Whose autonomy? Which choice?  
A study of GPs’ attitudes towards patient autonomy in the management of low back pain  
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**Background.** Respect for patient autonomy is an important ethical principle for medical practitioners; however, previous investigators have reported inconsistent attitudes amongst practitioners towards respect for patient autonomy. This study in empirical ethics used qualitative methods to investigate GPs’ attitudes towards respect for patient autonomy in consultations for low back pain.

**Objectives.** The aim of this study was to explore GPs’ attitudes towards respect for patient autonomy by analysing attitudes towards four issues in the management of low back pain which raise ethical and practical dilemmas.

**Methods.** Participants were 21 GPs selected from general practice in South Australia by stratified, purposive sampling aimed at maximizing diversity. Semi-structured interviews were tape-recorded, transcribed and analysed using codes developed from the transcripts, with additional theoretical codes. In the analysis, attitudes towards patient autonomy in the four issues were characterized as autonomy-respecting, intermediate or controlling.

**Results.** The results showed individual inconsistencies in GPs’ attitudes towards respect for patient autonomy. For example, the majority of GPs accepted patient autonomy in the use of complementary therapies, but were controlling with regard to the use of analgesics. Attitudes to duration of time off work were spread evenly, whilst controlling attitudes towards use of X-rays were modified by patient requests for X-rays.

**Conclusions.** These results suggest that GP attitudes towards patient autonomy are modified by ethical and pragmatic factors, and vary depending upon the nature of the issue in question.

**Keywords.** Decision making, ethics, general practice, GP attitudes, patient autonomy.

Introduction

Respect for patient autonomy is one of the cornerstones of contemporary medical ethics, and an important principle for medical practitioners. However, previous investigators have shown that GPs are inconsistent in their attitudes towards this principle. There may be several reasons, both ethical and pragmatic, why this is so. Respect for patient autonomy is not the only significant ethical obligation; preventing harm, acting for the good of the patient and issues of justice (resource allocation) are also important. Balancing these potentially competing principles may explain some of this apparent inconsistency. In addition, the decision-making process, through which respect for the patient’s autonomy may be demonstrated, is complex in general practice. Many factors, including the context of the consultation, the nature of the GP–patient relationship, the presence or absence of evidence or clinical guidelines and the quality of GP–patient communication, may all impact upon GPs’ respect for patient autonomy in making decisions about management. Empirical research has much to offer here; by opening actual practice to ethical scrutiny, it is possible to describe and investigate previously unreported aspects of practice, test the utility of ethical theory and evaluate the moral adequacy of medical practice.

The aim of this study in empirical ethics was to explore GPs’ attitudes towards respect for patient autonomy by using an ethical framework to analyse attitudes towards four issues which commonly occur in the management of low back pain. These issues were: use of narcotic analgesia;
use of plain X-rays; use of complementary therapies (especially chiropractic treatment); and duration of medically certified time off work. These issues raise considerations of harm prevention, the patients’ best interests and justice, thus providing valuable insights into the way these and other factors influence GPs’ attitudes towards respect for patient autonomy.

Methods

This study was part of a larger project. Ethics approval for the study was granted by the Social and Behavioural Ethics Committee of Flinders University. The methods are reported in greater detail elsewhere.9

Sampling

The participants were selected by stratified, purposive sampling from a master list of ~400 GPs working in the area covered by the Southern Division of General Practice in South Australia. The sampling strata, designed to maximize diversity amongst GPs interviewed, included gender, age, years since registration, practice location (urban or rural), practice size and number of sessions worked per week.10 Randomly selected GPs within each stratum were contacted to participate in the study. The final sample comprised 21 GPs, 10 female and 11 male, ranging in age from 28 to 70 years. These GPs had between 2 and 46 years’ experience in general practice and were located in a variety of practice arrangements (see Table 1).

