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ORIGINAL RESEARCH

A NEED ASSESSMENT OF ETHICS COURSE FOR PRIMARY CARE PHYSICIAN: PHYSICIANS' PERSPECTIVE IN YOGYAKARTA PROVINCE, INDONESIA

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ABSTRACT

Background: Primary care physicians, as first-line doctors, deal with ethical cases that challenge them to make the best patient decisions. Helping primary care physicians to be more aware of ethical cases and the process of case decision-making will improve all stakeholder's needs. Physician standard opinion on the best decision for their patient will be the baseline of suited training for them.

Methods: We conducted a mixed-method study to understand GP decisions regarding certain ethical cases. In the quantitative phase, we used and presented several standardized ethical cases with several "decisive" options followed by reason. For qualitative, in-depth guided interview was done with several physicians. The data was analyzed by close system coding.

Results: We gained 36 responses from several physicians with 12 in-depth interviews. In the quantitative, we found that two questions related to communicating the mistake and the rural problem had the worst response, showed by highly unfavourable answers. The interview found that most physicians find it hard to decide on ethical cases, acknowledge religion as one aspect for making the decision, and expect a clear guideline that will help them make a firm decision regarding "difficult" dilemma cases.

Conclusion: To avoid bad decision-making in ethical-related cases, the physician must take another training since low awareness of ethical cases will lead to unfavourable decisions regarding some dilemmas. Considering the methods and number of subjects in this research, the training should apply a specific strategy to all physicians.

Keywords: ethical cases; decision making; physician; primary care

ABSTRAK

Latar belakang: *Seorang dokter layanan primer menghadapi sebuah kasus dilema etika yang menantang kemampuan dokter layanan primer dalam menganalisis dan memutuskan aksi yang terbaik bagi pasiennya. Pengambilan keputusan yang baik terhadap kasus - kasus tersebut akan meningkatkan kepuasan seluruh pemangku kebijakan dalam sektor medis. Kepekaan dokter terkait dan pengetahuan dalam pengambilan keputusan menjadi sebuah dasar dari sebuah training yang tepat bagi dokter layanan primer.*

Metode: *Peneliti melakukan sebuah penelitian campuran untuk mengetahui pengambilan keputusan oleh dokter layanan primer terkait kasus etika. Pada fase kuantitatif, peneliti menggunakan dan menyajikan beberapa kasus etika dengan jawaban terstandarisasi dengan beberapa opsi keputusan yang disertai dengan*

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pertanyaan alasan dari keputusan tersebut. Untuk fase kualitatif, peneliti melakukan wawancara mendalam dengan sebuah panduan dan menganalisis hasil dengan sistem koding tertutup.
Hasil: *Tiga puluh enam dokter dengan dua belas diantaranya bersedia untuk diwawancarai. Dari fase kuantitatif, dua pertanyaan terkait dengan komunikasi kesalahan dan permasalan rural memiliki lebih banyak respon kurang tepat dibandingkan pertanyaan yang lain. Dari wawancara yang dilakukan oleh peneliti, diketahui bahwa sebagian besar dokter kesulitan dalam pengambilan keputusan, mengenali agama sebagai salah satu cara untuk pengambilan keputusan, dan berharap adanya panduan yang jelas untuk membantu dalam pengambilan keputusan.*
Kesimpulan: *Dalam rangka menghindari pengambilan keputusan yang buruk terkait dengan kasus - kasus etika, seorang dokter membutuhkan sebuah panduan atau bahkan pelatihan karena dengan rendahnya kesadaran adanya muatan etika pada kasus yang dihadapinya akan menyebabkan pengambilan keputusan yang tidak tepat. Mempertimbangkan kelemahan dari penelitian ini, sebuah strategi pelatihan harus didesain secara spesifik yang diharapkan dapat memfasilitasi seluruh dokter layanan primer.*

Kata kunci: *spiritualitas, resiliensi, depresi, mahasiswa kedokteran*

PRACTICE POINTS

- The decision-making process regarding frequent ethical dilemmas faced by a physician will depend on the physician's view and his/her sensitivity related to the ethical issue within the case and their knowledge on how to make a good decision for ethical related cases.
- How to decide a decision and act for ethical-related cases has several considerations, such as context - including culture and the ethical decision-making framework.
- There are several ethical decision-making frameworks which could be applied but four principles of ethics (autonomy, beneficence, maleficence, and justice) are the most common framework for the decision-making process.
- A good decision for ethical-related cases should consider the whole aspect of a good decision-making process which, in turn, will positively impact all stakeholders involved in the healthcare service system.

