Original Research Paper

Ethical dimensions of New Zealand rural general practice

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ABSTRACT
There is little empirical research in the extant literature describing the ethical issues arising in rural general practice. This paper presents a qualitative exploration of such issues in New Zealand rural general practice. Two major dimensions were identified relating to boundaries and resources.
Boundary issues included: patient confidentiality, intrusiveness, friendships, treating family members, self-prescription, intimate relationships with patients, and the use of chaperones. Resource issues included the restricted choice of health providers, difficulty in accessing hospital services, payment for services, locums and on call work. These defining ethical dimensions of rural medical practice, and the consequences for both doctor and patient, warrant wider appreciation.

INTRODUCTION and AIMS
Medical ethics has concentrated mainly on tertiary health-care issues and has largely ignored general practice. Where general practice has been examined there has been little attempt made to distinguish the ethical issues arising out of rural rather than urban practice. The aim of this study, therefore, was firstly to identify the breadth of ethical issues confronting rural GPs (RGPs), to develop a schema or taxonomy of rural ethics. Having developed this, an attempt was made to link this taxonomy to the most influential factors arising from the general structure of rural practice. The more immediate purpose was to aid in the construction of undergraduate and postgraduate courses in rural general practice, but the results potentially have a wider application.

METHOD
A qualitative study using face-to-face, semistructured interviews with validation via focus group audioconferences was used. Ethical approval

KEY POINTS

- Ethical dimensions related to boundary and resource issues are not exclusive to rural general practice, but the unique features of the rural situation brings these into prominence
- Boundary issues include patient confidentiality, intrusiveness, friendships, treating family members, self-prescription, intimate relationships with patients, and the use of chaperones
- Resource issues include the restricted choice of health providers, difficulty in accessing hospital services, payment for

for the study was obtained from the Department of General Practice as per the protocol of the University of Otago's Ethics Committee. Sixty-four New Zealand RGPs were selected randomly from a departmental database and invited by letter to participate. Some 35 responses were received (55 per cent response rate) and 11 RGPs were selected to be interviewed on the basis of geographical location, which allowed all interviewees to be reached in a single four-day trip (consequently all interviewees resided in the South Island). Sixteen RGPs were invited to participate in the audioconferences.

The interview structure was based initially on the responses of an earlier quantitative survey of GPs enrolled in the postgraduate Masters of General Practice (MGP) programme identifying their learning needs.1 Isolation was measured using the draft "Rural Ranking Scale".2 Further details of the interview structure are available on request.

Data from the transcripts were analysed by both study authors using an "editing analysis" style.3 Coding categories were revised throughout this process as new units of information appeared and the transcripts were re-examined to verify the categories.

Data analysis was performed independently by the two study authors and results compared. Two audioconferences were conducted to triangulate and validate the results. (The results of these audio conferences did not differ significantly from the interviews.)

services, locums and on call work
- An appreciation of the importance of these issues for rural GPs is essential when constructing teaching programmes in ethics
- Further study is warranted, including quantitative research to determine the frequency of these issues
- More importantly, rural medical ethics needs to be investigated from the patient's perspective

The 11 RGPs interviewed appeared to be broadly representative of rural general practice. They were between 32 and 50 years old (average 41 years). Eight were male and 10 were married. Medical qualifications had been obtained in New Zealand (six), the UK (three) or South Africa (two). The average time since graduation was 17 years (range of five to 27 years) and the average time spent as a rural GP (including outside New Zealand) was 17 years (range of one to 24 years). Nine RGPs shared practices, five with two other RGPs, four with one other RGP. One interviewee worked solo (in a town with other RGP) and one worked as a locum.

Average road travelling time to the nearest major urban hospital was 78 minutes (range of 30–150 minutes). Average road travelling time to the RGP's most distant practice boundary was 62 minutes (range 30–90 minutes). Average on call requirement was 1:4 (range 1:2–1:6). Eight RGPs were also on call for major trauma. One RGP conducted peripheral clinics.

RESULTS

Two major ethical dimensions were identified: boundary issues and resource issues. Boundary issues included: patient confidentiality, intrusiveness, friendships, treating family members, self-prescription, intimate relationships with patients, and the use of chaperones.

Resource issues included the restricted choice of health providers, difficulty in accessing hospital services, payment for services, locums, and on call work.

Boundary issues

RGPs struggled with a variety of boundary issues related to living and working in identical communities:

"You're so part of the community, sometimes it's so hard not to transgress

as far as privacy is concerned, because everybody – they may love or hate each other – is like one family."