Interviews

Semi-structured interviews, performed by the author and audio-taped, asked participants to describe a recent consultation for low back pain.11 The interview explored four specific issues arising in the management of low back pain (narcotic analgesia, use of X-rays, complementary therapy and certified time off work) as well as sources of knowledge, expertise, acting for the good of the patient and aspects of decision making in the consultation. The data relating to beneficence are reported elsewhere.9

Analysis

Tape-recordings of the interviews were transcribed and entered into a computer software program (NUDIST) for analysis.12 All participants were assigned code names to preserve anonymity. Emerging themes were developed into categories using codes derived both theoretically and from close textual analysis.10,13

In the study reported here, GPs’ attitudes towards patient involvement in and control over decisions
about the four low back pain issues were characterized as autonomy-respecting, intermediate or controlling. Autonomy-respecting decisions were decisions in which GPs reported that they would have a positive attitude towards patients exercising freedom of choice, whilst controlling were those decisions where GPs reported that they did not allow or encourage patient autonomy.

Results and discussion

The results indicated variability between practitioners in their attitudes towards respect for patient autonomy. In addition, most of the GPs were not consistent in their attitudes, in that respect for patient autonomy for one issue did not extend to all issues.

Figure 1 shows the response of each GP to the four issues. Two of the 21 GPs demonstrated a consistent controlling attitude across the four issues. No GPs were consistently autonomy-respecting for all issues.

The majority of GPs demonstrated issue-specific responses, with use of alternative therapies eliciting mainly autonomy-respecting responses, and use of narcotic analgesia eliciting controlling responses (see Fig. 2).

**Narcotic analgesia**

The most consistent responses occurred regarding the use of narcotic analgesia for pain management, with the majority of participants indicating that this is an area where it is not appropriate for patients to have control over decision making. The reasons for this revolved around avoiding the biomedical harms of addiction or medication abuse, and complying with legal prohibitions against the illicit use of narcotic drugs:

> “Well, I tell patients of the dangers of using those, such medications inappropriately. I tell them the situations where I think those medications are appropriate and safely used. I tell them what I think the safe alternatives are and if I am unable to agree upon a plan which I think is safe and medically appropriate, then I will . . . refuse to provide further prescriptions of drugs that I think are being abused or causing harm.” (Dr Gloria)

“I (t) was that women who said, ‘If I’ve got the pain, well it’s my right to take morphine if I’ve got the pain,’ and I said, ‘Well look, you know, you may see that, but it’s my right as a prescriber to refuse to prescribe if I see it as not helping you’.” (Dr Harold)

Interestingly, the single GP who expressed being comfortable with patients determining their own requirements for narcotic analgesics had himself experienced severe back pain which had influenced his subsequent management of low back pain:

> “It doesn’t worry me too much. I have got one woman who has had a complete spinal fusion practically . . . She’s on methadone; I have no problem with that at all. If I had that I would want to be on methadone too . . . I think you just have to put yourself in their condition and not get too stuck about the thing’s addictive. Alright it’s addictive, so what?” (Dr Edward)

Prima facie, preventing harm (such as addiction) to patients is an important ethical principle. In addition, patients with drug dependency problems often present with low back pain as a way of accessing narcotic analgesics. However, pain is a very personal experience, and it is odd to think that another person can judge the severity of pain more correctly, and so what level of analgesia is appropriate, than the person who is experiencing it.
Prescribing medication is an activity limited to registered medical practitioners, making it a core part of the GP’s role. This may explain in part a reluctance to share control over this decision. In addition, there are deeply ingrained professional norms governing attitudes towards prescription of narcotic analgesics, with strong social and sometimes legal sanctions against GPs who are seen as indiscriminate suppliers of narcotics. The fear of being seen by one’s peers as a ‘bad doctor’ may at times outweigh a realistic appraisal of a particular patient’s analgesic needs.

Use of X-rays
Most GPs had quite clear views on the lack of utility of plain X-rays in the early diagnosis and investigation of low back pain. At the time of the study, there were no nationally accepted guidelines for the management of low back pain; however, the existing evidence consistently recommended against X-rays.14,15 GPs used a number of strategies to dissuade patients from seeking X-rays, including mentioning the danger from exposure to radiation and also the monetary cost involved in obtaining X-rays:

“[I’ll say to them,] ‘You know, X-rays cost money and it’s going to cost you money and it’s going to cost the government money, and if we don’t need it at this stage maybe we put it on hold for the time being’, and I try and play it down a little bit because it’s not going to pick up any musculoskeletal problem, you know, it’s just a waste of time and effort and money to them.” (Dr Yvonne)

A subgroup of controlling GPs, well aware of the lack of proven utility, would order X-rays “if the patient really insisted”, as a manoeuvre to gain time, to be seen to be doing something or because, if they did not order it, the patient might go to another more compliant GP, to the financial detriment of the first GP.