INTRODUCTION

Most primary care physicians work in the front line of the health care system, whether in emergency settings or daily outpatients, either with acute or chronic cases. They face clinical cases with usual and non-usual patterns, either as individual or community cases. All of those brings consequences to primary care physician in dealing with specific ethics-related cases. Furthermore, unlike hospital physicians, primary care doctors do not have ethical boards that could provide consultation.[1]

When dealing with specific ethics-related cases, the primary care physician's perspective on cases will determine how they will react, think, and respond with the best decision for the patient. Dealing with such grey cases, not live death cases, make physician hardly perceive cases as ethical-related cases. A study of physicians' perspectives on ethics-related

cases in the UK showed that most ethical cases are perceived as pragmatic, not dramatic, and centre on patients' self-determination, adequacy of care, professional responsibility, and distribution of resources.[2] Another study in the US also mentioned that contraception, telling patients about the truth, pain control, sexual issues, informed consent, confidentiality, patients' rights, and controlling patients' behaviour with medication are ethics-related issues.[3] However, those perceived as ethical cases change with the times and setting and are bound by applied regulation. As shown by two previous articles, different context gives a different view of primary care perspectives on ethics-related cases.[2,3] Furthermore, there is a qualitative study on what is perceived as ethical cases within primary care as a team, which it is now; primary care services are more integrated and complex with several health workers.[4]

Deciding on ethics-related cases and making the best decision for the patients will make primary care physician use enormous effort since perceiving a clinical case as an ethics-related case need additional step before jumping to think about the best decision. The best option for the case also needs careful thought by using several ethical principles. Deontology, utilitarianism, the four principles of ethics, and the virtue of ethics are commonly used in analyzing ethics-related cases.[5] In primary care settings, casuistry, modified casuistry - the four boxes, feminist ethics/ethics of care, moral rules, and narrative ethics are commonly used in analyzing ethics-related cases within primary care settings.[6] While the four principles of ethics (maleficence, beneficence, autonomy, and justice) are the most used approach in analyzing ethics-related cases, but not being used as an applicable decision-making process since there is no behavioural model to frame the cases.[7] DeMarco, 2005[8] proposed the mutual principle as a new approach to analyzing ethics-related cases. In contemporary ethics, it is also proposed to use religion as a decision-making process.[9] Regardless of the approach in analyzing the ethics-related cases, a primary care physician should have virtue ethics to handle and react appropriately to daily ethics-related cases.[10,11] Therefore, ethics education should be embedded as early as possible within medical education until continuing education.[12] Nevertheless, any physician could use a guideline in deciding such ethics-related cases. An example of a guideline in deciding ethics-related cases was presented.[13]

Decisions in ethics-related cases need the physician's ability to make good decisions for each case. Before they get able to decide, it starts with the physician's ability to recognize the cases, whether it is part of ethics-related cases or purely clinical cases, which does not need additional steps to give the best decision for the patients[1]. This recognition will vary among physician, related to their background and contextual bounds.[14,15,16,17] A study in business mentions that nationality, age, religion, sex, education, employment, and personality affect how people decide ethics. In medicine, Wong et al. 2004[10] with Q methodology in care of life decision making, mentioned that the first influential thing in ethical decision making is bio-ethical values and personal traits of the physician. How a physician deals with and decides within cases often stands to patients' focus beneficence, family focus beneficence, and less frequently, to patients' best interest. As for how physician stands on the beneficence of patients or patients' family trait, this would be applied differently for each ethical case. Therefore, (Wood and colleagues, 2018)[18] proposed a four-step model of the ethical decision-making process for general practitioners that implies the need for advanced physician training.

