large, in the way in which they used their stories. These negative features provide a link to the way in which the GPs' use of stories reflected the social and organisational context of their work.

There are at least four parallels between the methodology of casuistry and the ways in which these GPs used stories in their moral deliberation. The first, and most obvious, similarity is that the GPs' use of experience embraced casuistry's emphasis on particular individuals and situations. Jonsen and Toulmin's view in *The Abuse of Casuistry* is that "*moral knowledge is essentially particular*, so that sound resolutions of moral problems must always be rooted in a concrete understanding of specific cases and

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California Press, 250-265, contains a detailed account of the material in this paragraph.

[19] See Jonsen AR. 1995 Casuistry: An alternative or complement to principles? *Kennedy Institute of Ethics Journal* 5: 241, for a definition of rhetoric. The notion of rhetorical analysis is central throughout Jonsen's (and Toulmin's) work.

circumstances".[20] This particularity is the great appeal of casuistry, and the nub of its critique of the abstraction of principlism.[21] The GPs' interest in detail illustrated, as casuistry does, how important it is to deal with *specific* problems rather than to speak in generalities about the moral issue of which this case might be an example.

The way in which the GPs used experience also shared with casuistry its case comparison method. In the simplest examples, the GPs merely moved from case to case, finding similarities and differences. In more complex examples, the experience was described as a 'case' might be, with detail about " who, what, when, where, how and by what means".[22]

In many experiences, the maxim or rule-of-thumb such as a casuist would use to define the case's 'type' was also explicitly mentioned.[23] This was seen most clearly in those experiences in which the GP used a deontological trump to make his or her moral point. For instance, a number of Dr Winters' and Dr Kingsford's stories could be seen as examples of "confidentiality" and "honesty" respectively. These GPs labelled their stories in much the same way as a casuist would use a case's type to establish the base from which one moved to compare the case with other cases, thereby providing the link they needed to draw comparisons with other events.

A third similarity with casuistry lies in the way in the GPs moved back and forth between different anecdotes and between different ways of reasoning about those anecdotes. We have already seen one example of this in how Dr Elwin developed his discussion of the general practitioner-patient relationship. Dr Silverman's arguments about honesty and confidentiality were also examples of this. For instance, one of his anecdotes began with the maxim that "I feel very strongly that people should know

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[20] Jonsen & Toulmin, *The Abuse of Casuistry*..., 331.
[21] Fins JJ, Bacchetta MD & Miller FG. 1997 Clinical pragmatism: A method of clinical problem solving. *Kennedy Institute of Ethics Journal* 7: 129-145. Fins *et al* provide an excellent example of the particularity of the casuistic method at work. See also Tong R. 1997 The promise and perils of pragmatism: commentary on Fins, Bacchetta, and Miller. *Kennedy Institute of Ethics Journal* 7:147-152, who identifies this particularity as a strength of Fins *et al*'s approach.
[22] Jonsen & Toulmin, *The Abuse of Casuistry*..., 250-265.
[23] Jonsen, Casuistry as methodology..., 298.

what's happening. I don't believe that any treatment or investigation of the patient should be done without people knowing why."(62) Then, Dr Silverman used the anecdote about his friend who died of bowel cancer to illustrate his rule-of-thumb (and in that sense it was a deontological trump). After this, he moved on to the anger and disillusionment his friend had felt about not being informed of the reasons for tests (and in that sense it was a consequence trump). His next move was to use the anecdote as a springboard to make some general comments about trust in general practice, and the need to:

> 64...build up a relationship. If you start off by deceiving somebody, or you undermine their confidence in you in any way, then they've two choices, they can change doctor, which breaks up the continuity of care and decreases the quality of care generally, usually. Or, they will question everything you do, which means that the consultations will take a lot longer to achieve the same ends. Or, they just won't do it, which can have disastrous consequences.
>
> Dr Silverman

Dr Silverman shifted easily between the particular - a friend's illness - and the general - the doctor-patient relationship - and between deontological reasoning and teleological reasoning.

Fourthly, the GPs' use of stories shared with casuistry a preference for the tentative conclusion, rather than the certain judgment.[24] The casuistic method encourages a flexible approach to moral knowledge and its proponents tend to couch their opinions as more or less probable and acceptable, rather than as absolutes. This similarity between the GPs' use of experience and casuistry is probably the weakest of the four, since much of the GPs' talk implied an absolute confidence in their own ability to make the right decision. Even the fact that they were most likely to tell 'disaster' stories about others, rather than themselves, suggests a certainty about their own conduct. That being so, there was still a range of stories that illustrated exceptions to their rules or usual ways of behaving. With these anecdotes to define the anomalies and exceptions, the GPs conveyed their sense that judgements are never final, that uncertainty and ambiguity are inherent in all moral decision-making.

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[24] Jonsen AR. 1986 Casuistry and clinical ethics. *Theoretical Medicine* 7:72.

While the GPs' use of experience shared with casuistry the four characteristics – of particularity, case description, eclectic movement between cases and forms of reasoning, and a preference for tentative conclusions - the success with which they used the casuistic method in their moral reasoning was limited. Casuistry's persuasiveness rests on the expertise with which it applies its tools. As noted above, for casuists, these tools are those of rhetoric, rather than those of analytic philosophy. One of the most important of these tools is the paradigm or analogy, used in a way that illuminates the unclear by comparison with the clear. Casuists move in their thinking from clear and obvious cases to problematic ones.

The GPs' use of stories, however, gave little evidence that clear (or paradigm) cases were being used to illuminate the unclear. In the GPs' moral reasoning, cases were not selected for comparison because they were clear or because they provided examples of moral certainty. The 'every-day' stories the GPs talked about were not chosen because the moral thing to do there was obvious, but rather merely because those events belonged to the same family as other events. In similar vein, 'anomaly' stories were not introduced because they offered good examples of what was morally required, but just to show how things differed. In other words, the stories the GPs were comparing were appropriately comparable (even if the GPs did not develop the comparison to any great extent), but they lacked the moral certainty required for a paradigm case in formal casuistry. Consequently they lacked the moral force that the paradigm case has for the casuist.

Even if one were able to identify stories that could qualify as paradigm cases in the GPs' thinking, these stories were very unlike the paradigm cases envisaged and debated by casuists. For both contemporary and classical casuists, paradigm cases are essentially public cases.[25] They may be public in the sense that they are reported and debated in the media and scholarly journals, rather as common law cases are open to public scrutiny. Alternatively, they may be well known within a hospital, clinic or

[25] Jonsen, Casuistry as methodology…, 295-7.

service, where they serve as an impetus for "local debate about ethical issues".[26] In both situations, as public cases there is a body of debate and discussion around them that the casuist can draw on. Most importantly, the casuist has access in these cases to the consensus that emerges about 'the right thing to do', and therefore a base from which they can reason.

The GPs' cases, paradigm or otherwise, were private, for the most part shared only with me and perhaps a few close colleagues. Eight of the thirteen GPs commented during their interviews that they did at times seek advice or discuss issues with their medical colleagues.[27] Yet, it is a huge step from a quiet conversation with a colleague to explore ideas and search for alternative solutions to the public debate that is required for the development of consensus around a paradigm case. In addition, it is also worth noting that two of the GPs said clearly (and regretfully) that they did not discuss ethical issues with their colleagues at all.

A considerable part of casuistry's power as a method rests on the impetus that paradigm cases provide. Just as much rests on the casuist's ability to draw appropriate links between paradigm cases and the case under scrutiny. The casuist creates these links by constructing the case as a set of circumstances (who, when, where, what, how) revolving around a core composed of maxims. The relationship between maxim and circumstances is developed using a logic built not on the deductive logic of the scientific method, but on the inductive logic of grounds, warrants, backing and modal qualifiers.

It was in this arena of the logic of casuistry that the GPs were particularly lacking. They used their stories as trumps, to top or beat their moral deliberation, rather than as tools to assist them in their deliberating. For instance, when the GPs used a story as a consequence trump they slipped easily from an outcome in one story to an outcome in another, paying scant attention to whether the circumstances of the stories did in fact

[26] Jonsen, Casuistry as methodology…, 295.
[27] See Chapter Ten on strategies for managing ethical problems.

warrant such slippage. The care that a casuist might exhibit in carefully setting out how things were like and unlike was lost; the GPs simply *assumed* that, if it turned out well in one situation, that was all the evidence needed to justify a similar action in another situation.

This lack of rigour was even more apparent in those stories in which the GPs played experience as a deontological trump. The deontological trump took part of casuistry's method, that of identifying the maxim or rule-of-thumb around which the case revolved, but again *assumed* that one could move from one story which illustrated a maxim, to apply the maxim generally. I have suggested above that the moral weight of the deontological trump turned on the GP's rhetorical skill: much of the time, this skill was lacking.

Perhaps the best examples of lack of rigour in the GPs' use of experience are those experiences that were simply descriptive. One of the dangers inherent in the casuistic method is that of sliding into mere situationalism. Good casuists avoid this by continually placing their cases in the context of other cases, and by searching for and applying relevant maxims. The story that was merely descriptive did none of this; it simply provided detail about time, place and person - the "circumstances" of the case - without identifying the maxims needed to give the case its moral identity.

I have argued so far that the way in which the GPs used stories in their moral deliberation – their casuistry-in-use – bore some similarity to the casuistry of bioethicists, albeit that this similarity was weakened by the absence of clear paradigm cases and poor rhetorical technique. Just as the GPs' casuistry-in-use had some of the strengths of casuistry as practised by bioethicists, so it also suffered from some of the pitfalls. One of the criticisms of casuistry has revolved around the argument that, in moving incrementally from case to case, casuistry assumes a great deal. It has a tendency to take "'what is' as given and [to treat] it as the starting point of moral

reasoning."[28] Casuists seem not to acknowledge that problems of bias can beset their reasoning as surely as they can any other selection process and they appear to question only rarely what gets on to the moral agenda as a case. [29] Neither is there much debate about what description of a case counts as an adequate one. In addition, the casuistic approach presupposes that what ought to be valued can be captured within a reasoning process that concentrates our attention on the particular, the personal and the specific.

In the GPs' case, casuistry's focus on the particular, the personal and the specific matched their own preoccupation with individual clinical cases. The 'case' for these GPs was almost invariably a medical problem, encountered in the clinic. The GPs coupled this focus on the medical to a preoccupation with the self. They presented these medical experiences predominantly through their own eyes - the eyes of a clinician. This did not mean, necessarily, that they privileged 'medical' facts over 'non-medical' facts.[30] However, they *did* tell the stories of their patients' medical, social and emotional lives from the perspective of a medical practitioner. And it *was* difficult, in their recounting, to hear the patients' stories. This may be what we might expect, but it is hard to imagine a full recounting of any moral dilemma that does not give patients' perspectives and patients' values a good hearing.[31]

The emphasis in the GPs' stories on the medical case from the medical perspective is important because it raises the spectre that this type of moral deliberation can "easily degenerate into clinical manipulation [or] a way to reassert physician paternalism over patient autonomy".[32] The danger for the GPs in using stories in this way, as for casuistry generally, was that it locked out perspectives that could challenge their own interpretation of events or offer a different assessment of what might be

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[28] Kuczewski MG. 1994 Casuistry and its communitarian critics. *Kennedy Institute of Ethics Journal* 4:101.
[29] Kopelman LM. 1994 Case method and casuistry: The problem of bias. *Theoretical Medicine* 15: 21-37.
[30] I am not suggesting here that there is necessarily such a distinction. See Veatch RM. 1977 The technical criteria fallacy. *Hastings Center Report* 7:15-16, on collapsing the distinction between technical and value questions.
[31] Tong, The promise and perils of pragmatism..., argues that a full discussion of any case must do more than give the patient's perspective a good hearing; it must place the patient's values at the centre of the case.
[32] Tong, The promise and perils of pragmatism..., 151.

morally justifiable. Put baldly, relying on medical views of medical experiences provided the GPs with a way to justify what they would want to do anyhow.

It is possible for casuists to guard against dangers like these, by paying close attention to how others, and particularly patients, see things. "The lesson for casuists here is not to become so identified with the point of view of health care professionals that they lose sight of other important values in our culture."[33] The same lesson might need to be learnt by the GPs in this study. By relying almost exclusively on their own medical experiences, the GPs ran the risk of ignoring values and perspectives that could contribute much to ensuring they made good decisions. To avoid this risk requires a sensitivity to other perspectives at all times and not just in those situations in which, for example, patients' values and professionals' values come into conflict.

There is a second aspect of the GPs' and casuistry's focus on the particular which raises other difficulties. As noted in Chapter Two, casuistry, in its preoccupation with cases and clinical experiences, finds it hard to lift its sights beyond the particular and to attend to issues of structure, power and the organisation of institutions.[34] In other words, casuistry can slide into a form of individualism. The way in which the GPs used stories in moral deliberation revealed a similar engagement in the affairs of individuals and no concern for broader questions of political philosophy. Generally, the GPs did not ask questions about how states of affairs came to be as they were, let alone try to answer those questions. The one notable exception, Dr Little, believed that he had acquired his understanding of why people seek days off when they're not sick through his study of the British industrial revolution:

> 13. It's mostly people, younger folks, and people in labouring sorts of jobs. Not very pleasant jobs anyway. And a day off now and then is justified, too, I think. And I always figure I don't mind being taken for a ride once by giving out pethidine injections for migraine, or whatever, but if it becomes a pattern then I worry. But on a one-off request I'm more lenient. And, perhaps also since I did some history study on the British industrial revolution and so on, I'm not so absolutist at all about the work ethic. If someone needs a day off now and then and needs a piece of paper to say so, I treat it as a mental health day for them.
>
> Dr Little

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[33] Arras JD. 1991 Getting down to cases: The revival of casuistry in bioethics. *Journal of Medicine and Philosophy* 16:45.
[34] Arras, Getting down to cases...

Dr Little's remarks were refreshing, precisely because views such as his were so seldom voiced. The casuistic reasoning by analogy that the GPs used just did not allow opinions like these to surface. It may not be that the GPs were blind to other ways of understanding problems and conceiving of solutions. When they used their experiences collected over a life time to assist them, however, their moral deliberation was restricted by a method of doing ethics that allowed them to attend only to concerns that were already in their field of ethical vision.[35] They were poorer for this loss, but then so are many casuists.

The emphasis on the particular in the GPs' moral reasoning through stories is not just a function of the similarity with casuistry. It also reflects the individualism and particularity of work in general practice. There is a clear and obvious sense in which general practice is individualistic, for general practice is oriented chiefly towards the care of individuals. On a daily basis, the work of general practitioners consists, for the most part, of a large number of consultations with individual patients. Although direct consultations with patients occupy only about 60% of general practitioners' work time, these consultations generate over 90% of their income.[36] In addition, a great deal of general practitioners' other activities are related to individual patient consultations - writing letters; making telephone calls to and on behalf of patients; and liaising with colleagues about patient care. There is also a range of administrative tasks indirectly associated with the consultation - the development of practice policies; dealing with the accounting and financial side of the business of general practice; and communicating with staff. At the centre of all of this work is contact with individual patients. Individual consultations are overwhelmingly the most important thing in general practice; they provide its *raison d'etre*.

[35] I have borrowed Arras' visual metaphor here.
[36] See Chapter Five for a detailed discussion of the nature of general practice work in Australia.

The individualist orientation in general practice encourages general practitioners to treat each patient encounter as a discrete and unique event, isolated from other patient encounters. In addition, patients do not present in ways that would assist general practitioners to make connections between discrete consultations. Patients do not appear in batches, neatly sorted so that all respiratory symptoms are on Wednesday mornings, or all cervical smears are to be done on Friday afternoons. The apparently random order in which patients and conditions file into general practitioners' rooms makes it difficult for them to see patterns of illness or associations between the problems patients bring and the environment outside the consulting room. In other words, the general practice setting is not conducive to a population or public health approach to the delivery of health care. To recognise patterns of disease general practitioners need to impose some sort of order on their work, and there is relatively little incentive for them to develop this population approach to their work.[37]

In Australia, the lack of a population perspective in general practice has been recognised and at least two strategies to address the problem have been developed. Neither shows much of evidence of being particularly successful. The first strategy operates through the continuing medical education and accreditation program for general practitioners, administered by the Royal Australian College of General Practitioners. One of the activities general practitioners can choose to maintain their status as vocationally registered general practitioners involves undertaking an audit of their practice. That audit provides them with information about the types of patients and problems they see most commonly. There is little information available as to what proportion of general practitioners choose this activity or, even more importantly, change their way of thinking because of undertaking it. The Divisions of General Practice Program also attempts to encourage general practitioners to apply a population

[37] There are notable exceptions amongst general practitioners, both in Australia and Britain. See, for example, Hart JT. 1988 *A New Kind of Doctor: The General Practitioner's Part in the Health of the Community.* Merlin Press, which contains a summary of his earlier work. In Australia, Jungfer's work in Lobethal, South Australia, provides an exemplary model of a general practitioner who brought a population perspective to his work. See, for example, Jungfer CC. 1944-48 *Child Health in a Rural Community. Report on the Work of the Adelaide Hills Children's Health Survey.* Canberra, L.F. Johnston, Commonwealth Government Printer.

perspective to their work. I have speculated in Chapter Five on the limitations of this program and argued there that its success will be limited by the dominance of the fee-for-service model of general practice in Australia. The same argument could be applied to the likely impact of audit activities in continuing medical education.

The analysis in this chapter has shown that the GPs I interviewed did link apparently isolated cases with each other. There are other examples from the literature which also suggest that doctors do link their cases with other cases, regardless of whether they are comparing medical or moral judgments.[38] In both the the medical situation, and in the particular case of the moral problems of the GPs in this study, the nature of the work of doctors, with its focus on particular experiences unrelated to other experiences, does not encourage the development of a systematic approach to the analysis of like and unlike cases. The GPs had no need or incentive to develop good rhetorical technique beyond the intellectual satisfaction it might offer. In the same way, they had little encouragement to develop an understanding of their encounters with patients that included a structural or population-based perspective. In this way, the organisation of general practice work supported and shaped the GPs' casuistry-in-use.

8.7 CONCLUSION

The purpose of this chapter has been to show that appeals to experience in the form of anecdotes and stories were important in the moral deliberation of the GPs in this study. These appeals were almost always to medical experiences, and usually the GP played a central role. The types of stories they told – their 'every-day', 'anomaly' and 'disaster' stories – and the moral purposes to which they put those stories – consequence and deontological trumps – all point to a way of doing ethics that was similar to casuistry. The GPs' use of stories shared with casuistry a focus on specific situations; the use of case comparison, with the aid of maxims or rules-of-thumb; a readiness to move freely between different types and levels of moral argument; and, less strongly, openness to uncertainty and moral ambiguity. Yet, this resemblance to

[38] See Hunter, "There was this one guy..." and Guillemin & Holmstrom, *Mixed Blessings...*

casuistry was not perfect. While there were parallels between the methodology of casuistry and the ways in which the GPs used anecdotes, those parallels were weakened by the absence in the GPs' moral reasoning of clear paradigm cases and good use of rhetoric to support their positions. In other words, the GPs' casuistry-in-use resembled, but was less rigorous and disciplined than, the casuistry of contemporary bioethics. In addition, the way in which stories functioned for the GPs fell prey to the same criticisms that have been raised against casuistry: its tendency to privilege dominant social meanings, in this case medical meanings, and the risk of a slide into individualism. The slide into individualism was also exacerbated by the organisation and structure of general practice work. In this, the GPs' casuistry-in-use bore the marks of the social and structural context of general practice just as their principlism-in-use had. The next chapter explores these two themes from the perspectives of virtue theory in the GPs' reasoning.

9 BEING A GOOD GENERAL PRACTITIONER: VIRTUE THEORY-IN-USE

9.1 INTRODUCTION

This chapter is about the third style of moral reasoning-in-use that the GPs used in their talk about moral problems. The two styles of moral reasoning discussed so far, principlism- and casuistry-in-use, were, to a greater or lesser degree, tools for thinking that the GPs brought to the moral encounter. When used effectively, these approaches offered strategies to resolve moral conundrums and, in that sense, they were methodological aids to reasoning.

The approach to moral deliberation discussed in this chapter was quite different in character to moral deliberation using principles or based around stories. It was not focused around solving problems or dealing with cases. Instead, it seemed to be about a way of being, about an understanding of what was contained within a professional role. When the GPs used this approach, they were not talking primarily about how they acted when faced with moral problems; instead, they were reflecting on how *being* a certain kind of general practitioner coloured their decisions and actions.

The fact that this style of moral reasoning was focused on being rather than doing raised certain difficulties for the analysis. The GPs' principlism- and casuistry-in-use could be described and evaluated by considering the logic and coherence of the GPs' talk about the ethical problems they had chosen to discuss. In contrast, the style of moral reasoning discussed in this chapter was not as easy to identify, because it remained hidden away in the background for much of each interview, nudging its way to the surface only in a throw-away line or toward the end of an interview. For example, it was there when the GPs talked about how general practice as a vocation or profession, rather than general practitioners as individuals, dealt with problems. It was there when the GPs described the difference between general practice and

specialist medicine, or when they talked about the "GP's style" or being "in general practice". It was apparent in comments like the following:

> *69... Do you think the way that you work together with patients, generally, is similar, or different to other doctors?*
> 70. I think every doctor has their own style of practice. I've given a lot of thought to this over the years, and I think you're influenced by your peers and your teachers, and you develop a style of general practice. And the way you treat every person is different. For instance, a lot of teenagers, boys come in - sprained ankle - everything's black and white. Whereas other people will come in with a physical symptom, and then you sense that there's something more to it than that, and you have to talk to them for longer, and do more digging to find out what the real problem is. And this comes, it's just every GP's style, I think. You get to know people very well over a number of years and you can sense when they need a different sort of approach...
>
> Dr Kingsford

> 45...There can never be black and white about one situation. I guess it's the, you really have to look at the whole picture. That's what we can certainly find in general practice is knowing the family, knowing the whole situation is much more useful than just knowing a picture, one frame of it, of the film.
>
> Dr Owen

> 62. In general, I believe that the general practitioner is ultimately responsible for the patient's care. In that he is the normal doctor that sees the patient and looks after her, their particular worries...
>
> Dr Elwin

These comments about "the general practitioner" and developing a "style of general practice" did not relate in a straightforward manner to the analysis and resolution of specific moral dilemmas. Nonetheless, they reveal that, for the GPs in this study, there were connections between their general understanding of their professional role and how they dealt with moral problems. In this chapter, I discuss and evaluate these connections by addressing two questions. First, what defined good general practice and the good general practitioner for these GPs? Put more formally, in the language of bioethics, what did the GPs articulate as the virtues of general practice? Second, how did these virtues and the model of general practice to which they related influence the GPs' moral deliberation?

The GPs in this study identified three virtues in their work in general practice: trustworthiness, empathy and the provision of holistic care. They regarded these virtues as significant both for the way they dealt with morally problematic situations and for the way they conducted their professional lives more generally.

There are links between virtue theory, as articulated by bioethicists, and the virtue theory-in use that the GPs articulated. At a general level, the links are similar to those I have discussed in the two previous chapters between principlism and casuistry in the bioethics literature, on the one hand, and the GPs' principlism- and casuistry-in-use, on the other. As with those approaches, the GPs' virtue theory-in-use bore some of the features of those moral theories we describe as virtue theories. However, unlike the GPs' principlism- and casuistry-in-use, the GPs' virtuist approach to moral deliberation was not as widely shared by all the GPs in this study as the other approaches were. A few of the GPs in this study – Drs Owen and Kingsford particularly – clearly had given considerable thought to the question of 'being a good general practitioner'. They identified strongly with their role as general practitioner. For some of the other GPs, the concept of a 'good general practitioner' or the 'virtues' of general practice was much more muted and inchoate.

Those GPs who articulated most clearly a virtue approach to moral deliberation were able to, in part, because they shared the experience of working in rural areas. This experience had helped them to develop an understanding of the nature of general practice - in particular, as it involved the provision of holistic care - that their urban colleagues were less able to draw on. In other words, rural general practice, far more than urban practice, provided a context that supported the provision of holistic care and this, in turn, sustained the GPs' beliefs about this particular virtue in general practice. In that sense, the structural and organisational framework of general practice in rural areas provided the context for their understanding of virtue in general practice.

