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ABSTRACT

This paper uses the case of solo doctors to explore whether working in relative isolation from one's peers may be detrimental to ethical decision-making. Drawing upon the relevance of communication and interaction for ethical decision-making in the ethical theories of Habermas, Mead and Gadamer, it is argued that doctors benefit from ethical discussion with their peers and that solo practice may make this more difficult. The paper identifies a paucity of empirical research related to solo practice and ethics but draws upon more general medical ethics research and a study that identified ethical isolation among community pharmacists to support the theoretical claims made. The paper concludes by using the literary analogy of Soderberg's Doctor Glas to illustrate the issues raised and how ethical decision-making in relative isolation may be problematical.

The ethical problems and attendant decision-making of doctors has come under more scrutiny than perhaps any other healthcare profession. Both normative and empirical approaches have been undertaken, to provide ethical guidance, to clarify ethical problems, and indicate how doctors try to resolve ethical problems in their work. However, there have been few attempts to explore ethical issues in the context of some specific areas of medical work, and that of solo or single-handed doctors is one such neglected area. Solo doctors are those who work alone and not as part of a group practice and are usually associated with medical work in the non-hospital setting. The aim in this paper is to explore concerns that solo medical practice and particularly doctors' relative isolation from their peers is a barrier to effective ethical decision-making. This will be done by drawing upon the importance of communication and interaction in several influential ethical theories, as well as the findings of a number of relevant empirical studies. In particular, the identification by Cooper *et al*[1] of ethical isolation among community pharmacists will be used to develop this claim. Before doing so, further background to solo medical practice is first provided, to indicate general patterns and concerns that have emerged in the literature and also to clarify what is understood by the isolation of solo doctors.

Patterns of solo medical practice vary considerably throughout the world. In countries such as Germany, Japan[2] and Belgium,[3] the majority of doctors work in solo practice, and in America approximately a third of family doctors adopt such working practices.[4] Factors such as rurality also contribute to a higher incidence of solo practice.[5] In other countries, such as the UK, there has been a steady decline in solo practice over the last half century, with approximately 6% now working in solo practice.[6] This has led commentators to suggest that solo general practitioner (GP) practice may be "dying out"[7] and "facing extinction",[8] and a range of factors have been attributed to this trend. These have included improved working arrangements in group practice such as holidays, part-time work and session hours,[3] governmental policy changes[8 9] and the development of health centres.[10] Solo medical practice has also been compared with group practice using variables such as clinical skills, prescribing patterns, continuing education, patient satisfaction and quality of care. In some studies, solo practice resulted in clinical measures that were comparable with group practice[11] but there has been an overriding concern that solo practice may have an adverse effect upon clinical performance.[12–15]

Sociological investigation of solo practice has suggested that it may represent an ideal, if anachronistic, model of practice, embodying a sense of community values while being unwilling to undertake new initiatives,[7] and one that, despite being from the "vestiges of all earlier time", retained an intimate biography of individual patients.[10] Commenting on American medical practice, Freidson[16] identified concerns relating to solo practice, noting that it may be an environment in which the beneficial influence of other doctors is lacking and bad practices could go unchecked.

In terms of medical ethical problems and decision-making, solo practice has not been the explicit focus of study. However, solo doctors have been included in more general studies and their practices indirectly reported. Hoffmaster *et al*[17] found solo practice to be a statistically significant practice variable in only one of six hypothetical scenarios that sought to evaluate patient autonomy or welfare value preferences. Qualitative studies have revealed some concerns relating to isolation, and Bremberg and Nilstun,[18] for example, identified frequent ethical tensions in GP practice among Swedish doctors, but although half reported regular contact with their peers at continuing education meetings, ethical issues were not frequently discussed. Moreover, solo practice appeared to be a factor in their study:

> Only a few GPs said that they had no colleagues at all to talk to or to discuss ethics issues with. They either worked in single practices or they lacked affinity to a colleague.[18]

References to peer interaction and solo practice have emerged occasionally, often framed in relation to clinical concerns. Kuyvenhoven *et al*,[19] for example, found that the practice setting and in particular solo practice had a negative influence upon peer interaction and quality of care among

GPs in The Netherlands. Solo doctors were significantly more likely to report no peer interaction, with 28% reporting no consultations with a colleague, in contrast to all of the GPs working with peers, who stated some degree of interaction. The Shipman affair in the UK, in which the serial killer doctor was found to have spent several years in solo practice, also led to concerns about isolation and solo practice in the subsequent inquiries:

> "single-handed practitioners tended to be isolated. This term connotes a lack of involvement with ones peers and a failure to keep up to date with current practice [and] common sense would indicate that the dangers of isolation were greater in single-handed than in group practice."[20]

Therefore, isolation and solo medical practice have emerged as possible concerns in a range of literature but without a specific focus upon ethics. Before going on to develop the argument that ethical decision-making may be affected by solo practice, and in doing so be drawing upon a number of theories that centralise the need for interaction and communication for ethics, it is necessary to clarify one further point. The isolation of solo medical practice is a relative and not complete isolation—in that some peer and much patient interaction and communication occurs—but that this is potentially less than doctors who work alongside their peers, and this is now considered.

THE RELATIVE ISOLATION OF SOLO DOCTORS

The title of "solo" or "single-handed" doctor is an apt description in some but not all ways. It conveys the working arrangement whereby such doctors do not enter into collaborations or group practices with other doctors, as others have documented.[16] However, this does not mean that they are by definition isolated or that they are geographically remote from others. For example, as the study by Kuyvenhoven *et al*[19] revealed, many solo GPs reported some degree of peer interaction. In the UK, it is possible for solo GPs to work in the same building as other doctors, but yet have separate patient lists, staff and facilities—Shipman's practice in Hyde, Manchester, was such an example. Other opportunities for interaction are possible, and social relationships, continuing education events and internet/video conferencing are all possible loci for interaction. Whereas these are argued to be possible, they may not be ideal opportunities for ethical[1 18] or indeed even clinical discussions.[16]

It should also be recognised that solo doctors interact frequently with the very objects of their work—patients—and so the isolation they are argued to experience is relative mainly to their medical peers and not patients. Solo doctors in England, for example, provide care for over 3 million patients (based on average patient per practitioner data).[6] As the ethical theories to be described in the next section indicate, the interaction of doctors with all relevant individuals, including patients, is key. The claim made in this paper, however, is that it is the relative lack of peer interaction and communication in relation to ethical issues and decision-making that may be lacking and thus problematical.

Before concluding this section, it should also be noted that doctors not in solo practice may yet feel isolated in their work; Geneau *et al*,[21] for example, reported that fee-for-service (FFS) doctors in their study may not interact with other doctors and could feel as if they were "solo in a group". What is argued is that solo practice is more likely to lead to ethical isolation by virtue of the organisation of such practice and this is now supported by considering the importance of communication and interaction in several normative theories.

ISOLATION AND ETHICAL DECISION-MAKING

The argument in this paper is that working in relative isolation of one's peers may be problematical for ethical decision-making, and the origins of this claim may be found in a study by Cooper *et al*,[1] who explored the ethical problems and decision-making of UK community pharmacists and identified ethical isolation. Although working in the community, the pharmacists were found to be isolated not only from their pharmacist peers (because UK pharmacies usually operate with only a single pharmacist present), but also other healthcare professionals and—somewhat paradoxically in the "community"—patients and customers due to increasing dispensing workloads and administrative duties as employees. Pharmacists were often aware of their isolation, and described being unable to talk to others about their ethical problems, or gain insights into other pharmacists' ethical problems and strategies for dealing with them. Cooper *et al*[1] then explored the importance of communicative acts to ethics and argued that Hambermas[22] and in particular his discourse on ethics was relevant. In this, Habermas sought to provide a modern account of Kant's deontological moral theory, but accommodating not merely universalised acceptance but rather universalised agreement between individuals that could be achieved only through communicative speech acts. Crucial to Habermas' theory is the need for interaction with others, both to engage in a dialectic process but also to reach an impartial judgement that incorporates the perspectives of all those involved. Discourse ethics thus involves agreement about the validity of norms that "meet (or could meet) with the approval of all affected in their capacity as participants in a practical discourse".[22] As Cooper *et al*[1] note, however, what is particularly relevant to healthcare professionals' isolation is that discourse ethics presupposes the inadequacy of individual decision-making. As Habermas states:

> "the justification of norms and commands requires that a real discourse be carried out and thus cannot occur in a strictly monological form, i.e., in the form of a hypothetical process of argumentation occurring in the individual mind."[22]