Ethical cases might not be considered as ethical cases by a physician. Contextual and setting are bounded by physicians' perspectives on cases. Recognizing and deciding on ethical cases could be frustrating for a physician. Facing such a dilemma would require advanced training for physicians. This study seeks primary data on physicians' ability to deal with such ethical cases in the Indonesian context.

METHODS

We used a mixed-method approach to embrace the data. The quantitative part used a Google form distributed by the WhatsApp application and an informed consent form using the Jot form

application. At the end of the Google form, we ask respondents' willingness and availability for in-depth interviews for the qualitative part. The researcher will follow up the form with a direct message. This study has been reviewed and approved by the ethical board of FKKMK UGM with serial letter No KE/FK/0435/EC/2020.

The quantitative part of this research was aimed at knowing the physician's decision with its' ethical consideration in several presented cases. We used several ethical cases presented on the official online web with standardized answers. We choose common thematic ethical cases such as communicating mistakes, medical representatives, facing patients' requests, placebo, and rural.[19,20,21,22,23] We provided several alternate logical answers to be chosen by the physician and asked their reason for choosing such an answer.

The qualitative part of this research aims to explore "real" cases related to ethics or having ethical consideration and how the physician decide on those cases. An in-depth interview was done using specific guidelines that the expert in ethics validated. The researcher asked about the setting where the physician works, common/usual faced clinical cases, their opinion on ethical cases (what was called ethical cases), and how they would decide regarding the cases.

RESULTS AND DISCUSSION

We collected 21 responses from 369 physicians who work in the Yogyakarta province area, which consisted of 7 female physicians and 14 male physicians. Nine have 5-10 years of experience, 6 have 10 - 15 years of experience, and 6 have more than 15 years of experience in practice. From 21 responses, only 12 respondents were willing to have an interview with the researcher. The interview was held for around 30 - 60 minutes. Most of them work in public and private primary care services with and without emergency service, one with a specific community (academia), one with traditional health care service, one with advanced care (e.g. HIV care), and one in rural settings.

Quantitative part

Among the five themes of cases we provided, we received a different response, and none of the cases shows a 100 per cent right decision. Two of the five presented themes, communicating a mistake and rural, had the most unfavourable responses regarding the correct answer/standard.

The participants were predominantly urban physicians with various specific contexts. Only several of them represented the rural physician without constraints in giving health care services. The common cases faced by primary care doctors were still perceived as a balance between communicable and non-communicable diseases. The most frequent non-communicable diseases were hypertension, diabetes mellitus, chronic degenerative diseases such as fibromyalgia (muscle problems), heart disease, and mental diseases such as depression, anxiety, psychosomatic disease - gastritis followed by communicable disease, upper respiratory infection. However, we got physicians with advanced healthcare cases like HIV and/or TB without complications. The physicians already charged those primary clinical cases through the national health assurance coverage system's management system.

Qualitative part

As also stated by the previous study, this research also revealed that the encountered ethical cases related to physicians' working context. The most prevalent ethical cases were related to internal conflict within family and community, followed by patients' autonomy and confidentiality, assurance, and services. Within the conflict of family and community, the physician also faced a dilemma sourced from social problems. Related to assurance, physicians faced patients as assurance recipients who had misbehaved regarding assurance, such as asking for unnecessary referrals, unnecessary treatment, or even unnecessary medical action. On the other hand, the physician should tell the patients about assurance limitation that is felt hard. The physician also felt that the system was not good since they could not give loop feedback to secondary service

regarding certain cases. At the same time, patients' autonomy and confidentiality were closely related to specific cases such as HIV and underage patients. Only several ethical problems related to services represent a conflict between physicians' private or interest with patients' interests.

We found several ethics-related cases in Primary Care were mostly related to dilemmas as part of their role within the community.