9.2 THE GOOD GENERAL PRACTITIONER - TRUSTWORTHY, EMPATHETIC AND HOLISTIC

For the GPs in this study, the good general practitioner was a doctor who practised in a certain way. Dr Kingsford, probably the clearest articulator of that

'way', described this as the general practitioner's "style". The discussion that follows shows that there were three features to this style or way of being a general practitioner: trustworthiness on the part of the doctor, associated with honesty and confidentiality; empathy; and care of the whole person, associated with accessibility, comprehensive care and continuity. These three features constituted, for the GPs in this study, the virtues of general practice.

I used two analytical tools to develop this analysis. First, I did a simple count of the number of times each virtue was mentioned. These simple counts, however, gave no sense at all of how important the virtues were to the GPs as a group or to individual GPs, because some GPs who mentioned honesty, empathy and confidentiality, for example, did not discuss these virtues in any depth at all. I decided that it would be more helpful to try to assess how significant each virtue was for each GP. My calibration of the importance of each virtue was based on my assessment of how central the virtues seemed to be for each GP's overall approach to ethical problems. In the main, that calibration derived from noting how much of the GP's conversation revolved around each virtue, and how often the GP returned to the virtue and issues related to it during the interview.[1] The results of that analysis are shown in Table 11, which shows that amongst the GPs there was a wide range of expression of and interest in the virtues and the notion of the good general practitioner. I discuss each of the virtues in turn, focusing on the views of the GPs who described them in the greatest depth and detail.

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[1] One potential difficulty with this measure of the importance of the virtues lies in its validity. I attempted to address this difficulty by asking a colleague to read through sections of some of the transcripts and to record how important she thought each virtue was for each GP. After discussion and comparison of our ratings, we agreed that the most finely tuned measure I could use was relatively crude: for each GP, I could describe each virtue as not mentioned, a little important (one tick in Table 11), quite important (two ticks), or very important (three ticks). When we rated another small set of transcript sections using this rating scheme, there was very high agreement between us on the importance of each virtue for each GP.

TABLE 11

THE VIRTUES OF GENERAL PRACTICE ARTICULATED BY THE GPS

GP	Virtues of general practice		
	Trustworthiness, confidentiality and honesty	Empathy	Holistic care – accessibility, comprehensive care, continuity
Dr Bright	✓		
Dr Dunt	✓		✓✓
Dr Elwin	✓		✓✓✓
Dr Johnson	✓✓✓		
Dr Kingsford	✓✓✓	✓✓	✓✓✓
Dr Little	✓		✓✓
Dr Masters	✓✓	✓✓	
Dr Newton			✓
Dr Owen	✓✓	✓	✓✓✓
Dr Silverman	✓✓✓		✓✓
Dr Sing	✓	✓	
Dr Stamos	✓		
Dr Winters	✓✓	✓✓	

The number of ticks indicates my assessment of how important these virtues were for each GP's discussion of ethical problems in their work. (✓ = a little important, ✓✓ = quite important, ✓✓✓ = very important)

9.2.1 The trustworthy general practitioner

The first virtue identified by the GPs as central to being a good general practitioner was the notion of being trustworthy. A good general practitioner established trust in his or her relationships with patients. Twelve of the GPs mentioned the concept of trust in general practice at some point in their interviews, and six of these GPs dealt with the notion of trust at some length, either directly of through its connection with confidentiality and honesty.

The GPs believed trust to be immensely important to the maintenance of a good doctor-patient relationship:

66... you want them to trust you, to go through it to make sure. If they say, "well, if you're not really sure", or "doesn't seem that right, then why should I do it?" But if they trust you, they do it anyway. I know that sounds odd. Trust is very important for the long-term management of patients. It is not in interim care, but in general practice it is continuity of care over a long period of time, and that means you've got to built up a relationship. If you start off by deceiving somebody, or you undermine their confidence in you in any way, then they've two choices, they can change doctor, which breaks up the continuity of care and decreases the quality of care generally, usually. Or, they will question everything you do, which means that the consultations will take a lot longer to achieve the same ends. Or, they just won't do it, which can have disastrous consequences.

Dr Silverman

33. So being perceived to be honest seems to be important to you.
34. Oh yeah.
35. Why does that matter?
36. Because I think people have to trust you. They have to sort of feel that if they come to you with a problem, whatever it might be, that they know that you'll basically give them, well. Well, I guess it's human nature anyway, that I think in terms of dealing with people here it's just part of the deal, you've got to be seen to be competent, and I think the honesty part goes with it. It's just all inclusive, you know, and if people know that you sort of lied or for whatever reason they, you know, I think they won't see it your way. I guess, I don't know, I can't really explain it, it just, you know it mean, it just isn't good, or wise. I think it's just part of the reputation, and it's how you'd like to be perceived. I mean I wouldn't say I'm totally honest in all aspects of my life, I'm not. But when it comes to dealing with people here in confidentiality and I see this as being a contract, and the contract is that, you know, I do my best by them and I'll basically be reasonably honest. And that's part of the deal. You know I just see as being a sort of contractual deal, so I'll abide by that. ..

Dr Johnson

The concept of trust, as described here by the GPs, is a complex one. Dr Silverman linked trust to openness, a lack of deception and to patient confidence in the doctor's judgment. Dr Johnson moved from the notion of trust, to faith in the competence of the doctor, to honesty, all in a matter of phrases. The range of concepts the GPs introduced around the key concept 'trust', reflected quite accurately the treatment of this concept in the bioethical and philosophical literature. Barber, in a key work on the nature of trust, notes how rare it is for 'trust' to be defined clearly in the literature.[2] He pulls together a number of definitions of trust under the theme of "expectations that social actors have of one another in social relationships and social systems".[3] Barber describes three types of expectations: that social and natural order will be maintained, that roles will be performed competently, and that partners in interaction will act for the benefit of others.[4] The second and third of these were

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[2] Barber B. 1983 *The Logic and Limits of Trust.* Rutgers, 1-6.
[3] Barber, *The Logic and Limits of Trust...*, 8.
[4] Barber, *The Logic and Limits of Trust...*, 8-18. Veatch also invokes notions of trust in his *Theory of Medical Ethics*. Dr Johnson's contractarian language bears some similarity to the third level of the

explicit in the way in which the GPs talked about trust. The GPs thought that the patients of a good general practitioner would expect their doctor to carry out his work competently and to watch out for their interests.[5] In addition, the first of Barber's types of expectations was implied in at least some of the GPs' interpretations of trust. For example, Dr Silverman valued trust, in part, because it contributed to an ordered relationship between doctor and patient. The visible marks of that order were: continuity of care, because trusting patients didn't "change doctors"; an efficient use of time in the surgery, which was not hampered by consultations that took "a lot longer to achieve the same ends"; and patient compliance.

Dr Silverman's and Dr Johnson's comments also introduce the two characteristics that the GPs linked most often to trust - confidentiality and honesty. The discussion of these two characteristics was usually, but not always, linked with trust. Five GPs discussed the role of the general practitioner in terms of honesty and confidentiality, without explicitly mentioning trust. I have connected them here because the seven GPs who did explicitly discuss the role of trust in general practice all linked it to honesty or confidentiality or both.

Trust and honesty were related for the GPs in this study, because the GPs believed that their patients would only trust them if they were honest with them. One way of construing the link between honesty and trust was the approach that Dr Johnson referred to in the excerpt from his interview above. For him, honesty was an insurance policy against being accused of deception. Dr Johnson's honest general practitioner gave clear answers, explained things to the best of his or her ability and, most important of all, did not deceive his patients, all to ensure, at least partly, that his good reputation was secure.

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triple contract that Veatch advocates. See Veatch RM. 1981 *A Theory of Medical Ethics.* Basic Books, in particular chapter 5.

[5] See, for a similar treatment, Beauchamp TL & Childress JF. 1994 *Principles of Biomedical Ethics.* (4th edn) Oxford University Press, 469.

Dr Kingsford's way of connecting honesty and trust was very different. He considered that honesty was not an all or nothing thing. Instead, there was more than one way to be honest:

> 44. I think you've always got to be honest, but there are ways of doing it. I wouldn't - I think you've also got to take into account their feelings, for instance. I think there are ways and means of being honest. If they come in and they ask you straight out, "have I got cancer?" - I would always say, yes, if that was the case. But then I could also say it in such a way that - I don't think I would say, "look, you're going to die", and be morbid about it, or something like that. I think you can be - the ways and means of breaking it to them gently, and let them form their own conclusions. I think this just comes with experience really, that you can treat people and say things to them, and be honest, but, by the same token, not take away all hope, as if they're going to go away and commit suicide or anything like that. You've always got to be honest, but then there is just a way of being honest, I think, a way of telling people things...
>
> Dr Kingsford

Here, the relationship between trust and honesty is not primarily a matter of playing it safe so as not to get caught out. Being honest, for Dr Kingsford, involved providing information in the way that was most appropriate to that situation. Honesty, in his case, had to do two things: it had to provide information, explanation and advice and, just as importantly, it needed to offer reassurance, confidence and encouragement.[6]

Confidentiality was the second theme in the GPs' discussion of trust in general practice. They interpreted it to mean that any information about a patient could not be divulged to anyone other than that patient. For Dr Owen confidentiality was "probably the most important factor in a doctor-patient relationship…":

> 109…and because they expect a doctor to maintain confidentiality they'll tell him many things they won't tell anyone else, and they'll tell him many things about themselves that they don't want anyone else to know, and that includes their husband or their wife or to anyone else, and it might involve really delicate and sensitive information which is no-one else's to hear. So, consequent on that, I think they probably expect doctors to be very impartial about what they hear in confidentiality, confidentially as well, and almost act as a sounding board I guess about that sort of information, so that although we listen and give advice that we're really not there, as it were, we're just a sounding board I suppose. But the information must go no further.
>
> Dr Owen

Dr Owen's treatment of the concept of confidentiality linked the assurance of confidentiality to patient behaviour and, through this, to the competence of the general practitioner. Patients would be more inclined to tell the doctor the whole story if they

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[6] See, for comparison, Brewin TB. 1995 Truth, trust and paternalism. in Davey B, Gray A & Seale C.

knew the doctor would maintain confidentiality. The GP's ability to make the right medical decision for the patient was contingent, at least in part, on getting a meaningful story from the patient, and an atmosphere of confidentiality encouraged patients to tell a 'fuller' story.

Dr Owen's comments also indicate that, for these GPs, the virtues of trustworthiness, honesty and confidence keeping had a primarily instrumental value. These virtues were valued, not as ends in themselves, but because they had the capacity to enhance the quality of outcome for patients. When general practitioners were honest and kept confidences, their patients would trust them. General practitioners who were trusted could achieve more, by developing a more complete account of the patient's problems, or by getting the patient to do things which she otherwise might not be prepared to try. Patients who trusted their doctors were compliant patients. The GPs would have agreed with Christie and Hoffmaster's judgement that the good relationship between a trustworthy doctor and her patient had "considerable therapeutic potential".[7]

9.2.2 The empathetic general practitioner

The second virtue of general practice that the GPs in this study identified was empathy. This involved an ability to stand alongside patients, to evince an attitude of "genuine concern" for them, and to be able to respond with reassurance and support.[8] Five GPs spoke about the role of the general practitioner as entailing an attitude of care, concern and support. Dr Masters, for instance, described her professional role primarily as a supportive one; she felt it was a particular characteristic of work in women's health in a general practice setting. She explained that this supportive role included the capacity to stand alongside people and treat them as your equals.

(eds.) *Health and Disease: A Reader.* (2nd edn) Open University Press, 327-331.

[7] Christie RJ & Hoffmaster CB. 1986 *Ethical Issues in Family Medicine.* Oxford University Press, 18.

[8] Campbell A, Charlesworth M, Gillett G & Jones G. 1997 *Medical Ethics.* (2nd edn) Oxford University Press, 17, discuss the way in which this genuine concern must be partnered by detachment.

38...So, in fact, I see people as equal and therefore I think it also makes it, that's the type of my approach in counselling people or treating people. But, I guess that's why we see a lot of people here from the lower socio-economic parts is that they actually keep on coming back because they will often say to Paul, my colleague, you know, "this is Paul, oh, this is Doctor Paul", and I'm often called Doctor Mary. They often see us as friends, I think, rather than, you know, they're the patients out there and we're the doctors up here. And they're prepared to be more honest, I think, because you establish trust and I think if I set myself up a line - "I'm a medical expert and you're sort of nothing", which sometimes seems to happen, then I just don't believe you get the same sort of rapport. You don't get to the root of the problem. Which I think we do quite often because people don't feel that they're put down. And a lot of the people we see feel as if they're put down most of their life. So, if you don't start putting people down, if you treat them as equals, then it's surprising the response you get back.

Dr Masters

Dr Masters' response here was complex. She felt that her commitment to treating others as equals encouraged a more open and honest attitude on the part of her patients. This in turn meant that she was better able to get to "the root of the problem". The virtue of empathy, linked to honesty and trustworthiness, was again instrumental, primarily to the patient's medical ends, rather than the doctor's professional ends.

When Dr Winters described the differences between his professional self and his private self, he also drew on these concepts. He understood that his professional role as a general practitioner required him to present a caring and reassuring attitude to his patients, something that he didn't always maintain at home:

80...my wife really gets annoyed with me, because she thinks our family gets inferior medical treatment. And I think I probably do, and maybe I need to make more effort, because I really don't like to get involved with them, therapeutically, unless we're stuck somewhere and it's me or nobody, then obviously I'll do it. But if one the children has a problem and it's nothing more than - oh how can I put it - my wife often thinks that there's more wrong with the children than I think there actually is, therefore I can be a bit off hand with and almost say "well, there's nothing much wrong with them". Whereas a mother coming in to the office, obviously concerned about a child. I mean, part of it is, sure examining a child, but there's the reassurance aspect, and perhaps I don't do that enough with my wife, because I can see that there's nothing wrong with them, don't worry about it. And that's not fair, I guess. I'm learning something today...
88... I guess maybe with my wife, if she's got some medical problem she's better off to go and see somebody else. If she's got a cold or flu, fine. But if she has some vague nebulous symptoms, I mean I sound like I'm not very caring ... maybe I'm not, maybe I should be better with my own family. If she says "there's nothing wrong". I say "fine, well, go and see so-and-so". Because, what happens, it's not just a case of my not caring - well I do care - and sometimes it's hard to present that reassuring, caring attitude because it's difficult to do it all the time at home and at work. But on the other side of the coin, also my wife doesn't necessarily trust my judgement either...

Dr Winters

Through making the distinction between his professional role as a doctor and his

private role as a father and husband, Dr Winters was able to articulate that providing reassurance and indicating a "caring attitude" was an important part of his role as a doctor.

Dr Kingsford also picked up the notion of providing patients with sympathy and reassurance. He reached this issue by talking about how doctors, and general practitioners in particular, needed to be good listeners and he emphasised that this was a skill acquired through experience in the general practice setting.

> 70...I think the most important thing is to be, in medicine, you've got to be a good listener when they come in, let them tell their story, then you may ask them certain questions. But they want someone to be sympathetic to them, and also guide them in what you think is the correct thing to do. And I think this is just a thing that GPs pick up as they go through the years, when they're treating people. They sense the ones that they treat in different ways.
>
> Dr Kingsford

9.2.3 The holistic general practitioner as provider of accessible, comprehensive and continuing care

The final virtue that seven of the GPs in this study identified as important for good general practice was care of the whole person, or holistic care. In Chapter Five I discussed the provision of whole-person care as one of the hallmarks of the altruistic professional model of general practice. Here, for reasons of economy, the term 'holistic' is used as a catch-all phrase for a number of elements in the altruistic professional model of general practice. Specifically, it includes the notions of accessible, comprehensive and continuing care.[9]

The GPs in this study believed that the good general practitioner should be *accessible*. Doctor Kingsford explained this as being available at short notice. Dr Newton had explored issues related to accessibility in her interview when she described how she had gone out of her way to visit elderly patients at home. Despite

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[9] Smith HL & Churchill LR. 1986 *Professional Ethics and Primary Care Medicine: Beyond Dilemmas and Decorum.* Duke University Press, 19. Smith and Churchill suggest that the term 'care of the whole person' has become an empty shell for a loose cluster of ideologies. Their preferred definition includes the terms "accessible, comprehensive, coordinated and continual care provided by accountable

feeling uneasy about what her patients were asking from her, she clearly assumed that general practitioners needed to be available to their patients, even if not always to the extent of her involvement.

Second, the GPs believed that good general practice concerned the provision of *comprehensive* care. In the professional literature, comprehensive care relates to the fact that general practitioners are generalists: they deal with all people and all problems presented to them.[10] In addition, comprehensive care often also carries the notion that good medical care must beyond physical and technical concerns to the social and emotional world of the patient.[11]

The provision of comprehensive care was a virtue for the GPs in this study in the sense that they believed that the good general practitioner accepted that patients brought more to the consultation than a physiological or pathological problem. Patients came with life experiences that the general practitioner needed to incorporate into the care he or she provided. For example, Dr Owen thought his commitment to the "whole situation" was significant in the way he dealt with ethical problems. During his interview he explored what this meant for the ethical problem he was facing - a young woman wanting to have her tubal ligation reversed.

> 45...There can never be black and white about one situation. I guess it's the, you really have to look at the whole picture. That's what we can certainly find in general practice is knowing the family, knowing the whole situation is much more useful than just knowing a picture, one frame of it, of the film.

Dr Owen's discussion of his ethical problem indicated that he had tried with this young woman to build up a picture of the "whole situation". He was as familiar with her social life as with her medical problems: he knew about her family, her relationships, and he had developed an understanding, over time, of what she wanted

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providers".

[10] See sections 5.3.3 and 5.3.4 for an account of the professional usage of the terms 'comprehensive care' and 'whole-person care'. In particular, see Strasser R. 1991 General practice –what is it? *Medical Journal of Australia* 155:533 for a brief discussion of the meaning of 'comprehensive care'.

[11] There are links here to Balintism. See Chapters Three and Five for brief descriptions of the Balint

and needed in life:

> 49... I think that she wants to have, I think that she wants to have another child, not for herself, but for her partner. That's the distinct impression that I get talking to her, that having a child would be part of binding their relationship together, making it more secure, and not any particular maternalistic reasons, reasons that she has. She is the sort of girl, I guess, who feels a desperate need to be loved and to have found a relationship which is satisfactory to her, something that's more than just a couple of weeks, or a night even, is something that's really good and she would hang on to that and probably try very to hard to hang on to that, because she's human, she needs the warmth and emotion that most people need. Whether those reasons are good reasons for her to have a baby is probably not for us to say yes or no to. And certainly, talking to her boyfriend, he's some sort of ex-bikie, ex-drug addict as well - I'm not sure how long he'll be around for as well because he's only been here for a short time. It's a hard one.
> *50. How many times have you seen her, talking about this particular episode?*
> 51. Seen her talking about having her tubes reversed? I've talked to her about four times about it, and she's quite insistent about it, about having it done, and I think, right she says she's cut down on her drinking. I've seen her do this before over the years, and it's just a likely to fall apart tomorrow if she has a big fight with her boyfriend, or if one of her old boyfriends turns up again and starts fighting. Two of her boyfriends had a big fight once before and they burnt half the house down in their fight. So they're pretty violent people sometimes.
>
> Dr Owen

Dr Owen's understanding of this woman's situation was not something that he had developed through one or two consultations. It was an awareness that has matured as he had come to know her well "over the years". This commitment to the provision of *continuity of care* was the third aspect in the GPs' understanding of holistic care.

Many writers regard continuity of care as the cornerstone of general practice.[12] As outlined in Chapter Five, in the professional literature continuity admits of at least two meanings. The first, 'relational continuity', focuses on the ongoing relationship between general practitioner and patient. Continuity, on this interpretation, develops over time as doctor and patient learn to know and trust each other and as the patient comes to identify one doctor as "his doctor". The second meaning, 'regular contact continuity', focuses on the capacity of the general practitioner to be available and accessible to patients. This meaning is often taken to refer to practices, rather than individuals; in that context, it can be interpreted as the proportion of general practice services patients receive from one practice versus all other practices.[13]

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movement and its relationship to Australian general practice.

[12] See 5.3.2 for a discussion of the meaning of 'continuity' in the general practice literature.

[13] See, for example, the Patient Continuity Index, the measure of continuity used in the Better Practice Program. Commonwealth Department of Human Services and Health. 1994 *Introducing the Better*

In principle, the relational and regular contact interpretations of continuity go hand in hand, because doctors who see their patients regularly are in the best position to develop trusting relationships. If we take continuity to refer to individual general practitioners, rather than practices, the doctor in the best position to offer continuity of care, on both interpretations, is the general practitioner in solo practice who does his or her own after-hours care. In reality, however, less than one third of general practitioners are in solo practice and even less provide a round-the-clock service personally. Even when the provider of continuity is practices, rather than individual general practitioners, the evidence suggests that any one general practice provides only about two thirds of the services which its regular patients receive each year.[14]

The GPs in this study believed that the provision of continuing care was one of the virtues of general practice, and they interpreted continuity in both a relational and a regular contact sense. Dr Little had found that being a provider of continuous care had profoundly shaped his understanding of his own role:

> 96... Working in [a country town] for twelve years, to get to know a whole community from that point of view and to see a whole community move on a decade - in their ageing patterns, their growing-up patterns, their maturing patterns and marriage patterns. It's useful to slowly come to the realisation that change for people is a process rather than an event. You can't fix most of the problems of life in one go. It's not going to be one event of fixing things. It's a pattern of change that they might or might not want to commit themselves to. And just to sit back and take a longer-term view of what's going on in each person in each situation rather than trying to be the big hero that fixes it in one go.
>
> Dr Little

Dr Little's interpretation of continuity carried both a sense of regular contact – watching members of a community grow and develop over time - and a sense of relationship – being with people as they grew up, matured and married.

A brief summary seems appropriate at this point. The GPs in this study

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Practice Program: Information Kit and Application Form.

[14] See, for example, Young D & Liaw T. 1996 The organisation of general practice. in Commonwealth Department of Health and Family Services. *General Practice in Australia 1996.* Australian Government Printing Service, 110, which uses Better Practice Program data. The figure probably over-estimates the commitment of patients to one practice.

articulated three virtues for general practice: trustworthiness, empathy and holistic care. Their virtuist voice was perhaps subtle and less clear than the principlist and casuist voices had been, and it was not expressed by as many GPs. Nonetheless, it reflected an important aspect of the moral reasoning of those GPs who enunciated it.

9.3 THE INFLUENCE OF THE VIRTUES OF GENERAL PRACTICE ON MORAL DELIBERATION

The task of discussing how the virtues the GPs described worked for them in their moral deliberation is a difficult one. Because the emphasis is on being rather than doing, at one level it does not even make sense to talk about this approach to moral deliberation as a way of 'doing' ethics, or as a cognitive tool that the GPs 'used' to deal with ethical problems. Yet, there are links between being ethical and doing ethical things. Even if our attention is focused on those "inner realities" that relate to being ethical – things such as motives, dispositions, intentions and attitudes - one way to comprehend these realities is through the ways in which people act.[15] We can have a discussion about how the GPs understood their virtues of general practice and used them in their moral deliberation precisely because there is a link between being and doing. If that discussion appears weak it is because the GPs were less concerned, in this arena, with what to do about moral problems than how to be a good general practitioner.

With these qualifications in mind, in what ways did the virtues the GPs described influence the way they dealt with moral problems? There were at least five characteristics of the GPs' virtue theory-in-use that were significant for their moral deliberation. These five characteristics are also to be found in virtuist approaches to bioethics and, in each case, I discuss the similarities briefly below.

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[15] Drane JF. 1994 Character and the moral life. A virtue approach to biomedical ethics. in DuBose ER, Hamel R & O'Connell LJ. (eds.) *A Matter of Principles? Ferment in US Bioethics.* Trinity Press International, 291. I am not suggesting that a discussion of character and the virtues based around actions alone is sufficient, only that how people act is one way, perhaps the main way, in which we

First, as noted above, the image of good general practice and the virtues of general practice these GPs described were as much about *being* a certain kind of general practitioner as they were about *doing* things in general practice. Because they were about being a good general practitioner, the image and the virtues associated with it covered all aspects of the GPs' work, not just the morally problematic ones. Virtue theory-in-use was not a tool for dealing with moral problems; it was the GPs' way of responding to everything that they encountered in general practice.

The emphasis in the GPs' virtue theory-in-use on being a certain kind of general practitioner resonates with virtue theory's concern with "habitual patterns of moral behaviour that make possible the claim of 'knowing the way some people are'".[16] Virtue theorists maintain that attending to the more-or-less routine way in which people respond to both the exceptional challenges and mundane events in their lives is central to our understanding of the moral life.