A number of GPs felt that the potential harm from radiation and the cost of X-rays were outweighed by the need to perform an X-ray if this was seen to be important for the well-being of the patient. These GPs discussed the importance of material evidence such as an X-ray in contributing to patients’ recovery, and the reassurance of a normal X-ray:

“I wouldn’t actively try and dissuade somebody from an investigation if it seemed to me that, that it was important for them to know that there was nothing wrong in their bones.” (Dr Anne)

Like prescribing narcotics, ordering X-rays is an activity limited to medical practitioners but, unlike the attitudes discussed above, attitudes to respecting patient autonomy in decisions about X-rays did not reflect a strong commitment to prevent or minimize harm. Yet there are harms from performing X-rays, including radiation damage, as well as creating anxiety in patients who take common age-related changes (not relevant in the pathogenesis of low back pain) as signs of permanent damage. Why would these harms not count? There are a number of conflicting factors here. There are no strong professional or legal sanctions against unnecessary X-rays, making it easier for GPs to meet patient demand in this area. Some decisions were openly justified on expedient terms, such as ‘giving in’ to requests/demands for X-rays. Fear of losing the patient to another GP was mentioned as one reason for following patients’ choices. There is a risk here that it may be possible to rationalize medically unsound or financially self-interested decisions as autonomy-respecting decisions. This is particularly relevant under the fee for service structure of Australian general practice.

The issue of X-rays raises questions about the relationship between widely accepted evidence-based information and respect for patient autonomy. Despite the accepted evidence regarding the lack of utility of X-rays for low back pain, some of the GPs would order an X-ray because this was seen to be important for the well-being of the patient. Part of the problem may lie in attempting to reduce the value of an investigation such as an X-ray to that of diagnostic information, without considering the other values it may hold, such as a sign of validation, belief in the patient’s symptoms or a demonstration of the GP’s efforts to do something. These values are less tangible than the outcome measures usually employed in generating evidence-based guidelines, but may prove to be important factors influencing adherence to recommendations for use of X-rays in low back pain.16,17 The need for further research in this area has been well documented.18

The wider issues of resource allocation and cost to society of unnecessary X-rays were not raised as a relevant factor by the GPs in this study.

Complementary therapies
The use of complementary therapies does not require the involvement or support of GPs, as patients are free to seek treatments without the knowledge, co-operation or permission of their GPs. However, most of the GPs held definite views about the value or lack of value of complementary therapies. Notwithstanding these often strong opinions, most GPs did not see it as their role to comment upon or advise patients on the use of these therapies except in limited circumstances:

“(A)s long as it’s not harmful, I don’t care what they use . . . but if it’s harming the patient, if it’s costing the patient money and it’s mucking up their quality of life and they’re taking days, hours out of their days to go and do things, then I say, ‘No, it’s a waste of time’.” (Dr Chris)

The most common approach was a permissive or pragmatic one in which GPs stated that they would not usually initiate complementary therapy but, if the patient
wanted to use, for example, a chiropractor, then the GP would not interfere with that:

“And if they want to continue with the chiropractor treatment, and then I have no objections, if they feel that it’s helping. See, a lot of them feel that it’s helping and they want to keep going.” (Dr Paul)

Only one of the GPs in the study stated specifically that she would not work with a patient who was simultaneously receiving chiropractic treatment. Similarly, only one GP would really support, rather than just tolerate, the use of chiropractic treatment.

Complementary therapies are costly in various ways and often require a substantial commitment in terms of number of appointments and following various regimes. Yet most of these GPs did not consider these kind of harms to be their concern, rather this was an issue which the majority believed to be a legitimate area for respecting patient autonomy.