> *"related to HIV cases, sometimes we had difficulties whenever we were going to follow up the patients in the community, we had to ask something, but then it became complicated if the patient was within our (clinic) neighborhood…."*
>
> *"We should trace at the school if we found a TB case moreover died because of TB. This complicated the situation because we dealt with students' mental conditions…..He/she could be shunned by his/her friends, which would be difficult for her/him since they were in a transitional phase in junior high school; also, he/she should adapt to new school hood but maintain a distance from his/her friends…."*
>
> *"it is when we brought patients to our specific consultation room for sexually transmitted disease/post-traumatic for domestic violence/ mental problem, I have just realized whether it endangered patients' confidentiality because if their neighbour or someone familiar with the patient saw it, what it would be…."*

Most of the dilemmas were related to sensitive cases with a strong "stigma" in the community. Dealing with such dilemmas would be a challenge for Primary care physicians since it could worsen the effect of the stigma on the patients that, in the end, could disrupt patients' mental managed care. From an ethical point of view, most cases are related to patients' confidentiality. Furthermore, a physician also senses dilemma within their social relationship aspect that deals with vulnerable communities with mental cases and HIV.

> *"is when a severe mental illness was asked to home by him/her self…"*
>
> *"it is when I collaborate with NGO, and I see a child almost sold by a pimp…."*
>
> *"When I faced an HIV patient who had ARV side effect…or when I had an ex-prostitute who is an HIV patient become a health cadre…"*

Not only externally with their community, but most physicians were also challenged by internally driven cases they faced within clinical services. Several physicians experienced and sensed dilemmas while they worked in clinics.

> *"if we had cases that involved a couple, we should inform the other partner, but we often get difficulty since the other partner never came together with the patients…we do not know their status. I frequently asked the one who took the patients, but it seems whenever we tried, he/she never told the truth…"*
>
> *"it was when HIV patients refused to permit us to access their partner because they were afraid that information about his/her disease spread…"*
>
> *"it was when we should ask parents' consent for our patients and our students.."*

The physician felt a dilemma regarding patients' autonomy and confidentiality. The aim was preventing the spread of the disease versus with patients' confidentiality or facing the under aged patients. Besides that, the physicians also find hard cases which challenge them to fight for the sake of the best for the patients.

> *"it is when the patients find it hard to accept our explanation…" or*
>
> *"it is when the guardian of the patients cannot accept his/her child's condition, accuse the wrong diagnosis…."*
>
> *"it is when a schizophrenia case rejected to swallow the drugs because of its side effect, sleepiness.."*
>
> *"when I faced a patient who did not commit their miss sexual behaviour.."*

Besides that, the physicians also sense the dilemma whenever they face conflict with patients or conflict within the patients' families. Thus, it brought difficulty to the physician since sometimes it was a life conflict that was not understandable by the physician yet. It brought the physician into the middle of the conflicts and was threatened by patients' distrust.

"it is when I faced elderly patients, and I often had to face the conflict within the family, could be with spouse, children….sometime they just pull through patients daily life that actually, might be hidden away by the patients…usually it leads to prolonged conflict between them. That made me uncomfortable since I saw the signal that they expected me to solve it….that out of my boundaries…."

"it is when we faced schizophrenia cases without family support…." or

"it is when we face schizophrenia cases that spouse rejects…" or

"it is when I face a childbearing woman suddenly ask us to abort her pregnancy….she could give rational reasons, things that make me understand her condition and make me hard to decide…."

"it was when I faced a sensitive child case that needs to interfere, parents, intervention to reveal the problems…. and I should maintain the secret, but in another way, I should inform the parents, conflicting, since with little mistake, I could lose my patients' trust…"

"it is when I faced a sensitive child case, I suggested the child tell the story to their parents.."

"it is when I faced parents who are too dominant to their child, sometimes I see the child get depressed…"

Regarding assurance, the physician faced several dilemmas regarding their limitation over the need to refer the patients or their abuse of referral service. All of those cases sometimes caused the physician to face hatred from the community since the patients blame the physician for the perceived under-standard health service.