Second, the virtues that these GPs articulated were not intrinsic values. Rather, to use Pellegrino's words, they were traits "oriented to ends and purposes".[17] The GPs seemed to value particular virtues because those virtues enhanced their capacity to 'get things done' for their patients. This was most clearly seen when the GPs were talking about why trust mattered in their relationships with patients. Trusting relationships, and the commitment to honesty and confidentiality that accompanied them, were thought worthwhile because they enhanced good outcomes for patients.

Third, becoming a good general practitioner was not something that happened overnight. It was a learnt way of responding to situations, grounded in one's life

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discern their character. See Chapter Two, for the discussion of contemporary virtue theory.

[16] Drane, Character and the moral life…, 292.

[17] Pellegrino ED. 1995 Toward a virtue-based normative ethics for the health professions. *Kennedy Institute of Ethics Journal* 5: 256.

experiences. Although it was difficult for them to articulate, the GPs did draw links between their personal and professional histories and the kinds of GPs they had become. Dr Masters and Dr Dunt reflected on facing difficult life situations and the impact this had on their style of practice:

> *13. You made... some change in the way in which you approached unplanned pregnancy and I'm interested in how you went from the position where you signed the forms but were uncomfortable about it to where you moved to a position of saying, "well, I'm not going to sign the forms anymore."*
> 14. I think it, I guess it was something, I guess I was learning more about me and what I really felt was important in my life and certainly I guess, yes, on a personal perspective, from talking to my pastor at church. You know, sort of, just in Bible studies looking into things to seeing what I really did believe and I guess why I was unhappy doing what, on one level, I see many people doing and not having a qualm about. You know, so I guess it's sort of a comparative sort of approach and I guess I realised that I wasn't going to compromise my values. And it was, it was a slow process. And I guess I was looking at, roundabout the same time, my marriage wasn't going very well - in fact, my first marriage broke up - so I guess I was looking at lots of issues in my life and I guess I was re-evaluating the whole, a whole lot of things...
>
> Dr Masters

Dr Johnson talked about growing up in a big family in which a moral responsibility for others was assumed. He also mentioned clinical teachers who were able to convey their love of their work:

> *59. Do you think that say, your medical education, both under-graduate and post-graduate, had any impact [on the way you practise]?*
> 60. I think that one thing I've really got out of medicine is that it is a unique club that in a way, because I think it does teach you that, I think it does teach you to be an honest person, and that came through in my teachers, to be honest. And I think, you know, because I've pretty good teachers all the way through, and you know I found that the actual training you got in the hospitals and stuff was excellent. You know, we found that it was really drummed into us in a clinical sense, we know how to learn things and also I think basically being honest. Yeah, I think it was a powerful influence. It wasn't actually explicitly said but it was just there, and you were expected to be honest. And if you weren't you were basically a bit of an outcast. I think it came through. I don't think it was that stated in so many words, but, you know the whole teaching process, especially in the clinical years. I never really liked the pre-clinical stuff much, I didn't enjoy it at all. I found when you got into the hospital and stuff it was a bit different, and so I think it is there.
> *61. So that's a general perception of that. Some people would be able to pinpoint some thing or some people during their education.*
> 62. Yeah, when I was taught, I was taught by - People who sort of stood for me, was a guy called Bill Jones down at Children's; you know Prof Kingston they were very honest sort of clinicians and Prof Langwood..., he's another one. And they just loved what they did and they were able to sort of convey it, you know and I found that they, you know, you sort of do get them as role models because you couldn't ever imagine them telling some bloke a lie...
>
> Dr Johnson

Dr Elwin described how his mother had been an important role model for him:

> *69... Can you describe any influences in your own life that have been significant in developing those morals and values?*
> 70. I think certainly my parents. My Mum's a very, she's a very self-sacrificing sort of person which engenders the idea that you have to very much consider the other person. Not just consider your own personal glory and so forth. You have to consider the other, the way that's going to impact on other people and move around that....

Unlike Dr Johnson, his medical education offered no positive role models, creating instead conflict and unease:

> ... I think notably my experiences in medicine brought a great deal of conflict between what I was seeing happening and what I believed was appropriate for the normal and humane treatment of people. Situations where fourth year students are dragged around from heart movement to abdomen to leg ulcer rather than from Mr. Bloggs to Mrs. Smith to whatever to - you know, not going from person to person, going from problem to problem. That creates a degree of discomfort for me, that people will, are prepared - I guess, in my naivete, I believed that people treated people reasonably well. That they understood that they had problems and that they understood that everyone was really doing the best they could under the circumstances and they tried to treat people well, but that people would just push that completely to one side for the sake of X issue and not, just not be aware that that's what they were doing. So I think the only thing that my medical school training did was to create a conflict.
>
> Dr Elwin

Six of the GPs mentioned specifically that their religious beliefs had played a role in the development or maintenance of their views and values. However, the nature of that role was quite variable. Two mentioned that growing up in Christian homes in which certain values were prominent and had influenced the values they now brought to their work. For example, when I asked Dr Johnson about influences in his life that had been important for the value he placed on honesty in his work, he answered:

> 58. I don't know that I've actually thought about this, I come from a sort of a pretty sort of standard sort of background. Well, you know I sort of come from a Catholic background, sort of fairly biggish family. And we had a certain set of moral obligations to each other and other people, and I think it comes probably from that, just that sort of family support. But I think a lot also comes from your inherent self, and how you also develop yourself, and one of the things I developed very early life was basically an ability to be able to admit I was wrong, or didn't know. And so I, if I didn't know something I wasn't like something, I would sit there and pretend I knew it, and ask, or even if it was fairly stupid question, which on occasions can get me into a fairly embarrassing situation. But if I don't know it well I'll ask, and it's a bit like that with me and making mistakes, I just always perceived that it's been a, you know it's the sort of probably very Catholic thing to sort probably do that, you know in a way, but it's also just a sort of philosophy that I think works. I guess that's the way I'd deal with it. If it doesn't seem right, well, you know, I'll say so, pretty much, or if I make a mistake. I mean, you could almost say is it a case of self-punishment. Well, I suppose you could almost make that case in some instances, but I think you, more often than not, that the over-riding factors that what I really worked on is 1) that if I'm going to be sort of sued, I'd like to know that I'd, brought it out in the open, and no-one else is going to do it for you, and so you basically open it up then just suffer the consequences for your own liability, and you create a precedent sometimes. But then again a lot of it's inherent too, I don't know where that came from.
>
> Dr Johnson

Two GPs described a personal religious experience or search that had been significant for their development. Dr Dunt, for example, spoke about his fascination

with religion from childhood.

> *67...Can you think of influences in your own life that have been important to you in developing that way of working with patients?*
> 68. Yes, I can. I guess my early, my childhood interest in religion influenced me because I was fascinated by the very (interruption - phone call).
> *69. You were telling me about influences.*
> 70. Early, and I mentioned, I was fascinated by religious concepts as a child and right through till the age of about seventeen and my need once I embraced this Darwinism, and therefore, no need for, at that stage, to see evolutionary concepts as being basically contrary to creation concepts, seeing no need at that stage for a religious view of life. I then needed to develop my own feelings about what was meaningful and what was purposeful about life. And I've spent a lifetime, therefore, looking at how people, looking at people handle adversity and seeing through their inability to explain and yet to live well in adversity. But there were ways of looking at things that I didn't understand. When I finally had massive adversity myself, 10 years ago, a lot of what I'd learned from patients started to become very useful to me and I didn't, I haven't changed my concepts, but I refined and developed them over the last 10 years as a result of needing to feel that I understand what's really important now. Basically that's what it is, it's a view, it's developing in my own view of life which is very similar to religious concepts, but without God. And I find that people whom I relate most comfortably to are people who have strong religious feelings and I can quite often have excellent conversations with those people who relate well to me and yet, yet I don't need, I don't feel the need to have exactly the same belief in God that they have. That's the sort of experience.
>
> Dr Dunt

The GPs' experiences – of family, adversity, role models, religion, and education - point to the close relationship between attitudes and character, on the one hand, and the social and cultural environment, on the other.[18] The way in which character is formed is influenced by the social settings in which we live. These GPs believed that they had become the sorts of general practitioners they were, in part, because of where they had come from. The values and beliefs they held were inextricably tied to their personal and professional histories and to their experience of the present and hopes for the future.

Fourth, in the GPs' talk about the virtues in general practice there was an emphasis on practical wisdom and discernment. Good general practitioners were sensitive to context; they knew how to interpret situations and to moderate their responses accordingly. When Dr Kingsford spoke about honesty and the ways of being honest he added that:

> 44....I think you can be - the ways and means of breaking it to them gently, and let them form their own conclusions. I think this just comes with experience really, that you can treat people and say things to them, and be honest, but, by the same token, not take away all hope, as if

[18] Drane, Character and the moral life..., 295-7.

they're going to go away and commit suicide or anything like that. You've always got to be honest, but then there is just a way of being honest, I think, a way of telling people things...

Dr Kingsford

In a sense Dr Kingsford is reflecting on the virtue of prudence: that "capacity, in a given set of circumstances, to discern what moral choice or action is most conducive to the good".[19]

Finally, the virtues of general practice that these GPs described all revolved around relationships with patients. At their core, good general practice, according to these GPs, was about establishing and maintaining good relationships with patients. A good doctor develops a certain way of being a doctor that includes a sensitivity to people's needs and "an ease with human relatedness".[20]

The five aspects of the GPs' virtue theory-in-use that I have outlined place this approach to ethics squarely in the virtue theory camp. It was not an approach shared by all the GPs, but it was important for those GPs who did articulate it. Just as the approach shared some characteristics with virtue theory, so it also faced at least one of the difficulties.[21] Critics of virtue theory have argued that there is a circularity about the definition of the virtues, when that definition is made contingent on agreement about the goods of medicine. This criticism seems particularly significant here. How did the GPs come to identify these virtues as the virtues of general practice, other than by assuming that such things are the goods of general practice? And what defines those goods? In the final section of this chapter I take up the issue of the source of these virtues by focusing on the social and organisational context in which good general practice was defined for these GPs.

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[19] Pellegrino ED & Thomasma DC. 1993 *The Virtues in Medical Practice*. Oxford University Press, Chapter 7 considers prudence as a virtue. See also May W. 1994 The virtues in a professional setting. in Fulford KWM, Gillett GR & Soskice JM. (eds.) *Medicine and Moral Reasoning*. Cambridge University Press, 85.

[20] Drane, Character and the moral life..., 287.

[21] The criticisms of virtue theory are softened by virtue theorists themselves, for no virtue theorist makes the claim that a moral theory based on the virtues can stand alone. See Pellegrino & Thomasma, *The Virtues in Medical Practice*...; May, The virtues in a professional setting...; Putman DA. 1988

9.4 THE VIRTUES IN SOCIAL CONTEXT: THE GOOD GENERAL PRACTITIONER AS RURAL DOCTOR

Two of the virtues that the GPs in this study ascribed to general practice - virtues of trustworthiness and empathy - might be said to relate to all branches of medicine and all areas of medical specialisation.[22] The third, holistic care, has a particularly 'general practice' flavour about it, resembling to a considerable degree the altruistic professional model of general practice discussed in Chapter Five. That model is based on the Royal Australian College of General Practitioners (RACGP) definition of the general practitioner:

> a doctor who provides primary, continuing, comprehensive whole-person care to individuals, families and their community.[23]

This 1984 definition was superseded in 1997 by the following definition that emphasises the general practitioner's role in coordination of services.

> "General practice is that component of the health care system which provides initial, continuing, comprehensive and coordinated care for all individuals, families and communities and which integrates biomedical, psychological, social and environmental understandings of health".
> "A general practitioner is a medical practitioner with recognised training, experience and skills, who provides and coordinates comprehensive medical care for individuals, families and communities."[24]

Whichever definition of general practice is adopted, the import is the same. For these GPs, good general practitioners were, at least in part, general practitioners who exemplified the RACGP definition of general practice. However, as I also showed in Chapter Five, side by side with this altruistic professional image of good general practice there has been a second model of general practice - the business model – that has been somewhat at odds with the professional model. In addition, against the positive picture that the altruistic professional model has painted of general practice,

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Virtue and the practice of modern medicine *Journal of Medicine and Philosophy* 13 : 433-443.

[22] See, for example, the virtues listed and discussed in Pellegrino & Thomasma, *The Virtues in Medical Practice...*

[23] Royal Australian College of General Practitioners. 1984 Policy Documents, Policy 30, Definition of General Practice/Family Medicine (Adopted 27/1 Council, September 1984).

[24] Royal Australian College of General Practitioners. 1997 Minutes of 26/27 July 1997 meeting of the

there has been a litany of complaints about deskilling and loss of career satisfaction. Did the GPs in this study communicate any of that sense of malaise about general practice? Why did their image of the virtuous general practitioner mirror so closely the altruistic professional model of general practice?

There are at least two answers to these questions, one more powerful than the other. The weaker answer relates to the design of this study. These GPs were a self-selected group, interested in issues related to ethics in general practice. They were also all in regular contact with the RACGP. As a group, they were perhaps more committed to general practice than many of their colleagues. I did not set out, in this study, to assess issues related to the GPs' commitment to and interest in general practice, nor did I try to assess the extent to which these GPs were similar to their colleagues, other than through their own assessment. However, at the end of the interviews a number of the GPs talked generally about what they thought the future held for general practice. Most were positive and even enthusiastic, but two – Dr Johnson and Dr Stamos – talked pessimistically about leaving general practice. Dr Johnson (when the tape recorder was turned off) described his growing disillusionment with general practice, based on his belief that "the government" was increasingly in control of doctors' work and incomes. Dr Stamos was leaving:

> 114...not for ethical reasons, but for purely lifestyle reasons. Yes, I think ... that no matter which government wins the next election, I don't think being a doctor is going to be particularly fun...
>
> Dr Stamos

Perhaps the GPs in this study were more representative of a larger population of general practitioners than I thought at the time.[25] Nevertheless, it is difficult to follow this line of argument any further. At most, I can only say that the way in which they

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RACGP Council. See Appendix 4 39/10 Council Minutes 26/27 July 1997.

[25] A report from the National Centre for Epidemiology and Population Health in 1995 found that dissatisfaction with general practice was common amongst Australian general practitioners. Although about two-thirds of general practitioners were satisfied with their current role, 35% said they would leave general practice if they had somewhere else to go. Baillie R, Sibthorpe B, Douglas B *et al.* 1997 *Mixed feelings: satisfaction and disillusionment among Australian general practitioners.* Discussion paper no. 12. National Centre for Epidemiology and Population Health, Australian National University.

defined the good general practitioner reflected something about the kind of general practitioners they were – general practitioners who were interested enough to take part in a study of ethics in general practice.

Even if I could not compare the GPs in this study with other general practitioners, I could compare them with themselves. That comparison leads to the second answer to the question about why these GPs defined good general practice as they did. In general, those GPs who spoke most convincingly about the good general practitioner shared one thing in common – a commitment to community based general practice, particularly as it is practised by rural general practitioners.

Seven GPs shared a history of work experience in and/or commitment to rural general practice. Five of these GPs were working in rural South Australia at the time I interviewed them. In addition, Dr Elwin was about to move to the country, hopefully to begin a career in rural practice[26], and Dr Little, now working in an urban casualty service, drew on his rural experience during much of his interview. I grouped these seven 'rural GPs' together and compared their talk about the good general practitioner and the virtues of general practice with that of the 'urban GPs'.

When the GPs were grouped according to 'rural' or 'urban' orientation, it became apparent that the rural GPs were largely responsible for the account of the virtues of general practice given above. Table 12 groups the GPs according to orientation and shows how significant each virtue was for each GP. As for Table 11, earlier in this chapter, the number of ticks indicates my assessment of how important these virtues were for each GP's discussion of ethical problems in their work.

[26] Two years later, while on holiday, I came across Dr Elwin's nameplate in a group practice in a small rural town about 100kms from Adelaide.

TABLE 12

THE VIRTUES OF GENERAL PRACTICE FOR 'RURAL' AND 'URBAN' GPS

GP	**Virtues of general practice**		
	Trustworthiness, confidentiality and honesty	Empathy	Holistic care – accessibility, comprehensive care, continuity
'Rural' GPs			
Dr Dunt	✓		✓✓
Dr Elwin	✓		✓✓✓
Dr Kingsford	✓✓✓	✓✓	✓✓✓
Dr Little	✓		✓✓
Dr Owen	✓✓	✓	✓✓✓
Dr Silverman	✓✓✓		✓✓
Dr Winters	✓✓	✓✓	
'Urban GPs'			
Dr Bright	✓		
Dr Johnson	✓✓✓		
Dr Masters	✓✓	✓✓	
Dr Newton			✓
Dr Sing	✓	✓	
Dr Stamos	✓		

There were small differences between urban and rural GPs with respect to the role that trustworthiness and empathy played in defining good general practice, with the rural GPs somewhat more likely to mention these or discuss them in detail. The greatest differences between rural and urban GPs were with respect to holistic care, which the GPs had articulated as accessibility, comprehensiveness, and continuity. Only one urban GP, Dr Newton, mentioned this virtue at all. Apart from her contribution, discussion of holistic care was restricted to the rural GPs, a number of whom talked about it in depth and detail, and with considerable passion. The way in

which Dr Kingsford described his association with his community provided an excellent example of his deep commitment to rural general practice:

> 121... I like the country medicine and you get to know the people here. I mean, they're all your friends, everything, I mean you're in the local Lions Club. You get involved with people on the Advisory Board, doctor for the council area, and all the people, your friends. I don't think they'd let you leave. You just know them so well...
>
> Dr Kingsford

What was it about the rural general practice experience of these GPs that created an environment for the articulation of the virtue of holistic care? One answer is that the rural GPs in this study were able to articulate holistic care as a virtue because the components of that virtue resonated with the social and organisational context of their work - as rural general practitioners. The urban GPs, however, practised in a different context, one that did not necessarily sit comfortably with the notion of holistic care as a virtue. The urban GPs became silent on the matter of virtue in general practice when their practice reality conflicted with professional conceptions of virtue.

For example, continuity of care, on both the regular contact and relational interpretations, is easier to provide in rural areas, and for reasons unrelated to individual general practitioners' skills, interests and concerns. With respect to regular contact continuity, patients in many rural areas have little, if any, choice of doctor or practice.[27] There may be only one general practitioner based in the town. Alternatively, in towns with three or less general practitioners, the general practitioners generally work out of one group practice. This practice may also provide services for neighbouring towns. Rural patients who do not wish to see the local doctor or practice for all their health problems may find it difficult to travel the large distances required to consult another doctor. Rural patients therefore have regular contact with the local general practitioner out of geographic necessity, rather

[27] See, for commentary on the impact of geographic isolation on both patients and doctors, Moorhead B. 1990 Some differences between Australian country and city general practice. *Australian Family Physician* 19: 531, 533-5, 537; and Fisher E. 1988 Rural practice: reward or punishment? *Australian Family Physician* 17: 141-2. For a comparison with the United States, see Flannery MA. 1982 Simple living and hard choices. *Hastings Center Report* 12: 9-12; and Purtilo R & Sorrell J. 1986 The ethical dilemmas of a rural physician. *Hastings Center Report* 16: 24-28.

than by choice.

The same sorts of structural considerations make relational continuity easier to provide in rural areas. The relative isolation of rural towns in Australia provides opportunities for general practitioners to develop and maintain relationships with patients that are not available in the city. Rural general practitioners meet their patients at social functions, on local committees, while doing the shopping, at church and when taking children to school. Few general practitioners in urban practice have this out-of-hours contact with their patients, so there is less opportunity for urban general practitioners to develop the relationships that are valued in the relational interpretation of continuity. These factors all function to ensure that rural doctors are in an excellent position to provide continuity of care, whether it is interpreted in relational or regular contact terms.

In a similar way, rural general practitioners provide a more comprehensive service than their city counterparts, in part because there are fewer alternatives available to their patients. Rural doctors provide a wide variety of services, including services that are routinely handled, in urban areas, by specialists or by other health professionals whom they know only functionally. They also have access, often denied to their urban peers, to local hospitals in which to maintain procedural skills. For example, many rural general practitioners still practise obstetrics, providing antenatal care, delivering babies and providing postnatal care. Urban general practitioners, if they provide obstetric care at all, focus almost exclusively on antenatal and postnatal care, leaving the provision of intra-partum care to hospital staff. There is anecdotal evidence to suggest that, although obstetrics is rewarding for the rural general practitioners who practise it, many would choose not to provide this service if there were other ways to arrange the provision of obstetric care for their rural patients.

The third aspect of holistic care that the GPs identified – accessibility – appears to be difficult to provide in rural areas, simply because urban GPs are usually geographically closer to their patients. Nevertheless, geographical proximity does not ensure that the general practitioner is accessible. Out-of-hours care is a good example. In urban areas, most general practitioners use a deputising service for out-of-hours care or they arrange with colleagues in the practices around them to share out-of-hours care. In addition, there are large clinics that operate a general practice service 24 hours per day, and some patients use these in preference to deputising services. These arrangements ensure that urban patients have relatively speedy access to general practice services outside normal practice hours. However, having access to *a* general practitioner is not the same as having access to *your* general practitioner. For the GPs in this study, accessibility was a virtue when the general practitioner provided it for his or her patients. Being accessible to one's own patients is, in some ways, not a virtue in rural practice: it is a necessity, for if the general practitioner (or his or her partner) is not available, there is no care available to that patient at all. The lack of alternative services in rural areas forces general practitioners to be available, whether they wish to or not.

The rural GPs spoke loudly and clearly about holistic care as a virtue for general practice because they had experienced it in their own work. In a sense, their image of the good general practitioner points to an idyllic image of the general practitioner as family doctor and respected figure in the community who brings to his practice a wide range of professional skills. It is an image of general practice that still has currency in rural areas. In the Australian context, rural doctors still provide care to communities they know and in which they are known; they see the same patients again and again; they treat all members of a family group; and out-of-hours care is provided by the general practitioners and their local colleagues. Because of these factors, rural doctors are able to develop relationships with patients through which holistic care can be pursued. In rural general practice this image of the good general practitioner can

be a reality.

While rural doctors are community doctors, in the sense that they provide medical care to members of a community they identify with and relate to, many urban general practitioners no longer identify with a community in this way. Their patients choose to see multiple doctors in multiple practices; ready referral to specialist colleagues and other health professionals is available to and pursued by patients; there is no easy access to hospitals for general practitioners; out-of-hours care is arranged through locum services. In this context, urban general practitioners are unable to provide the holistic care that is held up as a virtue for general practice. It is important here to note that Dr Newton was the only urban GP to mention holistic care. Her circumstances were unusual: she had taken over her father's practice in a well established and ageing area and worked there for many years. Perhaps she was able to identify a 'community' in the little section of suburbia in which she worked.

9.5 CONCLUSION

For the predominantly rural GPs in this study who were able to articulate it, the good general practitioner was a doctor who practised in a certain way, being trustworthy and empathetic and providing holistic care to his or her patients. The way in which the GPs used these virtues in their moral deliberation resembled virtue theory in style. It also exposed their moral deliberation to one of the difficulties with virtue theory: its tendency to define the virtues in terms of goods that are taken for granted. In the light of this criticism, the differences between rural and urban GPs that I have discussed are not surprising. Virtue theory does not really address how values, virtues and goods come to have the meanings they do. It therefore puts to one side considerations of the way in which social, organisation and political factors shape our definitions of the good. In this study, it became apparent that it was the social and organisational context of the rural GPs' work that allowed them to adopt a set of virtues for general practice that the urban GPs were unable to articulate.

10 MANAGING ETHICAL PROBLEMS

10.1 INTRODUCTION

This chapter moves from an interest in moral deliberation as a cognitive activity to an account of moral action: what the GPs did or, more accurately, what they said they did about their ethical dilemmas. This opening statement suggests a distinction between 'thinking' and 'doing'; this distinction is, however, an artificial one. Describing one's decisions and actions and the cognitive activities that contribute to those decisions and actions is an iterative process: ideas influence decisions and, equally, decisions influence ideas. In a similar way, the actions one takes on the basis of a moral decision are influenced by and also shape how one thinks about that decision. Although I accept this interrelatedness of moral thought and moral action, for conceptual clarity I have chosen to present a separate account of the GPs' moral actions in this chapter.