The complexity of this was readily apparent, eg, maintaining patient confidentiality was difficult but necessary to avoid becoming embroiled in disputes between community members. Friends and relatives of staff could be reluctant to discuss sensitive topics in a consultation, frightened another staff member may read it. Patients were known to avoid one practice (not in this study) altogether because of concerns regarding practice staff's ability to handle sensitive patient information. However, RGPs' families could be privy to patient information by fielding phone calls from patients, particularly when the RGP was on call elsewhere at night.

Sometimes family members overheard telephone conversations at the family home between the RGP and a patient. Furthermore, the absence of nearby medical professionals meant RGPs may confide in their own spouses or partners:

"Should everyone expect you to be a closed box about it all? I don't think any GP would be... I say it's just about impossible not to talk about work at all when you're at home."

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RGPs could be blamed if information about a patient's medical condition became known in the community, even if the information did not originate from them. Conversely, one RGP was more confidential regarding patients who were also family friends, explaining that his wife was unaware a friend was pregnant until halfway through the pregnancy. In one case, a RGP informed her patients about her spouse's illness without seeking his prior consent:

"I decided [against] pretending in a situation where there was nothing wrong, where there was obviously lots wrong…I didn't even consult [husband]. He was struggling in his way and I was struggling in mine."

Intrusiveness on the RGPs' lives could occur with inappropriate requests for consultations when not on call or in the practice (eg, in social situations). Requests for help could be inappropriately demanded by the volunteer ambulance service. One RGP reported that some community members had assumed he was conducting an affair with a patient because of repeated housecalls.

Intrusiveness could be felt, particularly by spouses, although this interest could also be positive:

"The other side of the coin is that if my wife has a miscarriage, then for the next week I don't have to cook because everybody brings food, and everybody walks in if they can help."

Responses by RGPs to intrusiveness included imagining or actually shifting practice, behaving "above reproach", avoiding community involvement outside work (and having no friends in the community), living out of town, and not disclosing their occupation in social situations. The price was a strong sense of isolation.

Particular difficulties could arise when treating friends. Friends could request treatment at inappropriate times. Other difficulties included non-payment of after-hours consultations by friends, patients withdrawing from their friendship if treated for a sensitive medical condition, and RGPs being uncomfortable performing intimate examinations on friends.

RGPs could attend major trauma involving friends. The emotional cost of this could be high, but not as high as the cost of treating family members:

"I remember when my little boy…had a nasty gash across his forehead…The anaesthetic went in and he was in pain, and he started pleading with me, saying 'Dad – this hurts!'. And his mother, who was my receptionist, she's holding his hand and she starts to crack up. And you just feel the 'mask': this is not my boy, I can't feel his pain, and I have to stitch this. I find it difficult

to express emotion now. I wish I could. I worry about when my patients die, whether I'll be able to grieve, or whether I'll be helping the rest of the family cope. Because that's all I've ever done for the last 20 years, helping other people cope with their problems and kind of deny my own."
However, never treating family members was seen as unduly restrictive and/or unrealistic in certain circumstances, eg, when the RGP was on call or the next nearest doctor was a considerable distance away. Self-prescription was viewed as a regrettable necessity in similar circumstances, although usually limited to minor drugs.

The potential for inappropriate doctor–patient relationships, including sexualisation, was recognised by all participants. RGPs avoided such intimacy by exercising particular caution with some woman patients, telling flirting patients their actions were inappropriate, using chaperones, and not granting special favours to patients with the "potential to be a problem".
It was suggested there should be better identification of doctors liable to encounter such problems, both at medical school and when assigning doctors to rural practice positions.
There were sharply divided opinions among RGPs on the merits of the "zero tolerance" policy of the New Zealand Medical Council.

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Eight RGPs disagreed with the policy, identifying circumstances in which relationships may be permissible. These included minimal professional involvement prior to the relationship (eg, few consultations, only treating "trivial" conditions, never performing intimate examinations, no gynaecological or psychiatric treatment), initiating the relationship outside of the practice, and getting the other partner to attend another RGPs for all/more serious medical conditions. Strict adherence to zero tolerance might also discourage single doctors from rural general practice.