"it is when I should refer the patients to the hospital, but I cannot since all hospital conceal their bed condition, especially in this COVID-19 condition…. "

"is when the first time the implementation of universal health assurance, only certain cases could be referred, sometimes the patient's complaints about that, they feel that we were the one who complicates the situation …"

"it is when we had haemorrhoid cases who asked for a direct referral to the hospitals."

"when the patients were angry since we cannot refer them, they reported to the media…"

"it is when I had to face a degenerative disease that still could be managed in a primary care setting, but then the patients ask for referral…"

"it is when a hypertension patient asked for steroid drugs…"

On a daily basis, the physician also had several little dilemmas brought by the service, like whether he should share his number to get the case follow-up or manage the long queue of patients' encounters while having limited time and finding that gossiping is one of the coping mechanisms. Thus, the case triggered the physician's personal values.

"is when I gave my WA number for follow-up consultation…"

"when I had so many patients' queues, make the patients' encounter and counselling shorten.."

"it is when I know the gossiping behaviour of the patients becoming their coping mechanism of stress.."

All of those dilemmas would depend on the physician's working context. A primary physician with clinical care with advanced services such as HIV care or a teacher with the students in an academic clinic would have a more prevalent ethical dilemma.

Regarding those ethical cases, several physician perspectives were captured, such as the acknowledgement of patient-centred care, patients' rights within patient-centred care, consequential obligation from patient-centred care, acknowledgement of being part of the assurance system, and acknowledgement of part of the community. While facing those cases, they felt confused, worry-concerned, incompetent, afraid, angry, and pissed off whenever they realized and faced ethical cases. Those perspectives and emotions led to how physicians act during their patient encounters.

"I feel confused, facing a suicide case…"

"I feel confused when trapped in between conflicted person.."

"I feel sorry if the patient self hurt aggressively…"

"I worry whenever the patient seeks another way to abort her baby.."

"I feel afraid since I had to face cold gaze as part of suicide attempt…"

"I feel incompetent in dealing with abortion case since I did not have the solution for her problem…"

"I feel annoyed to a patient who "ngeyel" (grumbling to refuse the doctor's advice).."

"I feel pissed off with the assurance, and sometimes the patients need the service but out of their pledge…."

Those emotions could influence how a physician will think the best decision would be taken. We also revealed some physician perspectives regarding their dilemma, such as socially constructed rights between physicians and patients, their awareness of community-sourced conflict, and uncertainty within the "new" unstable assurance system.

Regarding physicians' emotions and perspectives on their ethics-related cases, we revealed how physicians decide and act upon them. They try to do several actions such as referring if they do not understand the case very well, explaining - communicating more, even more with tenderness, controlling their emotion, consult-convey-deliver the decision to upper/supervisor or other stakeholders, giving feedback in junior-senior cases, and silence/ ignorance.

"refer if I still doubt the diagnosis…"

"refer if I cannot handle the case…"

"Even if I was emotionally driven, I should be able to mute my emotion…"

"explain national assurance coverage…"

"explain our consideration in choosing certain drugs…"

"explain the indication of using certain drugs.."

"convey the complaints to the head of primary health care unit…"

"deliver the problem to the head of the primary health care unit and ask for the solution.."

"give direct feedback if faced, junior.."

"Fortunately, I am rather ignorant….since we work in a team, sometimes the patients are angry with us, but actually it was not our fault.."

"...sometimes we lie (white lie) to the patients…"

"just silenced, let patients go.…since I assessed the patient was in still in good condition…"

In sum, how physicians think and decide on ethics-related cases far from the ideal construction of such ethical dilemmas. In the quantitative phase, from five representative thematic ethical cases in primary care services: placebo, rural, facing patients' request, medical representative, and communicating a mistake, two themes had an unfavourable dominant response, which means there is a chance one from five physicians will have wronged decision and action upon the ethic related cases. In the qualitative phase, we found that how physicians act upon ethic-related cases controlled emotion to be more confirming and explaining, giving feedback especially for close related junior, silence - ignorance, consulting to the supervisor or other stakeholders, and sometimes referring to secondary services. All those resolving actions were responses to ethical themes such as autonomy and confidentiality, family conflict, community-social problems, assurance and services. Those do not represent all ethical cases that could happen in a primary care service setting.