How did the GPs deal with their moral problems? What did they do to find morally acceptable solutions? The moral problems these GPs described were quite diverse in terms of the players, the settings and the nature of the problems.[1] Despite this diversity, common threads ran through the ways they dealt with their moral problems. Perhaps the word that best describes these common ways of managing moral problems is 'tactic' - those techniques or ploys that these GPs used to manage, resolve, get around, or ignore moral problems. It is used here to convey a sense of regular usage across a wide range of circumstances. However, the word 'tactic' is not ideal; it has military associations that suggest a plan of action, consciously adhered to, and an anticipated outcome.[2] There is a sense of intentionality and organisation about 'tactics' which is a little misleading in this context. It almost implies that, faced with a moral problem, the GPs opened their moral cookbooks, selected a recipe to deal with the situation, and followed the instructions. That was not the case here. With a few notable exceptions, these GPs did not have a conscious or readily articulated repertoire of

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[1] Chapter Six gave an account of the ethical problems the GPs described.
[2] The Concise Oxford Dictionary notes first its military usage, before defining it also as a "procedure calculated to gain some end". Fowler HW & Fowler FG. (eds.) 1964 *The Concise Oxford Dictionary of Current English.* Oxford University Press, 1317.

ethical problem solving skills. They acted in certain ways because it seemed to make sense at that time, for that situation. Generally, they did not hold in their heads the overall sense of strategy and planning with which the word 'tactic' is usually associated.

The common tactics that the GPs in this study shared were of two main types. First, there were 'major tactics' that were used by nearly all the GPs. These tactics fell into two main categories: using the passage of time and using conversation with patients. As a short form for these two common themes, I have adopted the labels 'timing tactics' and 'talking tactics' respectively. Clearly, these two tactics are interrelated. The GPs used time to create opportunities for talk, and talked to allow time to pass. Again, for conceptual clarity, I treat them separately. Outside of these two 'major tactics', there were four 'minor tactics' used by fewer GPs: discussion with or seeking advice from colleagues; referral; evasion; and the invocation of the law.

Despite the wide range of problems the GPs discussed, the GPs usually either 'talked' or 'timed' their way through moral problems, and most of them did both. The obvious question is then: why these tactics? I argue that the way in which the GPs described their actions leads to an account of moral action that draws primarily for explanation on the structure of general practice work and the ideology of general practice. To interpret why the GPs dealt with moral problems as they did we need an understanding of how general practice work is structured, organised and understood by its practitioners. Two aspects of that work in particular - the practice of 'ten-minute medicine' and the centrality of communication skills in the general practitioner's skill base - help to explain why the GPs in this study drew so heavily on timing and talking tactics to manage their moral problems.

10.2 MANAGING MORAL PROBLEMS - TACTICS FOR DEALING WITH ETHICAL DILEMMAS

My analysis of the GPs' tactics for dealing with moral problems began with the 'summary sheets' (discussed in Chapter Four) that I had created to assist me to gain an

overall perspective on the GPs' approaches to moral problems. Using the interview guide as a point of departure, I approached each interview with two questions: "what did the GP do?" and "why did he/she do it?" I used these guiding questions to record each separate instance of an action or a reason for an action on a summary sheet. The material covered under "what did the GP do?" became, as my classification scheme evolved, the material that I have used to develop an account of the tactics the GPs to deal with their moral problems.

As noted in the introduction, the GPs used two 'major' tactics, talking and timing, and four 'minor' tactics, talking with colleagues (medical and non-medical), referral, evasion and invocation of the law, to deal with their moral problems. The analysis set out below takes each of these tactics in turn. Table 13 shows the number of GPs who used each tactic. That summary gives no indication of the relative importance or significance of different tactics. To manage the problem of relative significance, I have used a number of other analytical tools, including looking for outliers (those instances in which the tactic was not used and instances in which it was used where one might not have expected it) and noting whether the tactic was referred to explicitly by the GPs in their talk and how it was used.

TABLE 13

TACTICS TO RESOLVE ETHICAL DILEMMAS

Tactic	**Number of GPs using specific tactic** (total number = 13 GPs)[3]
Major tactic	
Time	10
Talking with patients	12
Minor tactic	
Talking with medical colleagues	4
Talking with people other than medical colleagues and patients	3
Referral to other doctors	5
Evasion	6
Invocation of the law	4

[3] As with the previous chapters, the 'denominator' in this analysis is the 13 GPs for whom I had complete transcripts.

10.2.1 Timing tactics - delaying the outcome

Ten of the 13 GPs used timing tactics to manage their moral problems. These timing tactics took a range of forms: the GPs postponed making a definitive decision about what to do, they delayed patients' passage through the health system, they scheduled extra visits with patients, they kept patients in hospital for an extra couple of days and they sent patients away to think about their problems. What was common to all timing tactics was that the GPs managed to extend their involvement in the situation over a longer period of time than they would have had the situation not been a problem for them.

Dr Owen, for example, talked about the young woman he was seeing who wanted her tubal ligation reversed. He doubted that her request was in her best interests or in the best interests of any children she might have. One of his tactics for dealing with this situation was to slow down her passage through the medical system by delaying her appointment with the surgeon. He hoped that by the time she reached the surgeon she would no longer be with her current boyfriend and the problem would have disappeared.

> *54. What are your options at the moment? What could you do right now?*
> 55. The options are either to go ahead and do the procedure, to refuse the procedure, to wait and by waiting we could either delay it, or we can negotiate with her about her reasons for wanting to have this done, and we negotiate in terms of her behaviour, and all the reasons that she wants to have, get her to examine herself and her relationship and as to whether her reasons are really good reasons for a having tubal reversal done. Get her to look at herself a bit, I suppose.
> *56. Which of those options are you doing?*
> 57. Delay. Well, at the moment.
> *58. Now the delay one is together with negotiation, or just...?*
> 59. The delay is just straight delay, with no negotiation, but in terms of an overall plan we may go onto that second part, negotiation and compromise, I guess.
> *60. What are you telling her at the moment?*
> 61. At the moment we're just saying that she can go and talk with the surgeon about what her operation involves, but that there's no guarantee that this operation will go ahead, and that's all we've said to her. We've given her limited information about the procedure and she's aware that there can be delays, because I've said that to her, that there can be delays in her operation. So that's where it is at the moment.
> *62. So you actually haven't got into the business of talking with her about it?*
> 63. No, that's the next step.
> *64. Now, why are you in the "delay" mode at the moment, rather than "negotiation"? It seems to me that you've decided the other ones are not possibilities right now...*
> 65. No, that's right, yeah. I think that's too rigid, to go into either a black or white solution, for someone who appears to be changing as well. And maybe she is changing, completely, I don't know, maybe her behaviour will change in depth. But, buying a bit of time, we might just work out what her relationship's doing and what her intentions and expectations are doing as well. I don't think we'd lose anything by delaying, I think we can only gain by delay. I just think that's

something we often use in general practice, if we try and buy a bit of time, not in a sense that it makes it deliberately worse for someone, it just allows people to reflect, or allows things to develop, if it's a physical problem, it does, develops so we can make probably better decisions about what we're going to do.

66. So you actually do have time that you can play with -

67. Oh yeah, I mean there's urgency about whether this is done this year, next year or the year after. She's still going - if the operation's done, and if it's successful, she's still got plenty of years left to worry about a family, she has time.

Dr Owen

Dr Owen's comments picked up both the notion of delaying just to see what might happen and delaying so that the patient could think about her situation and hopefully come to accept his way of thinking about things. The key point in this excerpt from his interview was his observation that delay and "buy[ing] a bit of time" was "something we often use in general practice". Dr Owen clearly felt that he had time on his side and that he could use it to assist in resolving this problem.

Dr Silverman, similarly, used delaying tactics to try to persuade his patient to tell her boyfriend about the sexually transmitted disease for which she was being treated. He visited her every day in hospital and used these visits to apply "relentless pressures in the areas of what she'd be doing to everyone if you don't tell them". (32, Dr Silverman)

In other cases, the GPs used time not so much to try to bring patients around to the doctors' point of view, as to allow patients time for reflection. This helped the GPs to be sure that patients understood what was happening and the implications of their decisions. Dr Masters, for example, talked through the options when women came to her with unwanted pregnancies, and she included asking her patients to "come back again" in her strategies.

28...I just tend to work through the options and I, again, depending on how they can handle it. If they can't, if they become too emotional, too distressed, then I give them the option to come back again. I sometimes make an appointment for the next day or, if it's toward the end of the week, after the weekend...

Dr Masters

Both Dr Silverman and Dr Masters' comments indicate that the GPs saw the opportunity for reflection arising both in and outside the surgery. Discussing the issue with the GP could encourage reflection and thoughtful consideration by patients, and so

could thinking about the problem themselves or talking with friends and family. Dr Kingsford used this strategy when he recognised the role that 'time out' played in his decision to admit a young woman to hospital after she had been assaulted by her father.

> 66...We've got our own hospital [in this country town], and so it's easy to put someone in. And when I put this particular patient in I felt that she was very emotionally disturbed, very upset, and she needed a break from the environment, which I think, in retrospect was the right thing, because she was in for a couple of days, it gave her time to relax, gave her time to communicate well with her boyfriend. That situation may not always be available in the city, I think. It's a case of restriction of hospital access by GPs. So I think that was a factor, that it was good to be in the country. She needed counselling by an older person at that stage, someone that she could trust.
>
> Dr Kingsford

In analysing how these GPs talked about timing and delay, I did two things to assess how important this tactic really was. First, I looked at whether or not the GPs explicitly discussed their use of this tactic and I found that over half of the GPs were explicit about the role delay and timing played in the management of ethical problems. I defined an explicit reference as one in which the GP stated clearly that he or she had directed events in some way to extend the time available to resolve the problem. Six of the ten GPs were explicit about the role that delay played in the management of their ethical dilemmas. Dr Kingsford's comments above indicate how well he understood the role of time in influencing outcomes for patients. Dr Owen's reference to "buying a bit of time", and its role in general practice, similarly flags his use of time as a strategy to assist him to resolve a difficult ethical dilemma. Dr Dunt, on the other hand, did not mention delays in his discussion of how he assisted a patient who wanted a home birth. Nevertheless, "every antenatal visit was a long one" so that he could satisfy himself that the life of the baby would not be put at risk by a home birth (20-24). He used delaying tactics just as effectively as Dr Dunt and Dr Kingsford, but he did not label it as a tactic.

Secondly, I assessed how apparently urgent problems were handled. If the GPs dealt with problems that required urgent action by acting quickly and also somehow structuring in a time component to achieve delay, it would add strength to the thesis that delaying tactics were indeed central to their deliberate management of ethical problems. I defined each problem as urgent (requiring medical or social intervention within six

hours) or non-urgent, and then cross-tabulated the urgency of each problem by the use of delay as a tactic. Table 14 shows the matrix this analysis created.

TABLE 14

GPS' USE OF TIME AS A TACTIC AND THE URGENCY OF PROBLEMS

Urgency of problem	**Use of delay as a tactic**	
	used timing tactics	*did not use timing tactics*
urgent	2 - Dr Kingsford Dr Johnson*	
non-urgent	9 - Dr Newton Dr Stamos Dr Bright Dr Johnson* Dr Owen Dr Silverman Dr Dunt Dr Little Dr Masters	4 - Dr Winters Dr Elwin Dr Johnson * Dr Sing

* Qualitative analyses are not always tidy, and this matrix is no exception. Dr Johnson described three similar problems, but used time in different ways for each. While this makes analysis difficult, it also creates a valuable opportunity to explore the importance of different strategic responses. For the matrix, I have treated his three problems as three separate cases. I take up the analysis of Dr Johnson's problems below.

All but two of the problems these GPs discussed were not urgent, and this is not surprising. The problems with which most patients present in general practice are not life threatening, nor do they need definitive management within a few hours. Dr Owen and Dr Silverman had both suggested that general practice is not a discipline in which emergencies are common. Dr Owen felt that general practitioners were in an excellent position to allow problems to develop over time so that "we can make better decisions about what we're going to do"(65).

Viewed against this background, an analysis of those two cases around which there was some urgency is clearly enlightening. Dr Johnson's 'urgent' problem was a decision about what advice to give a patient whose toe he had mistakenly injected with adrenalin. He needed to make a split-second decision about what information to give

about a potentially dangerous mistake. Dr Kingsford's 'urgent' problem related to the need for quick and decisive action about the protection of a young woman who claimed her father had assaulted her. These two dilemmas are discussed below.

It would be understandable that Dr Kingsford and Dr Johnson, driven by the need for quick decisions, might seek to resolves their problems quickly. Yet, both GPs responded immediately and decisively and, at the same time, adopted a delaying tactic to assist them to manage the situation. Dr Kingsford admitted the woman to hospital for observation and, in doing so, created a breathing space for her to "relax" and "communicate well with her boyfriend" (66). He also used her presence in hospital to ensure his access to her, so that she could have the counselling over the next two days that he thought important.

Dr Johnson's case is more complex, because he did not consistently draw on timing tactics to help him manage his ethical dilemmas. His variable use of timing tactics, though, is an excellent vehicle for comparing instances where delay could be used with instances in which it was not. In the first part of his interview, Dr Johnson described three ethical problems from his work. In the first situation, he gave a child a vaccination using an empty vial and had to make a decision about what to tell the mother. He chose to deal with that situation immediately, by telling the mother of his mistake then and there. This was not an urgent problem, in the sense that, medically, he had done nothing that might harm the child or that might require further intervention. With this non-urgent problem, he responded quickly and made no attempt to extend his involvement in the situation beyond the consultation time. In his second problem, Dr Johnson included a polio vaccine unnecessarily in the immunisation regime for an 18 month old child; he only realised his mistake after the event and he "agonised about whether to ring the mother and tell her or not" (7). Finally, he did make the call. Again, this was not an urgent problem, for an extra vaccination was not going to harm the child, but it was a situation that was not fully resolved until Dr Johnson made the

telephone call. Dr Johnson's final example, unlike the first two, was one about which there was some urgency.

> 20...For example, once when I was doing some suturing I injected some adrenalin with a local in around the foot, and it was in my younger days, and I, you know basically, you know any digits is a no-no, and I remember, you know, with absolute horror and abhorrence but it was fairly high up and I was really concerned, but I didn't tell that person. And I asked them to come back and see me. I said to them, "look, you know, there's, there might be a bit of problem and I want to see you back in a few hours time". And as it turned out there was no problem...
>
> Dr Johnson

A little later in his interview Dr Johnson returned to this example to explain that he understood that his mistake might have had serious consequences for his patient, including the possibility of long term damage to or loss of the toe. However, there was absolutely nothing Dr Johnson could have done after the event to arrest the damage. The urgency about the problem, from Dr Johnson's perspective, related to whether he should tell the patient he had made a mistake. His comments later in the interview show that he recognised that, if he were going to admit his mistake at all, he ought to have done it straight away. The further removed in time he was from the situation, the more difficult it became to 'come clean'. Dr Johnson's immediate decision was not to admit that he had made a mistake, but he also built a component of delay into his actions by asking the patient to return to see him in a few hours time. From a medical point of view, this later consult was unnecessary, because the final outcome of Dr Johnson's actions would not be known for 12 to 24 hours. The important point to take away from Dr Johnson's use of delaying tactics is that, when faced with a problem that clearly required some kind of immediate solution, he also managed to delay the final moment of resolution, by asking the patient to return to be reviewed, but at a point in time that was medically unnecessary.

What motivated Dr Johnson to take the approaches he did to moral dilemmas? For a first indication, we can turn to Dr Johnson's own reasoning. In his interview, he provided three reasons for why he responded as he did to the moral problems in which he was involved. First, he weighed the likely harm to himself and, for the first two scenarios, judged that he needed to be seen to be honest to protect his public face in the community. He recognised that mothers talked and he wished to be seen as someone

who made honest mistakes and admitted them. There was no such positive trade-off for his reputation in the third scenario, probably because the mistake he made could have caused substantial harm. His second explanation for his actions focused on the extra value he accorded the lives of children. He reckoned that children's lives were particularly precious and mistakes in their care could have long term implications. He thought this was not necessarily also the case for older people. Finally, he differentiated between the scenarios according to the time that would pass before a definitive outcome would be known. In the final scenario he could expect a definitive outcome within 12 to 24 hours.

Only the first of these three reasons really concur with Dr Johnson's more general values about his role and work. Dr Johnson's use of delaying tactics in some settings but not in others makes most sense when measured in terms of what it would deliver for the ends he valued. A core value for Dr Johnson was protection of himself and his reputation. Committed as he was to protecting his reputation, he sought to use strategies that could secure that benefit for him. Dr Johnson's case reinforces the observation that these GPs did not act in a values vacuum. The tactics they drew on to manage their ethical dilemmas were grounded in values about themselves and their work as general practitioners. Dr Johnson was one of only two GPs who was openly pessimistic about what the future held for general practice and for himself as a general practitioner.[4] I gained the impression during my interview with him that Dr Johnson viewed general practice primarily as a means to secure an income and only secondarily as an opportunity to improve the health and well being of his patients. His negativity about general practice and the role of the general practitioner both influenced, and was influenced by, his concern to protect his reputation.

To summarise to this point, ten of the 13 GPs used time and delay to deal with their moral dilemmas and over half of these ten were explicit about their use of delay as

[4] Dr Stamos shared with Dr Johnson a pessimistic view of the future of general practice. See Chapter Nine for discussion of their views.

a strategy. In addition, both Dr Kingsford and Dr Johnson dealt with urgent problems, and yet still managed to incorporate the tactical use of delay.

10.2.2 Talking tactics - using conversation with patients

Twelve of the 13 GPs used conversation with their patients - 'talking tactics' - to help them resolve their ethical dilemmas. The one GP, Dr Newton, who did not actually talk with her patients about her dilemma indicated her awareness of this option in her interview. Three of her patients, all residents of the same nursing home, had suddenly decided to see another doctor and she had not pursued with them their decision to change doctors. I asked her to consider what other options she might have had.

> *53. What other options do you think you had for dealing with the situation? You've already suggested a couple, but are there any other ways of addressing the problems that went through your mind?*
> 54. I could have consulted them - all three of them - much more personally. And said - probably I should have, I guess, and found out exactly why. But, I felt embarrassed about the thought of doing that. Embarrassed and hurt, so I didn't really know whether I wished to involve myself in that. It's always easier to turn your back and walk away. And also, I'm not sure that that's fair to an elderly patient. I mean, if they'd made the decision to change then I don't think you should pressure them, and I don't think you should ... I'm not sure about this. I had an ethical dilemma there, as to how far I should go. But, I felt confident with what I did. It's made me feel much more cynical about the way I look after my patients.
> *55. It's a difficult situation. Why do you feel it would be putting them under pressure to confront them?*
> 56. I guess I think they have the right to change without having to explain to me why. And I think the wife of the couple would have been very upset about the whole thing, and quite distraught, and I didn't want to add to that. I thought that it was better for me to buy out. I don't think he'd have been upset at all. I don't know what his reason would have been. They were all very elderly , they were all - a touch of dementia. They were all personality problems, none of them were easy straight forward patients. I knew what I was going to be buying into if I tried to do that. Now I didn't think it was going to be helpful. I thought it would actually be unhelpful. It was better to ensure a smooth transition.
>
> Dr Newton

Although Dr Newton did not use talk with her patients to help her resolve her moral problems, she clearly understood its import and had good reasons for her alternative strategy.

Three distinctly different types of talking were apparent under the general rubric of a 'talking tactic' - advisory talk, information talk, and listening. Table 15 sets out the different talking tactics in summary form.

TABLE 15

TALKING TACTICS USED BY GPs

Tactic	**Description**	**Number of GPs using this tactic** (total number = 13 GPs)
Advisory talk	Setting out the course of action the GP thought preferable by: * setting legal or moral limits on their involvement; * prescribing a medically best solution.	9
Information talk	Providing information and laying out the options before patients	5
Listening	Encouraging patients to talk about their thoughts and experiences	4

These talking tactics are closely related to the GPs' principlism-in-use described in Chapter Seven. For example, the GPs' principle that 'patients should make their own decisions' (respect for autonomy-in-use) carried a correlative obligation to 'provide a balanced account of things'. That obligation surfaces here as information talk. In a similar way, the principle that the GP should 'do what's best for patients' (beneficence-in-use) was interpreted by seven GPs to mean 'biomedical best'. That interpretation appears in this discussion as medical justifications for advice. The parallelism between these two categorisations points again to the close relationship between values held and actions carried out. It is a reminder that a distinction between thought and action may be helpful analytically but it was not a distinction that the GPs made. I take up the limits to this parallelism at the end of this section.

The most common talking tactic, used by nine GPs, was *advisory talk*. This form of talk simply set out the course of action the GPs thought acceptable. The GPs couched their advice in terms of what was best, offering either a moral or legal justification for their point of view or a medical one. Dr. Little, for example, made it

clear to a patient who wanted an illegitimate sickness certificate that he would not be a party to such activities:

> *26. Can you tell me ... what you said to him?*
> 27. Well, my usual out for these things is to say, "look, Bill, this isn't just a piece of paper that I'm signing. This is actually a legal document which I have to be able to defend in court ultimately if things go wrong. And I have to be able to justify in court that you have a particular medical condition which I can certify and that it warrants giving you the time off." I put it in that legal context of saying it's a legal document that you're asking me to sign, not a medical document. When you explain it in that way most of them are quite different about it. Like saying they want a certificate for yesterday, and I say, "look, it's a legal problem that I cannot legally sign a document that says that you were sick yesterday when I didn't see you yesterday. It's not a medical problem, it's a legal problem." And that seems to take a lot of the heat out of the situation.
>
> Dr Little

Dr Winter and Dr Bright (discussing abortion) and Dr Stamos (dealing with euthanasia), also stood their ground and made it clear that they would not compromise themselves by being involved in activities which they believed were morally and, in the case of euthanasia, legally unacceptable. These GPs all attempted to resolve their moral conflicts by explaining their position on the issue, why they held it, and what they could or could not do for the patient. They justified their stance by recourse to personal and deeply held moral values or to law.

The second type of advisory talk also outlined for the patient the course of action that the GP thought best, but used medical reasons to justify it. The GPs who used this tactic proffered their course of action as medically optimal. In the extended quotation below, Dr Winters built his personal experience into a recommendation that vaccination against *Haemophilus influenzae* is medically desirable.[5]

> (24)...There would be areas in which, in some areas of medicine where you have to, to some extent, make the decision for the patient, because it's impossible to present - all the facts can be presented, but then the patient can be so overwhelmed by the possibilities of potential consequences that they, in fact, won't make the right decision because the judgement is not based on - I'm trying to explain this and not doing very well.
> *25. Can you give me an example? That would help me.*
> 26. This is just a small example. I had a number of patients come in and they're concerned about vaccination of children against *haemophilus* and they're concerned about the risks of their children getting meningitis and things like that. And I explain to them it's not a vaccination against meningitis, it's a vaccination against a specific bug that can cause specific type of meningitis, which is particularly serious and which can lead to some fairly serious sequelae, including death. And they're worried about what are the risks between having the vaccination and getting meningitis. And I try to explain to them that even though the risk of getting this sort of meningitis is small, the risk of getting any sort of meningitis, relatively speaking on a population basis, is small, and then getting this one particular type is even smaller. Nevertheless there is a risk and the consequences can be devastating. And then they talk about the risks from having the vaccination. Well, there are risks from having a vaccination, as well, albeit small.

[5] Chapter Seven discusses in detail the inherent contradiction in Dr Winters' principlism-in-use.

> And they're left with a decision of small risk if I don't have it and small risk if I do have it, and essentially then I just tell them "Look, have the vaccination" and I say, well they often ask me, "well, what would you do?" And I say, "if I had a child less than 5 years old, I would - if it was one of my children, I would have the vaccination". And then they say, "well, if you'd do it, I'll do it then". So that's the sort of situation where I don't think it's fair to ask people to make a decision because the risks of having the vaccination are small, but also the risks of contracting that illness, and the sequelae can be very very serious, so out of two small risks, I think the way to go is have the vaccination.
>
> Dr Winters

Dr Winters' advisory talk here focused on the health implications of vaccination. He used his status as a medical expert to convince his patient that vaccination was a good thing.[6]

The second type of talking tactic was *information talk* - giving patients information to help them make decisions. The five GPs who used this approach laid the options before their patients, including the possible treatment regimes, and the nature and benefits, anticipated inconvenience or discomfort, and risks associated with each regime. Essentially, they applied the disclosure element of a traditional informed consent model.[7] Dr Owen stated this clearly, when he relayed the dilemma that he and the surgeon faced with a young woman who wanted her tubal ligation reversed. Part of his long-term plan of action was to "describe the operation, the failure rates and success rates, and if she still says 'yes, I want to have this done', then we will probably do it." (47)

A minority of GPs used a third type of talking tactic. Four of the GPs focused on *listening*: they asked probing questions to elicit meaningful responses, they encouraged their patients to explore their own experiences and feelings, and they listened empathetically as patients described the problems they faced in their lives. They projected an image of reassurance and dispassionate interest. Christie and Hoffmaster note that this "interested listener" role is a "traditional and valuable 'hand-holding' function of family doctors".[8] Dr Little may have used advisory talk to manage his moral

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[6] Clearly, Dr Winters also invoked his experience of parenting to support his views. The general thrust of the advice, however, is dependent on his medical expertise.