Therefore, contrary to Kant but perhaps still somewhat formally,[23] individual ethical decision-making can be seen to be insufficient according to Habermas, and the need to include the views and claims of others is fundamental. This is succinctly described by McCarthy,[24] who notes that:

> "This shifts the frame of reference from Kant's solitary, reflecting moral consciousness to the community of moral subjects in dialogue. Whether a norm is justifiable cannot be determined monologically, but only through a discursively testing its claim to fairness."[24]

Habermas' theory of discourse ethics draws not only upon Kant but more recent influences and concepts such the "ideal role taking" and "universal discourse" developed by the symbolic interactionist GH Mead.[25] Mead was also influenced by Kant and the principle of universalisation, but his social psychology was grounded primarily in the claim that individuals are entirely social in their existence and part of their development involves developing an understanding of self-identity. This process involves not only looking inwards—at the "I"—but crucially outwards, in terms of how others see them, as the "me". This can only come about through the interaction

of individuals with others and, in much the same way that Cooley[26] referred to the "looking glass self", individuals must communicate and interact with others, to gain an understanding of who they are. The relevance of Mead's sociological and philosophical theory to this paper, however, is more than as an influence upon Habermas but because, as Crossley[27] notes, it is also essentially moral. This is because, in viewing ourselves in terms of others and how they act or would act, we are inviting normative comparisons with others, and:

> "because we 'take the role of the other' (both specific and generalised) our actions have a moral flavour. We judge ourselves from the point of view of others and from the point of view of abstract norms."[27]

The link between Mead and ethical decision-making was also recognised by Schwalbe,[28] who argued that by adopting the views of others, individuals could better understand and accomplish moral problems solving. Schwalbe[28] also recognised that moral problem solving is a social activity, and suggested that:

> "if mutual support is lacking, groups and group members tend to produce poor solutions to moral problems"[28]

The importance of communication to ethics is not only limited to the theories of Habermas and Mead, however, and also emerges in the neglected ethical aspects of Gadamer's hermeneutic theory, for example, and has also been argued to be a component of contractarian theories, such as that of Rawls, when individuals participate in a process of reflective equilibrium.[29] For Widderhoven,[29] Gadamer's philosophical hermeneutics was relevant to the development of ethical theory within biomedicine, but he also recognised the practical ethical aspect of Gadamer's work and of the need to understand and seek out the views of others via communication, arguing that:

> "The way in which experienced people in daily life handle moral questions can guide ethics. For Gadamer, philosophy and ethics are dialogical, just as moral life is dialogical."[29]

In describing the centrality of communication and interaction in the aforementioned theories of Habermas' discourse ethics, Mead's interactionism and even Gadamer's hermeneutics, the ethical relevance of solo doctors' isolation becomes apparent. Although these theories are not explicit in referring to isolation, it is an implicit assumption in each of them that social interaction, communication and discussion should occur. It is argued that for solo doctors, such opportunities are not impossible but much more difficult in comparison with other forms of medical practice. So solo doctors' relative isolation may make it more difficult for them to communicate and interact with their peers, to gain an understanding of not only other doctors' viewpoints and values but also to challenge or confirm their ethical decision-making.

Although it was noted that Schwalbe[28] had described the need for support in moral decision-making, one initial point of clarification is that the benefits that doctors obtain from communicating and interacting with their peers does not necessarily amount to a shifting or displacement of ethical responsibility.[30] Such assistance may occur in other healthcare settings and has been considered in, for example, the formal involvement of philosophers in the clinical setting,[31] or the informal substituted or deferred decision-making that Cooper *et al*[32] identified in terms of pharmacists' subordination. Rather, it involves interaction that can benefit decision-making by providing additional insights in the main, allowing solo doctors to resolve an ethical problem themselves based upon the insights, reflections and arguments of other practitioners.