Professional attitudes towards complementary therapies may reflect both ignorance and dismissiveness, leading GPs to disclaim knowledge of and responsibility for patients’ involvement in these therapies, in a way that would not occur with medically sanctioned treatments such as physiotherapy.

Duration of time off work
This issue involves determining the length of medically certified time a person should have away from their usual job following an episode of low back pain. The situation may vary depending upon whether the back pain is considered to be work related, in which case the patient may receive treatment as part of worker’s compensation, or whether the injury is not work related, but impacts upon the person’s capacity to work, with subsequent financial implications. This is the area in which GP attitudes are most evenly divided between autonomy-respecting, intermediate and controlling. Autonomy-respecting GPs made comments such as:

“(W)hat I’ll often do is say, ‘Well what can you do?’ and then I’ll get a person to say what they can do.” (Dr Vincent)

GPs with an intermediate attitude towards patient autonomy described a joint process:

“So we sort of work that out together, you know, in terms of what I feel they can do and what they feel they can do. Sort of like a combination of things, their expectations and my assessment of their capabilities.” (Dr Tamara)

As with accounts of pain, GPs often had to accept patients’ statements about their incapacity to work, even if they did not believe them:

“Well this is a fellow who injured his back from memory, and we’ve spent, all of us . . . have spent ages with him pointing out that his back isn’t as bad as he thinks it is, but he insists he can’t work . . .” (Dr Paul)

GPs’ attitudes towards this issue were tempered by medical beliefs about the importance of early mobilization and return to work together with the difficulty of imposing their beliefs upon a patient who did not necessarily share them.

For some patients, an early return to work was crucial for financial reasons. GPs realized that the health of a person’s back was not the only consideration:

“Judging time off work I think is a very real problem, it’s really difficult to say well the person can go back to work. But I mean if they need the money they should be back there.” (Dr Queenie)

Writing a medical certificate, like writing a prescription, is a restricted activity, yet the GPs in the study did not express the kind of controlling attitude elicited by prescribing analgesics. This seemed to be the issue in which GPs were most prepared to attempt shared decision making.

These results are based upon GPs’ self-reported attitudes towards respect for patient autonomy. There may be little relationship between the attitudes reported here and GPs’ actual behaviour in the consultation. In addition, lack of self-awareness about consulting styles may lead GPs to believe in their own autonomy-respecting behaviours which do not translate to practice. GPs are often unaware of patients’ preferences, creating a major barrier to respect for autonomy.

The complexity of general practice consultations makes it difficult to isolate specific factors impacting upon GPs’ attitudes towards respect for patient autonomy in the consultation and, despite limiting the cases to uncomplicated low back pain, other issues such as co-morbidity, the doctor–patient relationship or time constraints upon the consultation may have influenced these accounts. Participation was voluntary and it is possible that GPs who chose to participate differ from those who refused.

Despite these limitations, the results support the findings of previous studies in reporting variations in GPs’ attitudes towards respect for patient autonomy. Some of the reasons for these inconsistencies were justified in ethical terms. In particular, avoiding harm (such as the danger of addiction) appeared to modify strongly GPs’ attitudes towards respect for patient autonomy. GPs appeared more willing to respect patients’ autonomy in areas which are somewhat removed from the medical sphere, such as complementary therapy. However, for some GPs, ethical considerations were influenced by concerns about legal aspects, expediency and self-interested factors.

This study complements existing empirical research relating to ethics and general practice. Unlike previous research in this area, the use of qualitative rather than
quantitative methods has allowed mapping of the ethical terrain and detailed exploration of ethical reasoning which is not otherwise accessible. This kind of research can strengthen the discipline of medical ethics by demonstrating the limits of theory and by focusing debates upon practical concerns, as well as contributing to improvements in clinical practice.

Conclusion

Respect for patient autonomy is, rightly, an ideal of medical practice, providing the moral justification for many aspects of general practice care. In practice, investigating attitudes towards respect for autonomy raises a number of questions about the legitimate limits of medical responsibility and of patient demands, and the strength of professional beliefs. We need thoughtful debate about these issues in order to develop a robust and practically useful understanding of respect for patient autonomy in general practice.

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References