[7] Beauchamp TL & Childress JF. 1994 *Principles of Biomedical Ethics.* (4th edn) Oxford University Press, 144-5.

[8] Christie RJ & Hoffmaster CB. 1986 *Ethical Issues in Family Medicine.* Oxford University Press, 175-6.

problems over sickness certificates, but that did not preclude him from being interested in his patients' experiences. He used that too to deal with moral difficulties:

> *16. How do you differentiate between the certificate that you're not going to write and the one you are? What decides you?*
> 17. Well, if it's a first-up, as I said, I'm usually not too fussed. I try to find out what's going on, why they want it, what sort of job they've got, what their attitude is to the job, why they want this day off, and what else is going on about it....
>
> *38. How do you differentiate between those who are legitimately stressed out and those who are fiddling the system?*
> 39. Oh, by talking to them. Getting their history of what they do and how they're coping and what their home situation is and why they're feeling sick at this time. And the ones who are genuinely stressed out have all sorts of things that they want to talk to somebody about. The ones who are fiddling the system really haven't got anything to say to justify themselves.
>
> Dr Little

Dr Dunt similarly conveyed something of the flavour of his listening to Pam, his patient:

> *23. Give me some idea what of you talked about.*
> 24. We played through the various scenarios of what would happen if there was ante-natal bleeding. What would happen if there was bleeding during labour. What would happen if there was obstruction, and we played those right through to see what her response would be. She satisfied me consistently that if the baby's life really was at risk, she would be prepared to accept the outcome suggested. We did more than just go through that. We established the way in which we both felt and reacted. Pam is a very definite, direct person. She is, and so am I, and it wasn't a problem for me. It was a big problem with some other doctors who found that far too threatening....
> 28. It was important to do two things. One was to listen and make sure she understood, and would listen. And, two, it was very important to state very clearly what your role would be, and that Pam's too. Once it was clear that she wasn't making progress [in labour] Pam had no trouble accepting it, and no troubles accepting its consequences. She understood all the way through, and that's what she sought.
>
> Dr Dunt

Dr Dunt's summary in the last paragraph of the "two things" that were important in his talking and listening to Pam illustrates his facility with two distinct conversational strategies - advisory talk and listening. He provides perhaps the clearest example of two tactics at work together, but he was not the only GP to use a range of tactics to help resolve his moral problem. Figure 6 sets out the overlap between talking tactics for all of the GPs. It shows that no GP used all three conversational strategies, but that there was at least one example of every other combination.

FIGURE 6

TALKING TACTICS USED BY GPS AND THEIR OVERLAP

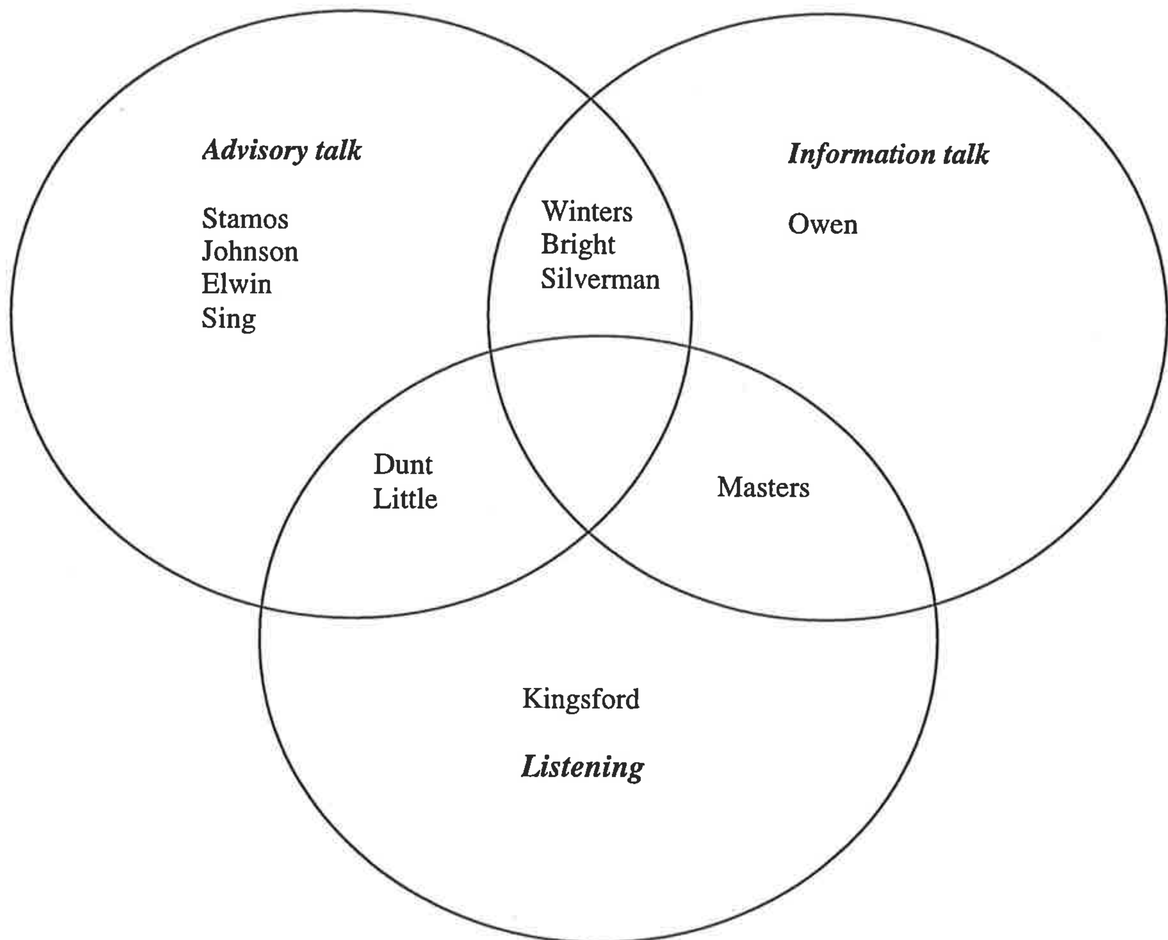

Figure 6 and the material I have presented above illustrate that the parallelism between the GPs' principlism-in-use and their account of what they did with their moral problems is a partial one only. In Chapter Seven, I suggested that the GPs' moral reasoning was informed by two principles. The first, that 'patients should make their own decisions' carried as one of its corollaries the specification that 'doctors should provide a balanced account of things'. This obligation translates in this account of moral action to information talk. In a similar way, the 'medical best' interpretation of the second principle, that 'doctors should do what's best for patients' becomes the conversational tactic of prescribing a medically best solution. The discussion of the GPs' principlism-in-use in Chapter Seven suggested that the GPs used the principles of respect for autonomy-in-use and beneficence-in-use about equally. In other words, in terms of cognitive style, the GPs situated themselves between these two principles, drawing on both as they saw fit. In the discussion of moral action in this section, however, it is clear that the GPs were not equally balanced between a reliance on advisory talk (in whatever form) and information talk. The GPs talked far more than they listened. As a group, they preferred telling patients what they thought - by explaining the GP's own position and the limits that imposed or by instructing patients in the range of alternative futures - to listening to what patients had to say. When it came to moral action, they relied on strategies that seemed to flow from the principle of beneficence-in-use rather more than strategies that related to respect for autonomy-in-use. Why this might be so is taken up in Section 10.3 below.

A brief summary is appropriate at this point. Twelve of the thirteen GPs used talking tactics to help them resolve their moral problems. Advisory talk, which involved setting out the course of action the GPS thought preferable, was the most commonly used tactic. The GPs also used information talk (providing information and laying out options) and listening (encouraging patients to talk about their experiences). These talking tactics were related to the GPs' principlism-in-use, but there were also subtle differences. The GPs' use of principles, as discussed in Chapter Seven, implied

rather a greater reliance on the principle of respect for autonomy than was evidenced here in the GPs' description of how they talked to their patients.

10.2.3 Minor tactics

What other tactics did the GPs draw on to deal with their moral problems? Timing and talking tactics were used more frequently than all other tactics, but there are four other tactics - talking it over with colleagues, referral, evasion and the invocation of the law - which were helpful to at least some of the GPs in this study. (See Table 13.)

10.2.3.1 Talking it over with colleagues

Four GPs had sought advice or information from medical colleagues to help them deal specifically with the ethical problems they discussed in the interviews. (See Table 16.) In addition, the GPs provided evidence elsewhere in the interviews that this strategy was used quite often. Towards the end of each interview, I included a question about whether the GP ever discussed issues like the ones we had explored together with peers, medical or otherwise. Eight of the 13 GPs indicated that they did at times seek advice or discuss issues with their medical colleagues. They used these discussions with colleagues principally to explore ideas and to search for alternative solutions. Dr Owen's response to this question is typical:

> *82...Do you talk about these kinds of things with other people?*
> 83. Yeah, we do. I mean I'm fortunate because of work in a group practice and we have a number of younger doctors, although, not that it has much to do with it, it's just that the younger ones tend to have slightly more open minds and attitudes towards a lot of these things, and if we do get difficult situations we tend to sit down and discuss them even formally, try to give ourselves different ideas, different ways of approaching difficult problems like this, because there's no answer to these sorts of problems. There's only a myriad of different solutions, some of which are good and some of which are bad, and which way you decide on really, sometimes it boils down to your own attitudes and judgements, rather than anything else.
>
> Dr Owen

Despite the rosy picture of GP collegiality that Dr Owen comments suggest, it is worth noting that two of the GPs said clearly that they did not discuss ethical problems with their colleagues. There was more that a touch of regret in Dr Dunt's voice when he made this comment:

> *76... do you talk about these sorts of things with other doctors?*
> 77. I've yearned to, but my own colleagues here are often very uncomfortable when I start to. They feel like, yes, that I'm telling them that I know better than they do. That's the problem. That may be partly my doing.
>
> Dr Dunt

TABLE 16

USE OF 'TALKING IT OVER WITH COLLEAGUES' AS A TACTIC TO RESOLVE ETHICAL PROBLEMS

GPs who sought advice or information from:	**medical colleagues**	**non-medical colleagues**
about the problems they discussed in the interview	4	3
about 'problems like these'	8	3

Three GPs had sought information and advice from non-medical sources to help them deal with their ethical problem. When three of Dr Newton's elderly patients transferred to another general practitioner, she felt that it was "not fair" to interrogate them, but she did seek more information from the patients' families and the Director of Nursing of the nursing home in which they resided. Dr Masters had sought out her priest for counselling. In addition, Dr Bright mentioned, in response to the question about whether he ever talked about problems like this with other people, that he had discussed the issue with church groups.

Overall, medical colleagues seemed far more important as sources of support and advice than non-medical colleagues did. This may have been because some of the GPs' non-medical supports were so obvious that they did not think to mention them. For example, despite their silence on the matter, the GPs may well have discussed these ethical problems with their spouses and assumed that I would understand and expect this. However, there was some evidence in the interviews that the GPs avoided conversations about sensitive issues with their spouses and significant others for reasons of confidentiality. Dr Winters, for example, explained that he told his wife very little about his work because he thought it violated confidentiality.

Although conversations with family and friends were sometimes perceived to be unacceptable for reasons of confidentiality, this perception did not appear to extend to

medical colleagues. The GPs had a preference for medical advice, even in the face of possible concern about confidentiality. This preference is consistent with the picture of moral problem solving as a medical experience that I painted in Chapter Eight and it is also consistent with the GPs' tendency to medicalise moral problems. In Chapter Eight, I showed that the GPs tended to draw on medical problems and their medical selves when they selected stories and anecdotes for their casuistry-in-use. That medicalisation of morality is also apparent here in the sources of advice that GPs sought. The GPs chose to speak primarily with medical colleagues about their moral dilemmas because, at least in part, they construed these dilemmas as medical problems, for which the most appropriate sources of support and advice were other medicos.

10.2.3.2 Referral

Referring the problem to another general practitioner or specialist colleague provided a compromise solution for their ethical dilemmas for five GPs. All three GPs who had taken abortion as their ethical dilemma found themselves an acceptable 'out' by referring their patients to colleagues who would be prepared to authorise an abortion for that patient. Similarly, Dr Stamos said that he would adopt the same approach, should euthanasia ever become legal. Neither Dr Winters nor Dr Masters were all that satisfied with this solution, but they believed it compromised their personal values less than other options.

Dr Elwin's use of the referral tactic was very different. He described his use of referral as a compromise if patients wanted a second opinion, even if he thought that opinion medically unnecessary. Over time, he had learnt to avoid specialists who "pinched" his patients, and he had established a referral list of specialists who could be relied upon to advise only, unless he specifically asked them to be involved more actively. Dr Elwin believed there was not much to be gained, but little to be lost either, by allowing patients to seek alternative opinions.

10.2.3.3 Evasion

For six of the GPs in this study, evasion and equivocation played a role in helping them achieve solutions that they could live with. They found ways to evade conflict and the arguments, disagreements and questions it engendered by expressing themselves ambiguously;

> (32)...The other problem, of course, is that her employer insists upon having a medical certificate that states her condition, and she doesn't want her condition stated on the medical certificate, because she's told him something else. She's told him she's got bad thrush. She obviously doesn't, so I've decided in the end to write gynecological infection on the certificate, that satisfies both.
>
> Dr Silverman

by avoiding settings in which conflict might develop;

> 47. Yes. Well that group is the second group of being a locum where you're actually in a day-time fill-in locum for somebody. And what you have to remember is that you're not employed by the doctor who's paying you to destroy their practice, but you get these people coming in who want a sick certificate who look like they're on one of these fiddles... And then I make a note in the notes that I'm not at all clear about what the actual condition is being certified here so that the doctor sees that I'm not happy with it as well.
> *48. And what sort of results does that have?*
> 49. I've no idea. Because I don't go back. Those sorts of practices tend to be problems in various ways. And I didn't go back to them as a locum.
>
> Dr Little

or by suggesting indirectly that things could be done differently.

> (64)...The case of hypertension, I guess, is another one where you've got people that are perhaps stabilised on drug regimes that are inappropriate or in excess or whatever. I generally, if the patients are happy with what they're doing, I generally don't interfere, but I might make a comment in the case notes of "have you thought of such and such a combination? It might be easier for them to manage", or whatever, and just leave it at that.
>
> Dr Elwin

In one sense, evasion as described here was often a form of talking tactic; it was a way of communicating information, even if its purpose was not to inform. What distinguishes it from other talking tactics is that the talk was designed primarily to obfuscate, rather than to achieve moral resolution. The GPs understood that these solutions were compromises - ways to get by until better solutions or ways to avoid the problem altogether presented themselves.

10.2.3.4 Invoking the law

Most ethics teachers understand that law and ethics are not the same thing, but many ethical dilemmas do have legal implications. For these GPs, though, the law offered relatively little by way of management tactics for their moral problems. Drs

Johnson and Elwin mentioned that they kept the likelihood of litigation in the back of their minds when deciding how to behave:

> (44)... And the third thing I thought about was the consequence of litigation which you could potentially see, and I could end up being a witness which I wasn't too keen on either. I would have been on a witness box saying, "well, yes I think this and no he didn't pick it" against my fellow doctor, didn't really amuse me either.
>
> Dr Elwin

Dr Little used the law as a trump to put an end to discussion about whether he could write an illegitimate sickness certificate - "look, Bill, this isn't just a piece of paper that I'm signing, this is actually a legal document which I have to be able to defend in court ultimately if things go wrong" - and Dr Silverman wished that he'd had the trump of a notifiable disease to play against his wayward patient.

This discussion on the role of the law may seem slight and poorly developed. However, it reflects the quite minor role this tactic played in the GPs' moral deliberation. Legal solutions were not popular with or important to these GPs. The law was something they kept in mind, rather than used to manage their moral problems.

In summary, against a backdrop of a wide range of moral problems, involving different people in different circumstances, and with different explanations for why certain actions were morally preferable, the GPs in this study behaved in a surprising homogeneous way. All of them either 'talked' or 'timed' their way through their moral dilemmas, and most of them did both. There are hints in my discussion of both talking and timing tactics that the GPs' actions were related to the styles of moral deliberation described in preceding chapters. For example, Dr Johnson's equivocation between honesty and dishonesty in revealing his mistakes to his patients says as much about his understanding of virtue in general practice and his perception of his role as a general practitioner as it does about his use of timing and delaying tactics. In a similar way, the GPs' talking tactics clearly paralleled their principlism-in-use, but there was also a subtle mismatch. The mismatch between the GP's use of principles and the type of talking tactics they favoured raises questions about the relative importance of respect for autonomy and beneficence in the GPs' daily work. Underlying these issues is a

more general question about why the GPs' chose the tactics they did. How did they come to rely so heavily, across a wide range of moral problems, on two particular tactical approaches? These questions are considered in the next section.

10.3 TACTICS AND THE ALTRUISTIC PROFESSIONAL AND BUSINESS MODELS OF GENERAL PRACTICE

The GPs' use of talking and timing tactics dominated their discussion of how they dealt with moral problems. Their use of other tactics was far more variable and, in that light, it seems reasonable to concentrate on the two dominant strategies they adopted to manage their moral dilemmas. As noted above, the obvious question is then: why these tactics? I argue in this section that the answer lies in an understanding of how general practice work is structured, organised and understood by its practitioners. Two aspects of that work - the centrality of communication skills in the general practitioner's skill base and the practice of 'ten-minute medicine' - help to explain why the GPs in this study drew so heavily on talking and timing tactics to manage their moral problems.

10.3.1 Communication skills in the altruistic professional model of general practice

In Chapter Five I described two models of general practice in Australia. The altruistic professional model offers an image of the general practitioner as "a doctor who provides primary, continuing, comprehensive whole-person care to individuals, families and their communities".[9] This model suggests a range of activities for general practitioners, many of which require a commitment to the development of skills in communication. The relationship between this model of general practice and the need for communication skills perhaps is clearest when one considers the meaning of the term 'whole person care'.

[9] Royal Australian College of General Practitioners (RACGP). 1984 Policy Documents, Policy 30, Definition of General Practice/Family Medicine (Adopted 27/1 Council; September 1984).

In the general practice literature, 'whole person care' is generally taken to refer to the use of a 'patient-centred approach'. For Murtagh, the patient-centred approach requires a commitment to listening to the patient; this involves understanding the patient's perception of his or her illness, and the impact of illness on the patient's relationships, family, employment, and psychological and emotional state. The general practitioner who uses a patient-centred approach provides psychological support, reassurance, and education; encourages self-responsibility; offers anticipatory guidance and health promotion advice; recommends changes to lifestyle; and investigates support through family and friends, self-help groups, and alternative therapies. A patient-centred general practitioner also takes the time to ensure that the patient is followed up in appropriate ways.[10]

The 'tool' or 'technique' that the general practitioner uses for these activities is 'talk' – communicating with patients. Just as the surgeon's toolkit includes surgical techniques and the radiologist's radiological investigations, so the general practitioner's skill base includes communication skills as an important element. Put another way, the general practitioner defines him or herself at least in part in terms of skill in communication.

The centrality of communication skills can be seen both in the views about general practice of the GPs in this study and in the general practice professional literature. Of the GPs I interviewed, Dr Owen and Dr Kingsford were the most articulate exponents of a model of general practice. Both differentiated themselves from their specialist colleagues partly on the basis of their communication skills. Dr Kingsford noted that one of the distinctive things about general practitioners was their ability to "talk" to people.

> 72...I think GPs - specialists - are a different type of doctor to a GP. I think specialists know a lot about a certain case. They can be very very bright in one or two areas, but quite often they have no bedside manner at all. They cannot really talk to people, even though they do their specialty very well. They may be a very good rheumatologist, or orthopaedic surgeon, but a lot of them have marked failings in other areas of general practice. They cannot talk to people, and this happens so many times. People come , they see a specialist, a surgeon (or someone like that)

[10] Murtagh J. 1994 *General Practice.* McGraw-Hill, 71-76.

and they come back to their GP and they say well, he's obviously a very intelligent guy, or something, but you know I really didn't know what he was talking about. And I think there's just worlds of difference between a GP and a specialist, in most cases. I mean, there's some very good specialists that are very good - like psychiatrists, - that they can talk to people very well, but so many of them are just technicians, purely technicians, and every very good technicians, but very poor doctors. I've found this many many times.

Dr Kingsford

In a similar way, Dr Owen distinguished between "hospital training" and "general practice training". Only general practice training "at the post-graduate level" offered education in counselling and in keeping options open for patients. Many general practitioners would acquire counselling skills through practice "over the years", but formal training ensured competency earlier.

88. Now, why do you think you're different?
89. Probably because I've done general practice training.
90. What is about the training?
91. The training encourages you to think through different options rather than go for black and white options which is what your hospital training teaches you to do. Hospital training says to you there's a series of symptoms, you do an examination, you have some hypotheses, then you come to a decision. And you must always come to a decision. In general practice less than 50% of the time you have a decision at the end of seeing a patient and it tends not to be so structured and formal and didactic. Because we also do training and counselling in general practice training, we are aware of not closing off interviews and closing off options in interviews, and keeping options open and then keeping the patient very much at the front of decision-making because we counsel them to make their own decisions themselves, about themselves and finding the avenues of treatment themselves, and I think that helps you a great deal when you come into difficult situations where you maintain your perspective of different options. And that only comes through by doing adequate general practice training at a post-graduate level.
92. So that would differentiate you from other doctors who have not done general practice training.
93. It helps. I think that a lot of GPs learn by mistake, by their mistakes over the years, that closing options is not the way to ultimately be giving a lot of solutions to deal with problems. By having the general practice training at least people get exposure to different theories of coping with this sort of problem and in managing interviews, and they can put them into practice much earlier, rather than take them ten years to learn them.

Dr Owen[11]

The focus on communication skills in general practice is also apparent in the general practice professional literature. Communication skills have been on the ascendant as a core skill for general practitioners since the 1970s. Bridges-Webb, one Australia's most respected and erudite general practitioners, situates their rise within the process of 'deskilling' of general practice.[12] He notes that the decline in general procedural work in general practice was matched by a rise in other, previously less

[11] This excerpt from Dr Owen's interview is also found in Chapter Seven, where it is used to make a slightly different point about the relationship between the principle of respect for autonomy and the patient-centred approach of general practice.
[12] Bridges-Webb C. 1996 General practice in Australia 1788 to 1990: a personal commentary. in Commonwealth Department of Health and Family Services. *General Practice in Australia: 1996.* Australian Government Publishing Service, 12.

emphasised aspects - doctor-patient communication, anticipatory medicine, continuing care and practice management. King, Edwards and Hicks' content analysis of the Royal Australian College of General Practitioners journal *Australian Family Practice* makes the same point. They argue that the early content of the *Australian Family Physician* reflected the 'new style general practice' with its emphasis, in descending order of priority, on :

> community and preventive medicine
> general practice tips on how to deal with daily practical problems
> the doctor patient relationship
> practice management - staff development, record keeping and pursuit of efficiency
> technical research amd pharmaceutical updates.[13]

Over time, the content of the *Australian Family Physician* moved from the more general notion of 'doctor-patient relationships', imbued with a commitment to openness and equality inspired by the nascent consumer and community health movements, to a focus on 'communication skills' which owed rather more to enthusiasm for patient compliance.

Support for the concept that communication skills are central to general practice comes also from other quarters. The RACGP policy document on the scope of general practice emphasises very clearly how important communication skills are to the altruistic professional model of general practice.[14] Published in 1981, the document was intended to provide a guide for the design of educational programs in general practice for individuals, groups and institutions. The lengthy opening chapter on the process of delivering care in general practice describes the "knowledge, skills and attitudes required by the family doctor to carry out his/her work".[15] The first of five headings in this chapter relates to interactions between doctors, patients, families and communities and the skills in applying this knowledge. The family doctor needs to have:

> 1.1.1 Knowledge of the patient as a unique individual that modifies the ways of eliciting data and making hypotheses about the nature of his/her illness and its management.
> 1.1.2 Knowledge of the effect of the doctor on the patient, and patient on the doctor, that is, the dynamics of the doctor-patient relationship.

