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General practitioners face ethico-legal problems too!

Len Doyal,^{1,2} Lesley Doyal,³ Daniel Sokol⁴

Much of the orthodox literature on medical ethics and law emphasises hospital care. This is because many of the classic dilemmas chosen for analysis are drawn from acute medicine in a secondary care setting. Do patients have the right to refuse life saving treatment? In the face of scarcity in intensive care, who should be treated and for what reason? Should adolescent young women be allowed to have abortions without parental consent? In what circumstances should life sustaining treatment be withdrawn? The list goes on. One might infer from this focus on secondary care that primary care clinicians face fewer and less interesting dilemmas and, indeed, have an easier moral and legal time of it. In fact, there are good arguments to the contrary.^{1,2} It is these quandaries, and the personal demands that they make on general practitioners (GPs), that is the topic for this issue's section on ethics and law.

A "SLICE OF TIME"

While the drama and stress of ethico-legal dilemmas in acute care should not be underestimated, they occur in what might be called a "slice of time". To use the jargon of linguistics, they are synchronic. Within a hospital, doctors and patients are usually strangers who will rarely meet again outside the context of outpatient follow-up. Even then patients may not see the same doctors. This has important implications for the ethico-legal texture of associated interactions.

For example, patients who refuse life sustaining treatment—or any other treatments deemed to be in their best clinical interest—may be a source of regret for clinicians. However, the clinicians know that in respecting the patient's right to refuse, they may not personally witness the patient's physical decline. The patient may become someone else's responsibility. Equally, contact with the relatives of patients in hospital also occurs in a slice of time and

with similar consequences. For example, in a variety of different clinical circumstances, relatives may make unreasonable demands for confidential information and, when these demands are rightly refused, they may become distressed and angry. Again, any negative feelings that such demands might pose for clinicians will be reduced by their knowledge that they will have limited or no future contact with those who make them.

This temporality means that we need to be careful about assuming that hospital doctors face more difficult and stressful ethico-legal dilemmas than general practitioners. Indeed, just the opposite can be argued and for three reasons. First, GPs do not treat patients in a slice of time. They provide care over a much longer period; sometimes for the duration of patients' lives (it is a diachronic encounter, rather than a synchronic one). This means that they cannot presume that their contact with patients and the dilemmas that emerge will cease after only a few consultations. Patients will return for consultation time and time again, perhaps wishing to revisit ethico-legal issues first raised in hospital. Second, GPs are family doctors. Whether in the short, medium or long term, they must attempt to serve the interests of related patients who may sometimes have conflicting demands and interests. Third, primary care can be a much more solitary activity where there may be little time or opportunity for professional feedback and reinforcement. Much decision making in hospitals is collective and the byproduct of repeated discussion and debate at management and multidisciplinary meetings, ward rounds and other venues. Practice meetings among GPs, on the other hand, focus more on organisational and business issues than clinical or ethico-legal uncertainties.

STRONGER SENSE OF PARTNERSHIP

The dilemmas posed by long term relationships with patients are clear. For example, we have seen that if a hospital patient who is a stranger refuses life saving or other treatment, their right to do so should usually be acknowledged; they will depart and perhaps not be seen again. GPs have no

such luxury and often have a stronger sense of partnership and even emotional attachment with the patients in their care. Thus in this richer emotional and narrative environment, they may well wish to resist a patient's refusal of treatment advice (for example, as regards not taking insulin, improperly using inhalers, or refusing to stop smoking). Indeed they may wish to do so in ways that would be deemed inappropriate in much orthodox ethico-legal discussions of consent. For example, they might remind a patient that they have repeatedly warned him or her of the dangers of their actions and that there is little point in future consultation on such matters if he or she continues to ignore this advice. This is not to suggest that primary carers should ignore the right of their patients to refuse such treatment. It is to argue that what might be interpreted as unacceptable coercion by a hospital doctor might be regarded as constructive and honest advice by a GP. Within primary care, the line between the two is blurred.

Situations can get even more complex when the family dimension of primary care is brought into play. Family members may clash over clinical matters and GPs may find themselves in the middle of the conflict. For example, a wife may want contraceptive medication without her husband's knowledge. As a result the husband may get depressed at his apparent inability to have children. The parents of an adolescent young woman may discover that their daughter was prescribed birth control medication without their knowledge. An apparently loving husband may visit the doctor to discuss the fact that his wife is not taking prescribed antidepressant medication and is suffering as a consequence. A belligerent wife demands to know whether or not the GP is aware of any illness affecting her husband that may be due to alcohol abuse or sexual infidelity. A husband may phone the GP surgery and ask whether or not his wife has made an appointment for that afternoon to see the doctor. Of course, there is no suggestion here that ethico-legal principles (in this case that of confidentiality) are fundamentally different in primary care or do not need to be followed. Yet they can be much more difficult to manage and can cause considerable confusion and stress among family doctors.

GREATER ETHICO-LEGAL PROBLEMS WITHIN PRIMARY CARE

These illustrations demonstrate why the depth, breadth and uncertainty of ethico-legal problems within primary care are greater than widely believed. Unlike their

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colleagues in hospitals, GPs are often left to deal with them alone. The same problems apply to the diagnosis, treatment and referral of clinical issues. Of course, lack of collaboration should not be exaggerated. GPs will have partners and other colleagues with whom to discuss difficult cases and dilemmas. As regards ethico-legal issues, they will also have their insurance companies and, if members of the British Medical Association (BMA), the excellent ethics department of the BMA from which to seek advice. However, unlike hospital medicine, there is nothing institutionalised about the collective process of decision making within primary care. This, along with large patient loads, can make effective debate and discussion with colleagues difficult. At times, such heavy individual

responsibility for decision making results in emotional problems and other personal hardships. This is why it perhaps takes a person with a special kind of moral character to have a successful and fulfilled life in primary care. As William Osler put it, "The practice of medicine is a calling in which your heart will be exercised equally with your head".³

In this issue (*see page 399*), Peter Toon explores these problems in further detail, particularly the types of pressures under which GPs have to work, the personal attributes that are associated with success, and how best to help doctors who for whatever reason lack these attributes.⁴ We hope that Dr Toon's paper will generate further discussion among readers, especially his conception of the "virtuous" practitioner. We would especially like to hear

from GPs willing to share experiences of some of the difficulties they face which, in their view, their hospital colleagues do not.

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