Resource issues
Resources are broadly interpreted here to include time, energy and personnel as well as financial elements and health-care infrastructure. RGPs recognised that resources for patients were diminished due to reduced choice of practitioner. A dispute could result in a patient not seeking treatment from any doctor in that practice because of perceived collusion between staff or perceived inadequacies in other partners. Gender issues could arise if female patients preferred a female RGP when only male RGPs were available.
Patients could face significant travelling times to urban-based hospitals. The governmental limitation of certain medicines as "hospitals only" further inconvenienced patients. Weather hazards occasionally presented a difficulty for patients requiring hospital treatment. The newly introduced booking system had not improved access. The closure of rural hospitals has had variable effects. Rural practice was very sensitive to any reduction in hospital services: the loss of even one specialist could greatly decrease rural patients' access to services.
RGP responses to these issues included: delaying transferring a patient; performing minor surgical procedures, usually the province of hospitals; and being more involved in treating chronic serious conditions.
Emergency service personnel were volunteers and there was a reluctance to overuse the service, since volunteers needed to be called away from their jobs for most of the day if a patient required transport to hospital from his/her area.
Specific areas of unpaid or inadequately paid work for RGPs included resolving family disputes, arranging nursing care, working with ambulance

services, obstetrics and travelling time. However, RGPs felt obliged to carry on performing those tasks.
Other resource issues, such as locums and on call conditions, were crucial issues which were not being adequately addressed. Anxiety over many of these issues had led to the imminent resignation of one participant.

'All the time I've been anxious about what's happening on the political front. It's really just worn me out.'

"All the time I've been anxious about what's been happening on the political front. It's really just worn me out. …I've had the neatest patients in the world and I've really, really loved my job and I would really like to stay here. But I cannot stay in general practice when I am going to be paid bonuses to undertreat my patients and penalties if I don't."

DISCUSSION
Several authors have emphasised the relational aspect of general practice, an aspect which is different (some would argue unique) to general practice. In medicine, this emphasis on the relation of the doctor and his/her patient is apparent in the general practice-led move towards "patient-centred medicine" which requires addressing both the patient's and the doctor's agenda in an appropriate context or relation.4
In ethics, this relational aspect is a key part of the "narrative ethics" framework of analysis, where the specific context of an ethical dilemma (including the relationships of those involved) must be considered in order to reach the best solution.5 Such attention to the context (termed "conversation") may well be particularly apt to ethical problem-solving in general practice.6
Brody goes further and argues that such a "relational ethic" distinguishes general practice from hospital-based medicine and hospital-based ethics where a "decisional ethic" is paramount.7

This study revealed that resource issues involve far more than simple monetary considerations

If it is true that general practice is characterised by this relational ethic, then it is not surprising that the ethically correct maintenance of relationships – boundary issues – features so prominently as a topic of interest. Equally, the prominence of resource issues again is not surprising as resources (or the lack of them) readily impinge on the doctor–patient relationship. This study revealed that resource issues involve far more than simple monetary considerations. Such dimensions must be considered when constructing a just and fair distribution of health resources within rural medicine.
In so far that this study pertains to the teaching of ethics at both the undergraduate and postgraduate level, several comments can be made. Firstly, the curriculum content. Traditionally, ethics teaching programmes (and the whole field of bioethics) have been largely based on hospital medicine and life-and-death cases; its relevancy to general practice overall, and rural medicine in particular, is questionable.7-9
Issues such as the withholding or withdrawing of therapy, or informed consent were barely raised in this study, whereas issues such as community intrusiveness on the GP's life (an unlikely situation for a hospital-based consultant) were discussed at length. For an ethics programme to be relevant for rural general practice, whether undergraduate or postgraduate, there must be a shift away from the traditional ethics content into those areas most pertinent and real to the lives of practising rural GPs.
Secondly, the mode of ethical analysis has to be appropriate to rural general practice. The application of depersonalised and abstract ethical principles, without addressing the context of the situation, appears particularly inappropriate for an area of medicine characterised by a naturally rich and

complex involvement with one's patients. The addition of a narrative ethics framework, with its emphasis on context, to any ethical analysis (which may still include the use of principles) would be most apt.
Thirdly, the process of education would have to take into account the isolation of rural GPs and the constraints on their time and energy. Whatever methods were chosen, they would need to be "user-friendly", easily accessible and adequately resourced.
Other resource issues, such as the provision of locums to allow attendance at educational meetings, also need to be addressed, primarily at a national (government) level. Without this, education in ethics will be limited in its ability to reach the rural GP community, regardless of any chosen method.

CONCLUSION
The ethical dimensions raised in this study – boundary and resource issues – are not exclusive to rural general practice. However, the unique features of the rural situation brings these into prominence. An appreciation of the importance of these issues for rural GPs is essential when constructing teaching programmes in ethics. Further study is warranted, including quantitative research to determine the frequency of these issues but, more importantly, to investigate rural medical ethics from the patient's perspective, an area of descriptive ethics even less researched than the medical perspective of this report.

Acknowledgements: Dr Jones was supported by a summer studentship in health sciences education from the Division of Health Sciences, University of Otago. The authors also wish to thank Drs Kath Ryan and Martin London for their assistance, and to gratefully acknowledge the GPs who participated in this study.
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