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[13] King C, Edwards J & Hicks N. 1991 "Good" general practice in Australia: The state of the art as seen through the *Australian Family Physician*. Mimeo, Department of Community Medicine, University of Adelaide, 3.
[14] Royal Australian College of General Practitioners (RACGP). 1981 *The Scope of General/Family Practice: The discipline of family medicine. A guide to educational programme design.*
[15] RACGP, *The Scope of General/Family Practice...*, 1.

1.1.3 Skill in applying this knowledge of the doctor-patient interaction to recognize and manage illness in the patient.
1.1.4 An attitude of self awareness in the doctor-patient relationship.
1.1.5 An attitude on non-judgemental acceptance of, and responsibility towards the patient, thus fostering a good doctor-patient relationship.[16]

The focus on skills and knowledge in communicating effectively with all patients is a common thread woven through all aspects of general practice knowledge and skills. For example, skill in the analysis and definition of health problems (heading 2 in the document) requires that the family doctor be "skilled in interviewing the patient, relative or others and eliciting information".[17] The general practitioner needs to be able to establish rapport with patients, put them at ease, elicit information, listen and question sensitively, and use skill and judgement to follow up cues or leads. Skill in the management of short-term problems requires a similar skill in "instructing the patient and others involved in short term management and in engendering their active cooperation".[18] The need for effective communication between doctor and patient underpins the whole chapter on how general practitioners should go about their work.

A similar accent on communication skills is also apparent in later documents produced by the RACGP. The *Report of the Knowledge, Skills and Attitudes Task Force* in 1994 sets out quite explicitly to distinguish between general practice and all other branches of medicine. It describes two models of general practice; the first is a "practitioner-as-scientist" model which is derivative from specialist medicine, reductionist and biological in orientation, and the second is a reflective practitioner model which emphasises decision-making in the midst of uncertainty, social responsibility and the "wisdom of experience".[19] The report clearly prefers the latter model and uses it as a springboard for an account of the appropriate knowledge, skills, attitudes and values for general practitioners.[20]

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[16] RACGP, *The Scope of General/Family Practice...*, 6-7.
[17] RACGP, *The Scope of General/Family Practice...*, 9
[18] RACGP, *The Scope of General/Family Practice...*, 11.
[19] Docker J *et al.* 1994 *Report of the Knowledge, Skills and Attitudes Task Force*. The Royal Australian College of General Practitioners Training Program, Jolimont, Victoria, Australia, 7-11.
[20] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force...*, 12-21.

Of the three skill areas that the *Task Force* report identifies, two - consulting and education - draw heavily on communication skills for their content. These skills were mentioned in Chapter Five, and they are worth including again here, for they also emphasise the centrality of communication skills for the general practitioner. The general practitioner must have skills in:

- communication - active listening, collecting information, exploring concerns and expectations, giving information, explanation and advice, communicating with special groups, telephone and written communication;
- patient management - in explaining, educating, sharing a management plan, the implications for families, workplace and community, advocating for the patient, brief counselling to provide reassurance and support, specific counselling in smoking cessation, lifestyle and stress, opportunistic prevention and health promotion, referrals;
- education - "'bringing about learning'" in patients.[21]

One reason that communication skills have played such a pivotal role in the altruistic professional model of general practice is the link with Balintism.[22] Balintism, while never a large movement in Australia, has influenced Australian general practice through its impact on academic departments, vocational training and the RACGP. The emphasis in Balintism on assisting patients to understand their illness and to integrate it into their lives requires a commitment to effective communication with patients. The Balint doctor must be a good listener and skilled facilitator who can guide patients to understand and deal with the problems in their lives.

The commitment to effective communication with patients and the teaching of skills to achieve this is something that general practice regards as quite distinctive, setting it apart from other branches of medicine. There is some justification in this view, at least from the perspective of formal educational programs. In a number of the ten medical schools in Australia the responsibility for teaching generic communication skills to undergraduates resides with Departments of General Practice, despite the fact that the skills taught will be needed across the full range of medical specialties. In addition, the RACGP training program is the only post-graduate medical training program in Australia that formally teaches communication and counselling skills.

[21] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force*..., 15-17.
[22] See Chapter Five for a brief discussion of the nature of Balintism.

In summary, the commitment to the development and maintenance of communication skills is one of the most important ways in which general practice is able to give meaning to the altruistic professional model of general practice it espouses. For general practitioners who accept this model as descriptive of their professional role, communication skills are immensely important. It is hardly surprising that the GPs in this study should adopt talk as a significant tactic with which to manage the ethically problematic aspects of their work. After all, talk was a key tool in their armamentarium.

10.3.2 The management of time and the business model of general practice

The second model of general practice discussed in Chapter Five was the business model. That model reveals a second side to general practice in Australia, one which reflects particularly the way in which the work of general practice is funded. The business model of general practice defines a general practice as:

> A business unit owned and controlled by one or more GPs whose objective is the provision of general practice medical services to its surrounding community. A practice may be a self-contained unit or it may operate in association with another (ie share one or all of room, support staff and facilities for economic reasons) and it may employ other GPs and paramedical personnel on a full-time or part-time basis to fulfil its objectives.[23]

The business model of general practice has a number of important characteristics. For the purposes of this discussion, I will focus on the way in which it shapes general practitioners' arrangement of their daily work.

The business model of general practice is based on the fact that most general practitioners are self-employed people who manage and provide services in a business that 'sells' medical care, packaged up as discrete items of service.[24] The model is complicated because the sales are underpinned by public funding. General practitioners

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[23] Knight R & Northrop M. 1996 Introduction: An overview of general practice in Australia: 1996. in Commonwealth Department of Health and Family Services. *General Practice in Australia: 1996*. Australian Government Printing Service, xxvi, and Young D & Liaw T. 1996 The organisation of general practice. in Commonwealth Department of Health and Family Services. *General Practice in Australia: 1996*, Australian Government Printing Service, 109.

[24] Chapter Five contained a detailed discussion of who works in general practice, how they are paid and how they spend their time. This section merely summarises that material.

in Australia work primarily in private practices, providing medical services to patients on a fee-for-service basis. Most of the patient fee is rebatable by the Commonwealth Government under a universal health insurance scheme funded by a levy on income, the Medicare scheme. Although general practitioners' incomes are underpinned by public money, structurally, financially and organisationally, general practices are small businesses.

As a small business, the core activity of any general practice is income generation. Like any business, general practice is not involved in income producing activity all the time, but general practitioners do spend around 60% of their time engaged in consultations with patients.[25] That consultation time is carved up into many short consultations with many patients each day. The median consultation length is probably between 15 and 20 minutes, although this may be an overestimation.[26] Anecdotally, it is well recognised that most general practitioners book patients at 10 to 15 minute intervals. The 'ten-minute medicine' booking pattern is enshrined in both the RACGP *Draft Entry Standards for General Practice* and in the Commonwealth Government's funding criteria for the Better Practice Program. Both suggest that general practices that meet minimum standards will have an "*average*" consultation time of "not less than 10 minutes".[27]

The funding and organisation of general practice work ensures that general practitioners develop expertise in dealing with problems quickly. Each consultation introduces a new problem or problems that must be resolved, to some degree, in the

[25] Pegram R, Calcino G & O'Connell D. 1996 General practitioner service characteristics. in Commonwealth Department of Health and Family Services. *General Practice in Australia: 1996*, Australian Government Printing Service, 99-100.

[26] It is almost impossible to calculate an average consultation time based on Health Insurance Commission data. Calculations based on data from the RACGP Interpractice Surveys suggest that median consultation times for male general practitioners are about 15 minutes and for female general practitioners are about 20 minutes. See Chapter Five for the financial structure that underpins this booking arrangement.

[27] Royal Australian College of General Practitioners. 1993/4 *Entry Standards for General Practice Accreditation: Draft Standards for Field Testing and Trials*. RACGP Standards Development Project, 9, criterion 1.2.2, italics in original. The *Entry Standards...* were prepared by a working party of the RACGP under a grant from the Commonwealth Government to develop standards for voluntary accreditation of general practice. See also Department of Human Services and Health. 1994 *Introducing the Better Practice Program: Information Kit and Application Form*. The Better Practice Program was a

space of about ten minutes. As a result, general practitioners spend their working day moving rapidly from isolated case to isolated case.

Chapter Five argued that the business and altruistic professional models exist side by side in both the professional literature and in the experience of practising general practitioners. There is, however, an unresolved tension between them. That tension is particularly apparent when one considers the impact of the short-consultation work pattern on the use of effective communication skills. The business practice of 'ten-minute medicine' by general practitioners does not sit easily with the altruistic professional commitment to effective communication with patients, simply because attention to meaningful communication can dramatically slow down the number of patients a general practitioner sees each day. If patients present with simple problems, most general practitioners are able serve both the communication and deadline masters. Complex and confusing problems, however, tend to require both lots of time and good communication and counselling skills. In these situations, the pressure of the appointment book and the patients in the waiting room impose severe limitations on what can be done immediately.

Faced with the limitations imposed on complex and confusing situations, what do general practitioners do? They manage by doing a number of things - they adopt a wait-and-see approach, hoping that the nature of the problem will become clearer with time; they do *something* and 'get the patient to come back later', so that they can explore and review the situation more fully at that later stage; or they refer the patient on to a specialist.

The GPs I interviewed used the first two of these common ways to manage the complexities of medical work and applied them specifically to ethical problems. They dealt with moral problems in the same ways they managed a complex medical problem - by delaying the resolution of the problem, scheduling extra visits for patients, and by

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Commonwealth Government accreditation program which offered a slightly different version of standards

extending patients' hospital stays - in sum, by using time to achieve morally acceptable solutions. They created the time that they wanted to resolve the problem, and they did so in ways that did not destroy the pattern of their working day. Dr Silverman's aphorism -

> 48...See, the problems that arise in general practice, there are very few ethical problems that remain a problem for any length of time.
>
> Dr Silverman

- provides a pithy summary of the close relationship between the ways the GPs used time to manage moral problems and the structure and organisation of general practice.

The ways in which the GPs set about creating extra time and delaying resolution also allowed them to apply their 'unique' skills in communication. With little else in their tool kit of skills that could be used, the GPs put their efforts into explaining, providing information, listening to and counselling their patients. Focusing on communication confirmed their status as 'good' general practitioners and expressed this important aspect of the altruistic professional model of general practice. Nonetheless, the limitations imposed by 'ten-minute medicine' surfaced even within the use of communication to resolve moral problems. The analysis of the GPs' talking tactics revealed a preference for talk in the form of advice and prescriptions over providing information and listening. This is understandable, if one takes into account that providing information and listening take much more time than giving advice does. The former approaches open the consultation out, inviting patients to extend the consultation until all issues are explored and all options canvassed. Giving advice is a much more closed activity: it merely provides information and does not offer patients the same opportunity to extend their time in the consulting room.

The obvious question at this point is: why did the GPs, in the main, eschew the referral option? One answer is that moral problems stand outside of the referral model with which general practitioners operate. Ordinarily, referral requires the general practitioner to identify the biological nature of the problem and also to nominate a

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for general practice.

suitable specialist. Referral is a simple process if the problem is 'the heart' and there are 'cardiologists' to whom to refer. Moral problems, however, defy categorisation, not least because they do not fit the biological systems approach on which referral is based. Although the GPs in this study attached the label 'moral' or 'ethical' to their problems, their explanations reflected diverse interpretations of what makes a problem an ethical problem. While some of the GPs' views about the nature of ethical problems accorded with the bioethical definition of an ethical problem as a conflict between values, beliefs and opinions, other views revolved around the public notoriety of problems or the GPs' anxiety about threats to their integrity and reputation. The referral option required, as a starting point, that the GP be able to label the problem a moral one. Dr Dunt, at least, could say that he thought a great deal of the problem with ethics in general practice was in identifying the ethical domain:

> 5. I see only one problem, and that is that very often the uncovering of the problem that exposes the ethical problem requires a lot of experience that is beyond the trainee.
>
> Dr Dunt

The referral option is, in reality, no option at all. Even if a problem could be labelled ethical or moral, there are no 'moral specialists' (recognised by general practitioners) working within the medical system to whom the general practitioner could refer.

Another answer to the referral question relates in part to the issue of 'moral specialists'. A lack of 'moral specialists' is not the only reason why these GPs were less likely to refer their problems on. More important, probably, is a suggestion that general practitioners are better placed than any other medical specialists to *be* the moral specialists, because they operate out of a world view which is more sensitive to the inevitable complexity of morality. General practice's commitment to providing "continuing, comprehensive, whole-patient care to individuals, families and their communities" and its particular skills in communication and tolerance of uncertainty[28] seem more appropriate to moral problem solving than does the biological reductionist model which general practice regards as characteristic of specialist medicine. General practitioners may not be the ideal moral specialists but their interest in all aspects of

[28] Docker *et al*, *Report of the Knowledge, Skills and Attitudes Task Force...*, 18.

their patients' lives, and their skills in dealing with ambiguity, make them more suited than any other branch of medicine. The altruistic professional model of general practice implies that general practitioners not only cannot refer on their moral problems; they should not do it, either.

10.4 CONCLUSION

The account of moral action that I have presented in this chapter explains the GPs' actions primarily in terms of the structure of general practice work and the ideology of general practice. In doing so, I stand in the tradition which has argued that ethical problems between health professionals and their patients and the ways in which those problems are resolved are related as much to social structures and ideological commitments as they are to cognitive errors. Traditional bioethics, with its focus on individuality and rationality, seems to assume that ethical problems arise because people don't think the same way. Resolving them is then a matter of getting people to think about things similarly. In this chapter, more than anywhere else in this thesis, one can see the limitations of this view. The experiences of the GPs whom I interviewed suggests that the ways in which moral problems are resolved owe as much to social structures, the organisation of the health care system and ideology as they do to errors in reasoning.

11 CONCLUSION: MORAL THEORY AND SOCIAL CONTEXT

This thesis has been about how people describe, explain and interpret ethical problems. The issues I have explored were stated as questions in the introduction:

- How do the styles and approaches used in bioethics relate to moral deliberation?
- To what extent and how do social structures shape moral deliberation and action?

My answer to these questions, summarised below, is that mainstream bioethics is relevant for ordinary moral decision-making and that the role it plays is shaped by the ways in which social structures shape ethical deliberation, decision-making and action.

This chapter takes up the challenge of expanding beyond the experience of one group of general practitioners to other settings and other actors. Accordingly, my task here is to bring together a number of diverse threads. I begin with a summary of the main findings of the thesis. I then suggest how one might generalise from my empirical work to other settings, acknowledging the difficulties inherent in this activity. Finally, ending with the same issue introduced in the opening pages of the thesis, I consider the implications of my findings for ethics education for medical students.

This thesis has moved from an account of ethical reasoning in bioethics, to the modest literature of general practice ethics, to the moral deliberation of a small group of general practitioners. Throughout, I have been concerned with two questions: what are the characteristics of the moral deliberation displayed here? and, what influences shape this moral deliberation? My account in Chapter Two of the preferred methods of moral deliberation of principlists, casuists and virtue theorists suggested a developing accommodation between their theoretical approaches, underpinned by an individualist paradigm. The analysis of empirical work on general practice ethics in Chapter Three also indicated the importance of paradigms. The three forms of scholarship described in that chapter – quantitative surveys, case studies and sociological accounts of general practice – are all informed to greater or lesser degree by a mainstream bioethics

paradigm and a general practice paradigm. In both cases, the forms the research has taken and the findings generated bear the marks both of theoretical concerns within the field and of the setting to which the intellectual activity is applied.

The moral reasoning-in-use of the GPs I interviewed for the empirical aspects of this thesis is similar to that of the professionals mentioned above in at least two ways. First, the GPs' moral deliberation displayed some of the characteristics of 'professional' bioethical practice. The GPs defined ethical problems, at least some of the time, in the conventional terms of conflict and choice between values, beliefs and options for action. The styles of moral deliberation they used were similar in form and content to principlist, casuist and virtuist approaches to moral reasoning.

The GPs' moral reasoning-in-use may have been similar to principlist, casuist and virtuist reasoning, but in each case the resemblance was only partial. Their ethical deliberation was, at best, naïve and disorderly. In addition, the GPs were eclectic in their choice of cognitive style. They moved between principlism-, casuistry- and virtue theory-in-use, selecting the approach that best suited the moment. Their talk resembled a jumbled array of styles – they recounted an anecdote here, grabbed for a principle there, and provided a brief insight into their interpretation of the role of the general practitioner. All this was brought together as every-day moral reasoning in the space of a few minutes' conversation.

Some of the inaccuracies, inconsistencies and eclecticism in the GPs' moral reasoning-in-use relate to the fact that one would not expect them to be experts in moral analysis. I have also suggested that the lack of rigour in the GPs' reasoning is associated with difficulties inherent in the theories themselves. This was particularly so for the GPs' casuistry- and virtue theory-in-use.

However, there is more to the GPs' 'bad ethics' than deficiencies in either the GPs themselves or the ethical theories they drew on. The social environment in which they

work also offers an explanation for their moral reasoning-in-use, and a second parallel with the moral reasoning of professional bioethicists and scholars in general practice ethics. Just as bioethicists work in a normal science world of individualism and scholars in general practice ethics reflect their different settings, so too the ethical deliberation of the GPs I interviewed was shaped by the social, financial and structural organisation of their work. Two models introduced in Chapter Five to describe the social framework of general practice in Australia - the altruistic professional model and the business model – were identified as playing a role in the moral deliberation and action of the GPs. Aspects of these models were displayed in the principles the GPs used and the ways they specified these principles and related them to each other; in the types of stories they told and the use to which they put those stories; and in the virtues they identified as important to their work as general practitioners. Both models also helped to shape the talking and timing tactics the GPs used to deal with their ethical problems.

To what extent it is possible to generalise from the detail of the thesis to other settings and to related matters? Some speculative responses to this question – about other general practitioners, other lay people doing ethics, and the task of bioethics more generally – suggest themselves at the end of a thesis like this. The conclusions I draw are relatively general. I am not arguing that all people are principlists, casuists and virtue theorists, even though I think it likely that much moral reasoning will share something in common with these approaches much of the time. Neither am I suggesting that the structure and organisation of professional work offers a means by which to understand all moral reasoning. My conclusions are more modest, namely that both moral theory and social context matter in moral reasoning.

Granted the relative modesty of these generalisations, it still seems reasonable to ask under what conditions one might doubt their validity. One reason for doubting that one can generalise from interviews with fifteen GPs to moral reasoning and action in other settings lies in method by which the GPs were selected. My concern is not that

the GPs were unrepresentative of all general practitioners in South Australia (which would be the concern of the quantitative researcher), but that the method of selection itself might have contributed significantly to the content of the findings. The GPs I interviewed had all expressed an interest in ethics in general practice. One might suggest that any person who volunteered an interest in matters ethical might be more likely to display, in her own reasoning, the approaches used in mainstream bioethics. In other words, it is possible that the GPs who took part in this study were self-selected 'moral experts' familiar with bioethical concepts and vocabulary.

The evidence offered in the interviews belies this 'moral expert' label. The fifteen GPs were generally unfamiliar with the formal language of moral philosophy or bioethics.[1] They struggled to answer questions about their values and beliefs unless these questions were framed in a relatively concrete way. Some asked for help to sort through the moral implications of the issues they were discussing. None of this evidence supports the 'moral expert' label. However, the GPs were not moral dunces: they were thoughtful about their work and the dilemmas it created for them. Indeed, it would have been considerably more difficult to conduct this study at all had the GPs not been able to reflect openly and deeply on their moral dilemmas, their work and themselves. In principle, thoughtfulness about moral matters does not equate to familiarity with moral theory. Nevertheless, there is an irresolvable tension here: the study needed general practitioners with a sense of the importance of the ethical life if the questions I was addressing were to be answered, but this comes at the price of uncertainty about generalising from their conversations.

My equivocation about the relationship between the sampling procedure and the research findings suggests at least one avenue for further research. A study of ethical reasoning amongst general practitioners who do not evince an interest in ethics might offer a helpful comparison with my own work. Rogers' recently submitted thesis on the

[1] Only three acknowledged any contact with ethics and ethical theory – Dr Owen through an Australian bioethics text, Dr Little by completing a university degree with a major in philosophy and Dr Dunt

way in which general practitioners and their patients understand and deal with the moral issues associated with chronic back pain is one such example.[2] This study and others that might be conducted on similar topics may shed light on the robustness of my categorisation of the moral reasoning-in-use of general practitioners. From here it is only a short step to comparative studies in other areas of professional work, medical or otherwise.

The validity of my conclusions can also be assessed by asking to what extent the findings of this research cohere with existing research on moral decision-making and general practice ethics. In some respects, there is a good fit between my findings and those of other scholars. Sociological accounts, particularly empirical studies in a range of health care settings, indicate clearly that social and organisational structures influence decision-making in health care. The general practice literature about morality, values and ethics names a range of problems similar to the ones that the GPs in my study discussed. It even implies, by noting the unique social context of general practice, that social and organisational factors contribute to the definition and articulation of ethical problems. In these areas, my findings are in accord with the established literature.

Notwithstanding this agreement, it is also important to note some areas in which my findings may appear inconsistent with those of other scholars. To address these points of disagreement, a brief reminder of the context for this thesis is relevant. The conclusion to Chapter Two discussed briefly the ways that bioethicists define and use empirical work in their writing. Based on that discussion, one might conclude that bioethicists have had a rather inflated view of their theories' importance for every-day moral reasoning. They appear to use their own experience of 'doing ethics' – sometimes in formal and professional settings, sometimes in ordinary life – to assert

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through self-education in a range of areas. All three provided some evidence of these experiences in their interviews and I have tried to indicate this in the thesis where appropriate.

[2] Rogers W. 1998 *The Moral Landscape of General Practice*. PhD, The Flinders University of South Australia.

that the theories they espouse do match real life moral decision-making. Against the bioethicists' view, critics have argued that there is little, if any, relationship between the moral theories of bioethicists and the moral deliberation and action of lay people. Elliott's view of the role of moral theory is indicative of a range of criticisms of this nature. He argues that ordinary people do not rely on ethical theories, in any obvious sense, when they deal with moral problems.[3]

The problem with these views is that they allow no compromise. According to the bioethicists and their critics, either moral theory is central to real life moral decision-making or it is irrelevant. Both groups seem to claim too much in their descriptions of the role of theory in every-day decision-making. It is simply not a matter of choosing between, on the one hand, no role for theory at all and, on the other, the absolute priority of any one theoretical approach. Both bioethicists and their critics are right with respect to the role of moral theories in every-day decision-making. Moral theories are important in ordinary moral decision-making, but the role that moral theory plays is much more inchoate and muted than bioethicists would have us believe. The social environment in which ethical problems arise and are addressed is important, and bioethicists need to find ways to acknowledge this.

If both moral theory and social context matter, then bioethics needs to take both seriously. This implies a large array of possibilities for bioethical activity. I have already mentioned one possible area for further research. In addition, there are implications for the description and analysis of cases, for the delineation and analysis of core concepts, for how empirical work in ethics is defined and conducted, for codes of ethics. Rather than merely listing these possibilities, I wish to return to the first pages of this thesis to speculate briefly on what my conclusions might mean for one area only - that of teaching ethics to medical students.

[3] Elliott C. 1992 Where ethics comes from and what to do about it. *Hastings Center Report* 22: 28-35.

During the past twenty years, goals and methods in bioethics education for doctors have witnessed an increasing emphasis on the clinical context of bioethics.[4] Ethics education in medical schools has moved from a concern to develop an abstract awareness of ethical issues and familiarity with moral theory and its role in medicine to include efforts to:

> foster students' flexibility, sensitivity to variations in circumstance that change meaning in ethically significant ways, appreciation of other feelings and interests, awareness of their own values and interactional style, and the impact of all of these matters on ethical decision-making.[5]

These changes have been accompanied by changes in pedagogical style, from large lecture style teaching to small group work and from hypothetical cases to real life cases in the clinic[6] and, in some circumstances, to students' own ethical dilemmas.[7]

These changes in bioethics education have clearly not taken place in a vacuum. There have been changes in bioethics theory and research along the lines discussed in Chapter Two. The challenge to the dominance of principlism in bioethics from alternative approaches such as casuistry, virtue theory, narrative ethics, hermeneutics and feminist ethics, must all have increased sensitivity to clinical context in bioethics. In medical education more generally, rote learning of knowledge in the biological sciences based around lectures from expert academic and clinical staff is giving way to an emphasis on student-directed learning in small cooperative working groups.[8] Formal courses in communication skills have also been introduced. Both developments are

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[4] The topic of appropriate goals, methods and content in medical ethics education is a large and important one. Although aspects of the topic are discussed below, I have put to one side a formal consideration of issues related to it.