Consequently, there is more chance of different action from physicians regarding ethical cases. Based on the physician's action, regarding their correct perspective and value, it could be concluded that the physician was in line with their perspective and value, which stands on patients' or family's rights and interests. However, in this study, silence or ignorance was taken as physician action regarding certain ethical cases, which is caused by the physician's judgement on the unnecessary intervention in a conflicted role situation. Furthermore, it was also captured that feedback was only given to closely related juniors. This condition also emphasizes that culture influences how the

physician acts upon certain conditions. Ultimately, it shows the importance of guidelines or training for the physician in order to deal with ethical cases.

They understand that ethical cases in Primary care are based on context and urge for guidance in deciding the best action/decision in every context and case.10 Therefore, they ask the module/training to be simple, interesting, based on equity between doctors and patients relationship, have clear guidelines (a step-by-step decision-making process, with evidence from the other physician on real cases (focusing more on community), and if possible, integrated with religious value.

Some input was gained regarding expected training or modules such as simple - easy to digest, interesting, clear in guiding thought to the action, focusing more on cases related to primary care setting (community, rural, certain population), and acknowledged with the other physician. Those could be facilitated by presenting several ethical decision-making principles: deontology, utilitarianism, four principles of ethics, the virtue of ethics, casuistry, modified casuistry (the four boxes), feminist ethics/ethics of care, moral rules, and narrative ethics. If those felt overwhelming, it might be helpful to use the proposed model from Woods and colleagues to simplify it into a four-step model for the ethical decision-making process[18]. Interestingly, the module was also requested to be embedded with religious values. This condition emphasizes that the physician acknowledged religious value as part of contemporary moral reasoning.[9] Therefore, an agreement on the ethical decision-making process should be achieved.

However, this finding is based on a specific physician community, which might not represent the whole Indonesian primary care physician. Consequently, this study might not cover several different settings with their specific ethical-related cases. Moreover, how the physician decides ethics-related cases will be based on their sensitivity to the moral dilemma in clinical cases. This study did not specifically focus on assessing sensitivity, which could be assessed using several valid and reliable tools. In guiding the physician to make a good decision, several frameworks should be chosen as the main guideline to make a good decision and acknowledged by all physicians

CONCLUSION

The ethical cases would depend on the service setting and item of provided service within the primary care context. As also previously found, ethical cases were faced by the physician that might be realized or not by the physician. In this study, the physician's action or decision regarding ethical cases aligns with their perspective and emotion. It already impresses the principles of ethics decision-making - based application for the patients' and family's rights and interests. However, all of those action were not yet proven consistent. Therefore, a module or training or a clear guideline regarding certain cases should be conducted to strengthen physician thought and action regarding ethics-related cases.

RECOMMENDATION

This study is limited to a certain physician community with qualitative. There should be further research with a larger scope to ensure the physician's sensitivity and how they make a decision regarding ethics-related cases. Primary care physicians need robust guidelines to make the best decision regarding ethics-related cases. It might also be not only a guideline but also a serial training. There are various ethical cases that could cause primary care physicians to jump into a confusing state and lead to the worst decision-making process because of their unstable emotions. Consequently, a primary care physician should have good emotional management ability and clear step-by-step guidelines for ethics-related cases in their decision-making strategies and conclusions. As also found by this research, religion could be one of those applied frameworks for ethical decision-making. Still, it should be based on firm religions' recommendations with a clear reasoning process.

COMPETING INTEREST

There is no conflict of interest from all authors. We hope this will strengthen primary care physicians in dealing with ethics-related cases.

AUTHORS' CONTRIBUTION

Hikmawati Nurokhmanti – developing research proposal, collecting data, data analysis, and publication manuscript.

Adi Heru – developing research proposal and collecting data.

Hari Kusnanto Joseph – developing research proposal and collecting data.

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