[5] Hundert EM, Douglas-Steele D & Bickel J. 1996 Context in medical education: the informal ethics curriculum. *Medical Education* 30: 354.

[6] See Jonsen AR. 1989 Medical ethics teaching programs at the University of California, San Francisco, and the University of Washington. *Academic Medicine* 64: 718-22; Jonsen AR. 1989 Casuistry and clinical ethics. *Theoretical Medicine* 7: 65-74; and Thomasma DC & Marshall P. 1989 The clinical medical ethics program at Loyola University of Chicago. *Academic Medicine* 64: 735-9 for discussion of the move away from lecture style teaching to small group-based discussions.

[7] See, for example, Christakis D & Feudtner C. 1993 Ethics in a short white coat: a report on the ethical dilemmas that students confront. *Academic Medicine* 68: 249-54; Bickel J. 1991 Medical students' professional ethics: defining the problems and developing the resources. *Academic Medicine* 66: 726-9; Fradkin R. 1993 Ethical dilemmas confronting medical students. *Bioethics News* 12:41-43; Dwyer J. 1994 *Primum non tacere*: An ethics of speaking up. *Hastings Center Report.* 24: 13-18.

[8] For example, in Australia the revision of curricula in a number of undergraduate medical schools and the development of curricula for new graduate schools has, in all schools, included the enhancement or, in some cases, establishment, of 'problem-based learning' streams. In problem-based learning, students work in a small group with the assistance of a facilitator. The group's task is to use the clinical case provided as a springboard for the acquisition and integration of clinically relevant knowledge.

compatible with the move in bioethics toward teaching in local clinical contexts and away from broad abstract theories.

How do the findings of this study speak to this changing situation? First, they inject a cautionary note if ethics educators are tempted to throw the ethical theory baby out with the bath water of moral abstractness. The rush to provide clinically relevant teaching for medical students based around 'real' cases should not be accompanied by the assertion that moral theory is somehow now irrelevant to decision-making in the clinic. The GPs in this study used a range of theoretical approaches in their moral deliberation, albeit in simple and sometimes inconsistent ways. A course in ethics for general practitioners might justifiably include the study of principlist, casuist and virtuist approaches to the analysis of moral problems as these approaches would be relevant to their ethical circumstances and helpful for the development of more coherent and rigorous analysis.

Something similar is appropriate in ethics education for medical students. The task of ascertaining theoretical approaches that resonate with students' differing cognitive styles can be addressed from a number of angles. Clearly, medical schools do not offer the curriculum time that would be required to determine *de novo* the styles of moral reasoning that students use. However, my own experience as an ethics teacher in a medical school suggests that similar outcomes can be achieved when one offers students a range of theoretical approaches to the analysis of moral problems and encourages them to assess the fit between those approaches and their own styles of reasoning. Some care needs to be taken here because it is all too easy to present a bioethical smorgasbord that provokes an 'anything goes' response. The presentation of a range of moral theories must be accompanied by opportunities to practise ethical reasoning in environments that encourage rigorous and critical thinking. One way to help create these environments is through working with students on tasks that involve 'thinking about thinking'. There is a large body of literature based on the work of writers such as De Bono, Gardner, and Bloom that offers strategies to enhance students'

awareness of their own cognitive processes.[9] Most of these strategies are better developed in primary and secondary education than they are at the tertiary level[10] and it takes a little ingenuity to adapt a strategy that works effectively with seven-year-olds to the needs of twenty-one-year-old medical students. Again, however, my own experience with medical students has been that they enjoy exploring their own cognitive styles and the logic, coherence and rigour of their moral reasoning improves as a result.

Teaching in ways that encourage students to reflect on their cognitive styles must go hand-in-hand with a commitment to work with problems that are of real relevance to the students themselves. Students need to see how they might relate the styles of reasoning they are practising to their own situations. This observation suggests a second link between the research conducted in this thesis and ethics education. Moral theory does matter, but it requires a context to be meaningful. This has two kinds of implications for ethics teaching. First, it reinforces the importance of local and personally relevant factors in ethical decision-making. The GPs did not do their ethics outside of the circumstances of their professional lives and students should not be forced to do this either. Ethics education needs to respond to the students' setting if it wants them to develop ethical, sensitive habits of practice.

Strategies that encourage medical students to identify and reflect on ethically significant events in their own lives are one way to develop both skill in ethical analysis and an awareness of the role of that analysis. For example, Grundstein-Amado's values journal, which brings together students' reflections on cases in the clinic and important issues in their own lives, offers them the opportunity to contemplate the similarities and dissonances between their responses to the medical world and their own experiences.[11]

[9] See, for examples of the original work, De Bono E. 1987 *Six Thinking Hats*. Penguin; Gardner H. 1985 *Frames of Mind: The Theory of Multiple Intelligences*. Paladin; and Bloom BS *et al.* 1956 *Taxonomy of Educational Objectives*. McKay.
[10] One significant exception to this observation is the work of Angelo and Cross. A number of their evaluation techniques involve metacognitive or 'thinking about thinking' tasks. See, for examples, Angelo TA & Cross KP. 1993 *Classroom Assessment Techniques. A Handbook for College Teachers.* (2nd edn) Jossey-Bass Publishers.
[11] Grundstein-Amado R. 1995 Values education: a new direction for medical education. *Journal of Medical Ethics* 21: 174-8.

Nicholas and Gillett's narrative approach in a workshop on medical ethics using participants' stories of clinical interactions that had gone well similarly respects the experience that participants bring to a learning situation.[12] In my own teaching I have set a tutorial paper on 'an ethical problem of my own' to explore with students how they come to give problems the label 'ethical', and what makes those situations similar to or different from others in their lives. Giving students descriptions of other medical students' experiences has also been helpful in developing their sensitivity to the ethical implications of their work as medical students.

The significance of context for moral theory has a second implication for ethics education, related to the wider social and organisational context. Although the importance of clinical context has been addressed in recent developments in ethics teaching, the broader context of medical education has been relatively neglected. Just as the moral deliberation and action of the GPs I studied were shaped by the social context of general practice, so ethical sensitivity and skill in medical students is influenced by the structures in which they learn and of which they are a part. Structural and institutional factors are at work in the knowledge offered to students, in the way in which students absorb and process that knowledge, and in the ways they apply it. The literature on this topic is vast and, in these concluding pages, I wish only to flag its importance.[13]

One of the possible reasons for the neglect of the social and organisation context in medical education relates to the contention that the entry of medical ethics into the medical curriculum has been at the expense of sociology. Wegar, quoting Fox, suggests that medical ethics teaching in the curriculum has displaced sociology's contribution

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[12] Nicholas B & Gillett G. 1997 Doctors' stories, patients' stories: a narrative approach to teaching medical ethics. *Journal of Medical Ethics* 23: 295-9. For cautionary observations on some of the difficult issues related to power, impoverishment of stories, and the impact on the teacher that teaching within a narrative framework raises, see Newell C. 1998 The ethics of narrative ethics: some teaching reflections. *Health Care Analysis* 6: 171-4.

[13] See, for preliminary reading, Shapiro M. 1978 *Getting Doctored: Critical Reflections on Becoming a Physician.* Between the Lines; Merton RK. 1957 *The Student-Physician.* Harvard University Press; Becker HS. 1961 *Boys in White : Student Culture in Medical School.* University of Chicago Press; Atkinson P. 1981 *The Clinical Experience: The Construction and Reconstruction of Medical Reality.* Gower.

concerning the ways in which social structures shape the experience of health and illness. Medical ethics does take an interest in the study of the social context of health, illness and medicine, but it tends to ignore large-scale, societal analyses in favour of a micro-analytical approach.[14] This is hardly surprising, given the individualistic orientation of bioethics.

Developing an awareness of the social context of health, illness and medicine amongst medical students is challenging. Teaching about the social determinants of health and disease does not sit comfortably within the individualist orientation of the clinical encounter. It is not easy to find ways for students to 'encounter' and learn from groups and populations in the same way that they encounter and learn from individual patients. In addition, the ability to see people and their health issues in a social context relates, in part, to the setting in which students meet these people. Medical students who meet users of health services in clinical settings - the hospital or surgery - see those people through eyes attuned to clinical and individual solutions and there is often resistance to thinking about the problem and its solutions in different ways.

One strategy to address the clinical and individualistic bias in medical education that has worked particularly well in my own teaching involves giving the users of medical services the opportunity to be teachers outside the conventional doctor-patient encounter. For example, in two-day workshops for senior medical students on the social context of rural general practice I embedded a stay on a farm within more formal teaching on the social and economic factors that influence the lives of rural dwellers. Students were billeted overnight with farming families and expected to use this time to observe and ask questions about the health issues their farming families faced. The students had a variety of experiences during their farm stays. In addition to conducting a 'formal' interview, most students had a farm tour, and some also experienced

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[14] Wegar K. 1992 Sociology in American medical education since the 1960s: the rhetoric of reform. *Social Science and Medicine* 8: 262. See also Fox RC. 1985 The evolution of American bioethics: A sociological perspective. In Weisz G. (ed.) *Social Science Perspective on Medical Ethics.* Kluwer Academic Publishers, 201-217.

something a little different - spotlighting, sand-boarding, a barbecue on the beach, or playing board games till late at night.

Student evaluations at the end of the workshop indicated that they particularly valued the farm stay and the input from people who were "not strictly within the health care system". More significantly, the evaluations and student presentations showed that they had understood that health status is influenced by a complex set of social, structural, environmental and economic factors.

Why did the workshops succeed? First, I had tried to take account of the context of medical education by recognising that senior medical students do much of their learning in clinical encounters. The workshop was able to mirror that encounter by attaching students to farming families and providing them with opportunities to experience the some of the issues discussed in class. For example, the first day of the workshop included discussion of the tendency for some rural people to fail to bring injuries and illnesses to the attention of health service providers. I had linked that to the culture of independence and resilience dominant in many rural communities, and to the difficulties that farmers face in leaving the farm at busy times. One of the students returned the next morning to tell the group that a member of "his" farming family was nursing an injury that he "just hadn't gotten around to doing anything about". The student added, "I wouldn't have believed it if I hadn't seen it".

Although the students' attachment to a farming family was similar to the clinical encounter in some respects, in others it was very different. The students met people who were not sick, who were not there to see the doctor, and they talked together about problems that were never going to reach the surgery or hospital. The voice of local people, with its focus on social, economic and political concerns, muted the clinical perspective of the medical practice. In addition, the farming families probably felt more able to criticise their health services in their own homes than they might in the clinic or

hospital. For example, the students reported that there considerable dissatisfaction amongst their farming families with local medical services.

Second, the unfamiliarity of the experience for most of the students had a significant impact on their interest and receptiveness. Over half of the students in the workshops had never visited or stayed on a farm and many had rarely travelled the distance they had to travel to attend the workshops. The students regarded their farming families as 'experts' on rural life, in the same way they regarded a cardiologist as 'expert' in heart disease. They listened openly and sensitively to the experiences and views of the people who were using the local health and medical services and this enhanced their ability to be constructively critical of the health services offered in the area and of the role that doctors played in providing those services.

A similar approach can be taken to ethics education. For example, some medical schools, including my own, have 'family attachment' schemes that attach medical students to families with experience of chronic illness. The students follow the family throughout the year, and they are encouraged to discuss with the family their usage of services and contact with the health system. Like the farm stays above, such schemes introduce students to patients' interpretations of encounters with doctors, other health professionals and health services. However, care needs to be taken in the way families are selected to take part in these schemes. There is anecdotal evidence in my own school that the students report very favourably on their families' contacts with the health system. This is a little surprising, given recent media attention in Australia to declines in availability of and access to health services. However, the selection process probably contributes to the glowing picture of doctors and health services that students form. Families are recruited to the family attachment scheme through general practitioners, who are asked to select a family whose service usage displays how a range of services can be coordinated to meet patient needs. Patients and families who are unco-operative, discontented with their health care, or non-compliant are unlikely to be

selected, but such families might in fact be particularly helpful for the medical student seeking to understand how ethically acceptable medical care might be provided.

A second, and probably less effective, way to introduce students to patients' experiences, involves encouraging students to read literature written by lay people about the experience of being ill. In the scholarly literature, Frank's work on the experiences of ill people when they are not being patients is an excellent starting point.[15] The less 'scholarly' literature is, perhaps, less threatening for students, and it also offers great insight into the experience of illness and the health system. For example, Monette's account of the death of his lover from AIDS, L'Engle's description of the death of her husband from cancer after a long and happy marriage, and Moore's recounting of his experience as a clinician of the impersonal quality of medical care all make compelling reading.[16]

Approaches such as these that focus on the experience of being a patient at the micro-analytical level help students to take an outsider's view of medical work. Another way to emphasise the outsider's perspective involves offering students a critical account of the process of medical education to help them understand how medical schools, hospitals and clinical role models both enable and constrain their learning and moral development. Such an account might assist them to make better sense of where they find themselves in the medical system, so that, for example, they have ways to explain their failure to 'speak out' against unethical or inhumane treatment of patients.

Raising issues of power and control with students can be costly for teachers and students. Some students become uneasy and anxious about their role in 'the system'.

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[15] Frank AW. 1995 *The Wounded Storyteller: Body, Illness and Ethics.* University of Chicago Press.

[16] Monette P. 1988 *Borrowed Time: An AIDS Memoir.* Harcourt Brace Jovanovich; L'Engle M. 1988 *Two-Part Invention. The Story of a Marriage.* Farrar, Straus and Giroux; and Moore T. 1991 *Cry of a Damaged Man. A Personal Journey of Recovery.* Picador.

Peter's comments in the opening pages of this thesis about the impact of doing an ethics course suggest that he found it a sobering experience:

> With all due respect and in all honesty, this is how I feel...The third year medical course is really quite challenging. I just feel that I didn't have the time to fully understand the deeper issues the ethics course was trying to address and it's an awful feeling. I'm too busy learning to actually *understand* the big picture. Ethics is essential to the training medical student and an understanding of ethical analysis appears to be very important too. Unfortunately, it just doesn't gel with everything else we're learning at the moment. I think this turns many students off ethics. In lectures I'm learning about blood cells, fevers and drug interactions – kids' stuff in many ways compared to ethics.

For teachers, also, educating in this vein can be challenging. How does the ethics teacher respond to complaints about a faculty colleague who consistently belittles students and demeans patients? Is it possible to address quite specific concerns of students without breaching confidentiality?

Ultimately, concerns and challenges such as these can not be dealt with merely by tinkering with the goals, methods and content of ethics courses. They require the will to change those aspects of the structure and organisation of medical education that do not enhance the development of physicians who will be ethically sensitive and compassionate. Andre notes that students' developing "ability to see the moral landscape" is constrained by a number of factors. She cites the stress and suffering and the "sometimes desperate lack of time" during medical training as obstacles to clear moral vision.[17] Students who are occupied for most of the day in lectures, tutorials, ward rounds and, even, problem-based learning, and overwhelmed and exhausted by the volume of material to be learnt, are too tired, both physically and emotionally, to reflect. They also have little opportunity to experience a world outside medicine that might offer a different perspective. Students caught in this world more than anything need time to reflect and be other things besides a medical student. Ironically, creating more time for life outside the confines of the medical curriculum is perhaps one of the most powerful ways to enhance medical students' sensitivity and skills. Like the rest of us - bioethicists, scholars in general practice ethics, ethics teachers and fifteen GPs in South Australia – medical students need to be encouraged to treat ethics as part of every-day life.

[17] Andre J. 1992 Learning to see: moral growth during medical training. *Journal of Medical Ethics* 18: 148-152, quotations at 148 and 150.

APPENDIX 1: INVITATION AND REPLY PAID CARD

Ethics in General Practice Study

Have you ever worried about a 13 year old patient who wants contraceptives and won't tell her parents, or been concerned about the patient who won't tell her husband she has VD, or puzzled over how to counsel a patient appropriately? General practitioners face ethical problems like these frequently and they have accumulated a great deal of wisdom and experience in dealing with them. This knowledge is rarely tapped, because much discussion of 'medical ethics' revolves around hospitals and high technology and ignores the experiences of general practitioners.

The Family Medicine Programme and the Department of Community Medicine, University of Adelaide, are jointly sponsoring a study of ethics in general practice. The aim of the project is to assess the value of teaching ethics to FMP trainees, by interviewing trainees before and after they take part in an advanced workshop in which the discussion of ethical problems in general practice has been integrated. We are looking for about 20 general practitioners with at least five years post-FMP experience who are prepared to help this project by being interviewed for about an hour. You would be asked to describe one or two ethical problems you have experienced in your work, what you did about it and why. Obviously, confidentiality would be observed and your responses would be anonymous. (This is, after all, an ethics study.) Together with others, your interview would be used to develop the ethics material in the advanced workshop and to devise questionnaires for the trainees.

If you would like to learn more about the study and/or are interested in taking part, you can ring Chris Holmwood, FMP on (08) 267 3455 or Annette Braunack-Mayer at the Department of Community Medicine on (08) 228 4637.

Alternatively, you can simply complete the reply paid postcard enclosed with this Newsletter, and you will be contacted in due course.

Ethics in General Practice Study

No postage stamp required
if posted in Australia

REPLY PAID 5447

DEPARTMENT OF COMMUNITY MEDICINE

THE UNIVERSITY OF ADELAIDE

G.P.O. BOX 498,

ADELAIDE, S.A. 5001

Ethics in General Practice Study

Name: ....

Address: ....

....

....

Telephone: (   )....................................

☐ I am interested in taking part in the Ethics in General Practice study.

☐ I would like to learn more about the Ethics in General Practice study.

APPENDIX 2: LETTER OF CONFIRMATION TO GPS AND INFORMATION LEAFLET

January 14th, 1993

Dear

Thank you for agreeing to take part in the Ethics in General Practice Study. I am enclosing a leaflet we have prepared with more information about the study. In addition to reading this you might like to think about the following questions before I interview you on Thursday, January 28th at 2.00pm.

I will start by asking you to describe one or two ethical problems you have encountered in your work as a general practitioner. The number of problems you choose to discuss is up to you. I am interested in:
Who was involved?
What information about the people involved in this situation is significant for the problem?
Where?
When?
What was the context or setting?

Then I will ask about what you did, how things turned out and how you worked out for yourself how to deal with the problem. I will ask questions like:
Why was this situation a problem for you?
Why would you say that this problem was an ethical problem?
How did you deal with the situation?
How did things turn out?
Were you happy with the outcome?
Why did you make the decision you did?
What issues did you take into account when deciding what to do?
Were there other options than the one you chose? What were they? Why didn't you choose those options?

Since my aim is to tap your experience, these questions are merely a loose guide to what we might discuss. I doubt that all of them will be appropriate to what you wish to talk about, or that we will cover them in the order above. There may also be other questions you wish to discuss and I may also ask you to talk more generally about how you think you have acquired the beliefs you have about these problems and what sustains those beliefs.

Thank you again for your interest and preparedness to take part in this project. Both are deeply appreciated.

Yours sincerely

Annette Braunack-Mayer

Department of Community Medicine
University of Adelaide

Family Medicine Programme
South Australia

Ethics in General Practice Study

Information for participating general practitioners

Contact:
Annette Braunack-Mayer
Department of Community Medicine
University of Adelaide
GPO Box 498
ADELAIDE 5001

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Family Medicine Programme
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15 Gover Street
NORTH ADELAIDE 5006

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Have you ever worried about a 13 year old who wants contraceptives and won't tell her parents, or been concerned about the patient who won't tell a spouse he has an STD, or puzzled over how to counsel a patient appropriately? General practitioners face problems like these frequently, and they have accumulated a great deal of wisdom and experience in dealing with them. This knowledge is rarely tapped, because much discussion of 'medical ethics' revolves around hospitals and high technology and ignores the experiences of general practitioners. This study of Ethics in General Practice, jointly sponsored by the Family Medicine Programme and the Department of Community Medicine, University of Adelaide, tries to place the experiences of general practitioners on the agenda for ethical discussion.

What are the aims of the study?

The overriding aim of the study is to try to ensure that, in the long term, ethics is taught in Australian universities and post-graduate programs in a way that is pertinent to general practice. We want to know what ethical problems general practitioners face, how they regard those problems and what steps they take to resolve them.

The Ethics in General Practice Study aims to assess the value of teaching ethics to Family Medicine Programme trainees, by interviewing trainees before and after they take part in an advanced workshop into which the discussion of ethical problems in general practice has been integrated.

What does the study involve?

The first stage of the study is a set of interviews with 20 general practitioners who have at least 5 years general practice experience. These general practitioners are asked to describe one or two ethical problems they have experienced in their work, what they did about them and why.

In stage two of the study we take the experiences of these general practitioners and develop teaching materials for the advanced workshop from them. We also base two sets of standard ethical dilemmas to be used in questionnaires for the trainees on interviews with the general practitioners.

In stage three, two groups of advanced trainees are recruited to the study. One group is an intervention group who receive ethics education as part of their advanced term workshop. The second group is a control who receive no formal education in ethics during their workshop. All trainees in both groups are interviewed before the advanced term workshop begins, given a questionnaire which includes a standard set of ethical dilemmas, and asked to describe what should be done about the dilemmas and why. On completion of the workshop, the trainees are interviewed again, given a different set of standard ethical dilemmas, and asked to respond as before.

How can I be involved?

If you are a general practitioner with at least 5 years general practice experience, you can help this study by being interviewed about your own experience of ethical problems.

What will involvement entail?

If you agree to become involved in this study, you will be interviewed for approximately one hour. During this time, you will be asked to describe:

one or two ethical problems you have encountered in your work;
why they were problems for you;
what decisions you made (and other options you contemplated);
what happened;
and your reasons for choosing as you did.

You will also be asked to talk about your approach to thinking about and resolving ethical problems.

We will ask you to allow your interview to be taped.

Later in the study, when we are developing 'standard ethical dilemmas' for use in questionnaires for FMP trainees, you may be asked to comment upon one or two dilemmas, if they have been based on your own experiences.

How will confidentiality be protected?

Care will be taken to ensure that you can not be identified by name in any communications (written or oral) about the study.

The tape from your interview will be transcribed and the original interview will then be erased. A code number will be given to each transcription before it is stored, without identification, in a locked filing cabinet. The key to the code numbers will be kept at a different location.

When the 'standard ethical dilemmas' questionnaires and the report of the study are written, and during the FMP workshop, great care will be taken to ensure that no individuals can be identified in any way.

What is in it for me?

During the interview you will talk about the ethical problems you face in your work in a fairly formal way. This may help you to see these experiences differently or to understand more clearly why the problems arose and why you responded as you did.

APPENDIX 3: INTERVIEW GUIDE

ETHICAL ISSUES IN GENERAL PRACTICE
Questionnaire for expert GPs

Before we start, can you tell me what you understand about the Ethics in General Practice study? Check:

- why doing study;
- who is involved as investigators;
- confidentiality protected;
- use of information - FMP, thesis, other uses;

As we have discussed over the phone, I am going to ask you some questions about one or two ethical problems you have experienced in your work. I will start by asking you to describe the problem itself. Then I will ask questions about what you did, how things turned out and what things you took into account when thinking about this problem. I may also ask you to talk more generally about how you think you have acquired the beliefs you have about these problems and what sustains those beliefs.

Please also feel free to interrupt, and to ask for clarification.

Code:

Date:

Place:

Gender:

Age:

Marital status:

Religion:

Education history:

Professional history:

Please tell me about an ethical problem you have encountered in your work as a general practitioner.

Description:

- Who was involved? What information about the people involved in this situation is relevant to your story?
- Where?
- When?
- What was the context or setting?
- *Probe (participants): age, gender, m/s, history of contact with GP.*
- *Probe (setting): time span of story, rural v urban...*
- *Probe: how long ago? what time in professional career?*

Why is this an ethical problem?
Why was this situation a problem for you?
Why would you say that this problem was an ethical problem?

- *Probe: compared to a problem of medical knowledge, a technical problem...*

Choice/action:

- Did you have to make a decision about what to do at some time?
- When?
- What did you decide to do?

Outcomes:

- How did things turn out?
- Were you happy with the outcome?

Reasons:

- Why did you make the decision you did?
- What issues did you take into account when deciding what to do?

If they identify particular values/beliefs:

- What is generally involved in x [identify value/belief]? How do you usually go about being x [identify value/belief]?)
- Did you talk about this problem with other people? Who? What was their reaction?
- *Probe: What if things had been a bit different? Eg?... How would this have influenced your response/ how you thought about the situation?*
- Did you think about other ways of handling the situation? What were they? Why didn't you follow those options?

Beliefs and values:

- If identify key values/beliefs:
  You have talked about how .... is important to you in your work. When some people talk about beliefs like these, they will describe influences in their lives which have been significant for them in developing and sustaining their beliefs. Are there influences in your life which have been important to you in relation to your beliefs about ....?
- *Probe: family, friends, colleagues - role models (who), important experiences, education*

- Do you usually talk to other people about problems like the one we have discussed?
- *Probe: talk with other doctors*

- Do you think other doctors would have acted with this problem as you did?

- Do you think your attitudes and beliefs about .... are similar to or different from the beliefs of other doctors?
- (What makes you different?)

- Generally, do you think your attitudes and beliefs about medicine are similar to or different from other doctors? What has influenced you in the development of your beliefs generally?

Thank you. I have found your story to this point fascinating. Before we finish (if you'll bear with me a little longer), I want to ask you about a couple of other things to do with ethics in medicine.

Definitions:
One of the things we are trying to do in this study is to look at how well the formal theory and language of ethics fits with what we all think about when we make decisions about perplexing decisions like these. I'm going to give you, one by one, a list of terms that crop up in the medical ethics textbooks. Could you tell me what they mean to you and whether they play any role in your everyday work:

rights, confidentiality, respect for autonomy, paternalism, beneficence, justice, informed consent, deontology, utilitarianism....

(anything else they have raised during discussion)

- Is there anything else, concerning the things we have discussed, that you wish to add?

- Why did you decide to become involved in this study?

APPENDIX 4: CONSENT FORM

I, ____, consent to taking part in the Ethics in General Practice Study.

The following has been explained to me:

* Aims
* Methods of the study
* Use of information I provide:

  In particular, the development of curriculum materials for FMP trainees, evaluation of those materials, and thesis research of Ms Braunack-Mayer.

  My permission will be sought before the information is used in any other way.

* How my privacy will be protected:

  In particular, that no information which could identify me or my patients as individuals will be made public.

* that my interview will be taped.

I am satisfied that I understand the above.

Signed ________________________________ Date __________

Witnessed ________________________________ Date __________

APPENDIX 5: A BRIEF ACCOUNT OF THE CONTEXT AND SOURCES FOR CHAPTER FIVE

The focus in Chapter Five is on the professional, social and organisational context of general practice for the GPs I interviewed. This appendix introduces the primary sources used to construct a picture of that context, and summarises the policy environment that contributed to it.

General practice in the period 1985 to 1997

Changes in elected governments and, particularly, associated changes to health insurance have played a major role in health policy in Australia. A government sponsored health insurance program was first introduced by the federal Liberal-Country Party coalition government in 1953. This program partially subsidised the cost of health services, but participation in it was voluntary and contingent on membership of a private health insurance fund. By the late 1960s, the program was subject to considerable criticism because it did not cover all people and because, at times, there were substantial gaps between the refunds available and the fees doctors charged.

In 1972, a federal Labor government was elected on a platform that included the introduction of a universal, publicly funded and administered, health insurance scheme. The Australian Medical Association (AMA), the industrial voice for doctors, the private hospitals and the federal opposition parties vociferously opposed the scheme. Legislation to introduce the program was finally passed after a double dissolution of parliament and a subsequent election, in May 1974, at which the Labor party was returned to office. The program, called Medibank, was then introduced in 1975 and the Commonwealth Health Insurance Commission was established to administer the program.

Under Medibank, all doctors in private practice could choose to bill the Health Insurance Commission direct. If they took this option, they were obliged to accept 85% of the government-set schedule fee as full payment for their services. Alternatively, they were free to bill patients directly, and the patients could claim 85% of the schedule fee back from the Health Insurance Commission. Doctors were under no obligation to stick to the schedule fee – they could charge patients whatever they wished – and patients were not able to insure themselves to cover the gap between the 85% rebate and the fees their doctors charged. For doctors, then, Medibank maintained their independent status as providers of medical care on a fee-for-service basis, but underpinned the fees with public funds. Medibank also provided free public hospital

care, but allowed private health insurance funds to offer insurance to people who wished to be private patients in either private or public hospitals.

The short period under federal Labor (which governed for only 18 months after its re-election) also saw the introduction of a program of graduate training in general practice, the Family Medicine Program.[1] The Royal Australian College of General Practitioners (RACGP) applied for, and received, funds to establish graduate training under the Commonwealth Government's new Community Health Program. The title of the program mirrored the recently renamed RACGP journal, *Australian Family Physician.*[2]

After constitutional turmoil and a bitter election campaign, in which the Liberal-National Party coalition promised to retain Medibank, the coalition displaced Labor in government in December 1975 and proceeded to dismantle the publicly funded health insurance scheme. The first changes in 1976 offered the public the option of opting out of the government program by purchasing private health insurance. People who remained in the government program had to pay a levy of 2.5% of their taxable income. Further changes in 1978, 1979 and 1981 culminated in a return to the voluntary health insurance that had been in place prior to 1975.

The return of Labor to power federally in 1983 was followed, in February 1984, by the reintroduction of a system of universal, taxation-funded health insurance for all Australians, this time called Medicare. Under Medicare, the billing arrangements for private practitioners and free public hospital care for those without private insurance that had existed under Medibank were reintroduced.

From 1972 onwards, the medical profession was a significant source of opposition to universal health insurance. An important reason for this was the perceived threat to medical incomes posed by free public hospital treatment. The main opponents of Medibank and Medicare were therefore the specialists who worked in the hospital sector, rather than general practitioners whose work was primarily outside hospitals, especially in urban areas. Even so, general practitioners seemed to have the same in principle opposition to any publicly funded health insurance scheme. However, because general practitioners did not acquire a truly

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[1] In July 1993, the Family Medicine Program changed its name to the Royal Australian College of General Practitioners Training Program, to focus attention on role of the College and the program as the source of post-graduate training for general practice.
[2] See also Bridges-Webb C. 1996 General practice in Australia from 1788 to 1990: a personal commentary. in Commonwealth Department of Health and Family Services. *General Practice in Australia: 1996.* Australian Government Printing Service, 17-18.

independent political voice until the mid to late 1980s (for reasons discussed below), it is difficult to extract their views from the views presented by the AMA on behalf of all doctors.

A distinctive general practice voice began to appear from around 1985. The distinctiveness relates to a number of factors. First, general practitioners found an ally of sorts in Neal Blewett, the health minister in the newly elected Labor government. Blewett had acknowledged the important role of general practitioners before taking office, and he continued to develop this theme as minister. In 1986 he increased rebates for general practice services above that of specialist services, and he expanded funding for the Family Medicine Program.[3]

Second, Blewett was helped in a significant way by disenchantment in and about general practice, not least with respect to its status *vis a vis* the medical specialties. There had been a steady stream of complaints about morale and status in general practice, and not only from general practitioners. A number of reports published around 1985 documented these complaints. The RACGP published the results of a Delphi study on the standards and practices of general practice in 1985.[4] This study used "panels of experts"[5] from the RACGP, non-College general practitioners, specialists, medical educators, patients, planners and regulators, allied health professionals and health insurers to obtain opinions on quality of care in general practice, current and desirable practices, and the likely impact of trends in health care. The Commonwealth Government's Better Health Commission also published reports that included commentary on general practice.[6] In addition, in 1988 the South Australian Health Commission, the AMA (SA) and the RACGP (SA), together sponsored a survey of all general practitioners in South Australia.[7]

These reports all noted general practitioners' dissatisfaction with general practice incomes under Medicare and their concern about the loss to specialists of many areas of general practice work. There were mixed views about the general practitioner's role in prevention and community activities, but they agreed that current funding mechanisms did not encourage general practitioners to fulfil this role.

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[3] Backhouse PJ. 1994 *Medical Knowledge, Medical Power: Doctors and Health Policy in Australia*. PhD, University of Adelaide, 282-289.

[4] Royal Australian College of General Practitioners. 1985 *The Vision of General Practice: Now and in 1995*. Arthur Anderson and Co., Melbourne.

[5] The report does not clarify how "experts" were defined or selected, beyond noting that "the key selection criterion relating to all panelists was their ability to contribute as an 'expert' to the study" (29).

[6] Better Health Commission. 1986 *Looking Forward to Better Health*. Volumes I to III, Australian Government Printing Service.

[7] South Australian Health Commission, Australian Medical Association (SA) & Royal Australian College of General Practitioners (SA). 1988 *Review of General Medical Practice in South Australia. First Report: Identifying Problems and Issues in General Practice*. South Australian Health Commission.

There is some independent justification of general practitioners' disenchantment with their lot. If they compared themselves to their specialist colleagues, they had reason to be concerned about their incomes. After the introduction of Medicare, gross income for full-time general practitioners rose by 42% between 1984-5 and 1989-90. Over this period, incomes for surgeons rose by 61% and for obstetricians/gynaecologists by 57%. In the same period, the consumer price index rose by 47%, average weekly earnings by 40% and awards pay rates by 30%.[8]

Blewett's activism and the dissatisfaction about morale and status in general practice culminated in the introduction of a package of reforms concerning general practitioner fees, continuing education and vocational registration in 1989. Until 1989, general practitioner fees were divided into four levels, based solely on the length of the consultation. Any medical practitioner who had completed a one-year hospital-based internship was eligible to practise as an unsupervised general practitioner and to charge general practice or non-specialist fees. This arrangement was superseded in December 1989 by the introduction of a schedule of fees based on content as well as on time. The new time- and content-based fees offered higher rebates and therefore gave more freedom to charge higher fees, but only for doctors who were on a general practice 'vocational register'. Patients of doctors not on the register could continue to claim only the lower, time-based, rebates.[9]

Initially the register was open to all general practitioners who had undertaken approved training in general practice, or who had a minimum of five years experience in general practice (a 'grandfather' clause that expired in 1994). To maintain their vocational registration, general practitioners need to undertake an approved program of continuing medical education, which was, and still is, administered by the RACGP. Since 1994, vocational registration has been open only to medical practitioners who have passed the RACGP fellowship examination.[10]

Blewett's program of general practice reforms was made possible, in part, by differences of opinion that arose over the representation of general practitioners in the political and

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[8] See Deeble J. 1991 *Medical Services through Medicare.* National Health Strategy, Background paper No. 2.

[9] Backhouse, *Medical Knowledge, Medical Power...*, 286.

[10] Dickinson J et al. 1996 The supply and distribution of general practitioners. in Commonwealth Department of Health and Family Services. *General Practice in Australia: 1996.* Australian Government Printing Service, 28. Policy changes by both Labor and Liberal governments since 1994 have decreased further the capacity of general practice to act as an 'safety valve' for medical graduates not accepted into other graduate training programs, by limiting the number of training places in general practice and, since 1996, by restricting right of independent practice to doctors who are undertaking an approved training

industrial arena. Australian general practitioners are represented by a number of organisations in the political realm, of which two are most significant for the period covered in this chapter.[11] Traditionally the AMA has represented both general practitioners and medical specialists to government on workforce, employment, and economic issues. The RACGP, which organises and supervises graduate training, is responsible for the graduate examination for entrance to general practice, and controls the continuing education program, has been responsible for professional standards. Clearly, there are areas of overlap but, until relatively recently, general practitioners have allowed the AMA to negotiate on their behalf on industrial and political issues, and the RACGP to represent them on educational issues. However, significant differences of opinion between the AMA and the RACGP emerged during 1988 and 1989 over the introduction of the reforms concerning the general practitioner fees, continuing education and vocational registration arrangements cited above.[12] It was fuelled by general practitioner dissatisfaction with the way the AMA represented them politically. By 1989 the RACGP was emerging as such an independent political voice that all major general practice initiatives since this time have involved tripartite negotiations between the AMA, RACGP and the Commonwealth government, even when they relate to essentially industrial issues.[13] The RACGP's gains in the political arena have not been accompanied by any loss of control over educational issues and professional standards. Rather, the transformation of the College's fellowship examination into a barrier examination for entrance to independent general practice, and its control of the continuing education program that maintains the general practitioner's vocational registration, have helped it to consolidate its position as a key voice on professional issues, particularly those which relate to professional standards, and the knowledge, skills and attitudes required for good general practice.

To summarise up to this point, the period between 1972 and 1983, while turbulent for Australian health care generally, was relatively quiet for general practice. The Medibank and Medicare insurance changes did put general practitioners on a secure economic footing, and doctors' historic opposition to insurance weakened to the extent that they gave up active

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program or who have qualified for entry to one of the medical colleges.

[11] A number of other organisations have played more minor roles. These include the Australian Association of Academic General Practitioners (AAAGP), the Rural Doctors Association (RDA), and the Divisions of General Practice. Academic general practitioners tend also to play a significant role in the RACGP, gaining a voice in that forum. The RDA deals with rural issues, and it has focused specifically on the needs of rural general practitioners. The Divisions have only existed in Australia since 1992, and they were largely unknown when I conducted my interviews. See Chapter Five and Pegram R, Sprogis A & Buckpitt J. 1995 Divisions of general practice: A status review. *Australian Health Review* 18: 78-94 for a brief discussion of the emergence of Divisions of General Practice.

[12] Backhouse, *Medical Knowledge, Medical Power*.... Chapter 5 analyses the GP fees reform package and documents the emergence of "deep divisions between GP and specialist groups within the AMA and between the AMA and the Royal Australian College of General Practitioners" (281).

[13] See, for example, the document: General Practice Consultative Committee. 1992 *The Future of General Practice: A Strategy for the Nineties and Beyond.* Australian Medical Association, Department of Health, Housing and Community Services and Royal Australian College of General Practitioners.

opposition and gave their support, if somewhat begrudgingly, to it. The period beginning 1985 marks a point in time at which changes to general practice that influence the nature of the work and the self image of the profession, begin to be mooted and the general practice voice is more clearly enunciated. By 1985 a general practice voice with a clearly defined sense of its nature and identity was beginning to emerge. The changes to the funding of general practice in 1989 indicate that that voice had become effective.

The period from 1990 to 1997 has been a time of further rapid change for general practice.[14] In 1991, the Commonwealth Government announced an 'Agenda for General Practice' which included practice grants and a compulsory co-payment by the patient for general practice consultations. There was considerable resistance to the proposals from many sectors. Both general practitioners and specialists were active in their opposition to the practice grants, seeing them as the beginning of a slippery slope to the introduction of a nationalised health service. Considerable opposition from the left of the Labor Party, principally to the compulsory co-payment, forced a review of the proposals and, finally, a decision to drop the co-payment. At the same time, the AMA and RACGP were discussing a range of initiatives[15] and a number of papers floated ideas for reform[16].

The General Practice Strategy, introduced in 1992, reflected discussions between the AMA, the RACGP and the Commonwealth Government on issues concerning workforce, standards and quality in general practice. These discussions culminated in 1992 in the sentinel document, *The Future of General Practice: A Strategy for the Nineties and Beyond.* The program of reforms implemented on the basis of that document, the General Practice Strategy, has injected up to $250m per year into general practice programs and projects. One of the initiatives mooted in the strategy, Divisions of General Practice (geographically based networks of general practitioners) has begun to have some impact on the involvement of general practitioners in health planning, health promotion beyond the consulting room, the integration of general practice services with services provided by hospitals and other health professionals, and the income sources of general practitioners. The programs funded under the General Practice Strategy therefore have the potential to change the way in which general practice defines itself and the way in which it carries out its work. However, at the time I interviewed the general practitioners for the empirical part of this thesis, the implementation of the General

[14] Knight R & Northrop M. 1996 Introduction: An overview of General Practice in Australia: 1996. in Commonwealth Department of Health and Family Services. *General Practice in Australia: 1996.* Australian Government Printing Service, xxxi.
[15] Pegram, Sprogis & Buckpitt, Divisions of general practice: A status review..., 78-94 (79).
[16] Douglas RM & Saltman DC. 1991 *W(h)ither Australian General Practice?* Issue paper no 1, National Centre for Epidemiology and Population Health, Australian National University; and National Health Strategy. 1992 *The Future of General Practice.* National Health Strategy Issues Paper no. 3, Australian Government Printing Service.

Practice Strategy was only just beginning, and its existence was largely unacknowledged by general practitioners who had not been directly involved in negotiating the reforms or participating in early trials.

Major sources for Chapter Five

Chapter Five uses primary source material written mainly by general practitioners as the basis for analysis. The description of general practice developed from these sources is refracted against what is known from published data about the general practice workforce. There are a number of ways to approach the questions posed at the beginning of Chapter Five - What does it mean to be a general practitioner? What is general practice? - of which the use of documentary sources is only one. Other possibilities are to approach key leaders in the field or to conduct empirical research of one's own. The published materials about general practice included in Chapter Five focus on the public voice of the profession (through documents from the RACGP) and the views of general practice leaders (through their textbooks or published articles).

It is possible to argue that drawing primarily on professional literature to develop an analysis of the nature of general practice presents a one-sided account, because it ignores the voices of consumers of general practice services. However, the omission is not an absolute one. A number of the reports referred to, particularly those from government sources, draw on consumer perspectives, despite the relatively small literature that does focus on consumer views about general practice.[17] In addition, the main purpose of Chapter Five is to provide the background for accounts later in the thesis of how both the professional self-image of general practice and the organisation and structure of general practice work influence the way in which the GPs I interviewed dealt with ethical problems. There is considerable evidence that, until quite recently, consumers' views about the medical profession in Australia and the services it provides have had very little impact on the organisation and delivery of medical services.[18] They have been allowed an even lesser role in the self-definition of general practice.

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[17] For a discussion of consumer perspectives on general practice in Australia, the reader is referred to: Broom DH. 1991 *Speaking for Themselves: Consumer Issues in the Restructuring of General Practice.* Discussion Paper no.4, National Centre for Epidemiology and Population Health, Australian National University; and Jolley GM. 1995 *Obtaining Consumer Views on Primary and Community-Based Health Care Services: A Literature Review.* South Australian Community Health Research Unit.
There is very little available in an Australian context which attempts to set the relations between consumers and general practice in an intellectual context. Newell C. 1996 *Quality and Ethics for GPs and Consumers with Disabilities: A Pilot Study.* Monographs in Community Health No. 1, Division of Community and Rural Health, University of Tasmania, is a significant exception.

[18] See, for example, the Committee of Inquiry into Medical Education and the Medical Workforce. 1988 *Australian Medical Education and Workforce into the 21st Century.* Australian Government Printing Service (informally known as the Doherty Report) which received submissions from a large number of

Two groups of primary sources have been used to develop this analysis.[19] First, Chapter Five uses papers, reports and documents prepared by the RACGP between 1985 and 1993, particularly those which relate to the definition and nature of general practice work. In some ways, the RACGP was a natural choice because it was the vehicle through which I contacted the GPs whom I interviewed. In addition, it has already been noted that the RACGP emerged early in this period as the major voice for general practice in Australia, combining an educational and standards accent with an increasingly confident industrial accent. It is therefore an excellent professional source of material that documents the way in which Australian general practice defines and understands itself.

Second, the analysis makes use of two key general practice textbooks. The RACGP does not "set" a text in general practice for its registrars. Rather, it provides some photocopied articles, and recommends two textbooks.[20] John Murtagh's *General Practice*[21] is frequently purchased by general practice registrars because of its comprehensive coverage of medical topics. It is not the preferred choice of RACGP educators, by whom it is regarded as rather 'conservative', but it has two features important to this chapter. It is the only Australian text on general practice available, and it is the one book with material on the definition and content of general practice that is likely to be found on an 'average' general practitioner's shelf.[22] The second text, Ian McWhinney's *A Textbook of Family Medicine,* is regarded by Australian general practice educators as the seminal text on general practice.[23] McWhinney's work has probably been less influential with 'average' general practitioners than it has been with RACGP staff and academic general practitioners. Nonetheless, it figures significantly in the model of general practice that both groups propose to registrars and in their commentary about the philosophy of general practice.

Chapter Five also draws on a range of secondary sources, principally in the form of key reports on the status of general practice in Australia, published over the last ten years. These

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consumer groups.

[19] Materials from other sources are quoted; frequently they relate to the main sources identified here.

[20] The main journal paper recommended is Stott NCH & Davis RH. 1979 The exceptional potential in each primary care consultation. *Journal of the Royal College of General Practitioners* 29: 201-205.

[21] Murtagh J. 1994 *General Practice.* McGraw-Hill, was published in 1994 (and a second edition in 1998), and represents the culmination of a large body of articles and papers Murtagh published from about 1981. A Medline search indicated that, between 1981 and 1996, John Murtagh had published, either solely or jointly, 241 papers in medical journals of Australian origin. A large proportion of these papers appeared in the *Australian Family Physician*, the journal of the RACGP. The content of the papers is similar to the content of *General Practice*, reflecting Murtagh's interest in both the medical aspects of general practice and its conceptual basis.

[22] Personal communication, Lorraine Ruthborn, Medical Educator, RACGP (SA).

[23] McWhinney I. 1989 *A Textbook of Family Medicine.* Oxford University Press. McWhinney's other text (1981), *An Introduction to Family Medicine*, covers a similar terrain. A second edition of *A Textbook of Family Medicine* was published in 1997 and it contains revisions to the material on the philosophy and

reports provide quantitative data related to the general practice workforce.[24] Chief of these is the Australian Commonwealth Department of Health and Family Services publication, *General Practice in Australia: 1996*. This publication came at the end of four years of funding under the General Practice Strategy and was intended to "review the current state of knowledge of general practice" in Australia, providing a "'snapshot' taken at a time of major change in general practice".[25] *General Practice in Australia: 1996* provides the best source of data for the period when the GPs who took part in this study were interviewed, and its authorship reflects both general practice and bureaucratic commentary on the changes in general practice. Of the twenty-six authors of ten chapters in *General Practice in Australia: 1996,* thirteen are general practice academics, and six are health bureaucrats from the General Practice Branch in the Commonwealth Department of Health and Family Services. (The other seven are a mixed bag of non-general practice university academics, consumers, lawyers and area health service officers.)

The National Health Strategy Issues Paper *The Future of General Practice* is a second useful source of quantitative data.[26] This report, one of a series of reports on directions for public health policy in Australia, attempts to place general practice in a broader public health context. It is much less an 'insider's' account of general practice than the other reports cited.

Other reports also provide relevant material. In 1988 the South Australian Health Commission, RACGP (SA) and AMA (SA) jointly sponsored a survey of all general practitioners in South Australia, as part of its review of general medical practice in South Australia.[27] Of the 1232 general practitioners practising in South Australia at the time, 78% completed a questionnaire which asked about socio-demographic and practice characteristics, workload, remuneration, qualifications, services provided and preferred, job satisfaction, and perceptions of the general practitioner role and the state of the health system. The report of the survey attempts only in a very limited way to evaluate the extent to which the general practitioners who responded to the survey were representative of the whole population of general practitioners in South Australia. Nonetheless, it is particularly relevant because it provides local material from the same population as yielded the GP interview participants in this thesis.

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nature of general practice.

[24] The Report of the Inquiry into Medical Education and the Medical Workforce also canvassed a wide range of issues relevant to general practice. I have excluded it from this analysis because its brief was rather wider.

[25] Commonwealth Department of Health and Family Services. 1996 *General Practice in Australia 1996.* Australian Government Printing Service, xix and xxiv.

[26] National Health Strategy, *The Future of General Practice...*

[27] SAHC, AMA (SA) & RACGP (SA), *Review of General Medical Practice in South Australia. First Report...*

The Australian Treatment and Morbidity Survey is widely quoted as an important source of quantitative data on both the general practice workforce and the problems encountered and treated in general practice. The survey has been conducted three times since 1962-3. The most recent survey collected details of all surgery consultations and home visits provided by 495 doctors over two one-week periods during 1990 and 1991.[28]

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[28] Bridges-Webb C *et al.* 1992 Morbidity and treatment in general practice in Australia. 1990-1991 *Medical Journal of Australia* 157: Supplement, and Britt H *et al.* 1993 A comparison of country and metropolitan general practice. *Medical Journal of Australia* 159: Supplement.

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