The benefits of such peer interaction have also been formally recognised in practical terms and a number of pragmatic, prescriptive models of ethical decision-making have been advanced that include specific reference to doctors' need to seek the views of others, including their medical peers. British Medical Association[33] guidance, for example, includes a stage that requires doctors to seek relevant information from patients and others, but the involvement of peers is seen most obviously in the discussion by Schneider and Snell[34] of teaching medical ethics and their development of a four-stage model. The last stage involved asking what has been the experience of others in the past when faced with similar medical situations and they recognised that:

> "Providers, medical students, and residents automatically look around to see what others are doing. If all else fails, many will just do what he/she has seen others do."[34]

To illustrate these theoretical concerns, an example is provided in the penultimate section of this paper, which illustrates how a doctor's relative isolation can lead to difficulties and ultimately harm in terms of ethical decision-making. That the example is neither theoretical nor empirical but literary in nature should not detract from its relevance because, as McLellan[35] has influentially argued, using examples of doctors in literature and the arts can offer important insights into actual practice. These could illustrate not only good practice but also poor, because:

> "the image of the physician may be a warning, with an insistence on the inextricable links between doing and being, between the private person and the professional role […] the fictional doctor may show us what we may become if we are not careful."[35]

DOCTOR GLAS

Doctor Glas is a family doctor in the eponymous novel by Soderberg[36] [i] working alone in practice in Sweden at the end of the 18th century. The story centres around an unfolding dilemma that began with the visit of a female patient, who confides to Doctor Glas that she is in an unhappy relationship with her husband, the local clergyman and also one of Glas's patients. Glas becomes increasingly convinced that he must intervene to spare his female patient any more suffering in a most dramatic way by giving the clergyman a fatal dose of medicine. The epistolary form of the novel reveals in Glas' diary entries his deliberations about this dilemma, and most clearly, the difficulties associated with making ethical decisions in isolation. Glas is all too aware of his own isolation, when he reflects that "I wish I had a friend to confide in. A friend to consult, but I have no-one"[36] and this isolation leads him to try to resolve the ethical dilemmas involving these two patients—one whom he wants to help, the other whom he feels he must kill to help the other—by an internal dialogue. What is apparent is the profound difficulty he experiences in trying to resolve his dilemma alone, and the following extract illustrates the almost rhetorical nature of this monological reasoning:

[i]The example of Soderberg's *Doctor Glas* was chosen particularly for its relevance because the central character is a family doctor working alone and thus represented a more fitting literary example than, say, Hesse's lonely eponymous character *Steppenwolf* or the moral agonising of Dostoyevsky's Raskolnikov in *Crime and Punishment*.

> ''So lets think:
> A woman comes to me in her hour of need and I promised to help her. What she requested of me was, after all, so simple and easy.
> […]
> ''First and foremost. Do I really seriously want to kill the clergyman?
> […]
> ''*Well then:* do you want to?
> I want to; and I don't want to.
> I hear conflicting voices. I must interrogate them; I must know why the one says: I want to, and the other: I don't want to.
> You first, who say 'I want to': why do you want to? Reply!
> —I want to act. Life is action, When I see something that makes me indignant, I want to intervene
> […]
> Morality, that's others' views of what is right. But what was here in question was my view. True, in many cases, perhaps the vast majority, and in those that occur most often, my view of what is right is in tolerable agreement with others', with 'morality''[36]

What resonates in the novel is not just the difficulty Glas experiences in trying to resolve the problem himself, but the debate about the relevance of other's views, or ''morality'' more generally. He refers to the values and duties of the medical profession and does appear to adopt some aspects of professional conduct, such as not performing abortions, for example.[ii] However, Glas appears to subvert professional values and there are crucial points in the novel when he finds justification for action in terms of professional values of helping others:

> ''You're a doctor. How many times haven't you uttered that expression: your duty as a doctor. Well, here it is now. Perfectly clear, I think. Your duty as a doctor is to help the person who can and should be helped, and cut away the rotting flesh which is spoiling the healthy.''[36]

At such moments, it is interesting to reflect upon what a medical peer would have made of such comments, and how such values were being used to support his planned act. There appears to be no moderation or discussion with others about his proposed action and although he does try to consider other ethical arguments, these are not informed by the insights of others, most particularly his peers. Indeed, on one of the few occasions that he considers his peers, this is done only to facilitate the reporting of a death.

CONCLUSIONS

The aim in this paper has been to argue that the relative isolation of solo doctors from their medical peers may be detrimental to ethical decision-making. It is hoped that this has been supported with reference to the relevant theory, empirical research and finally a literary analogy. It is recognised that such a conclusion may add further pressure to existing claims in countries such as the UK, for example, that solo medical practice should be replaced by group practice. However, this has not been the intention, and it must be stressed that the ethical relevance of isolation in solo medical practice remains only a potential detriment to ethical practice and decision-making, and, indeed, could occur in group practice also. It should also be noted that solo medical practice in many countries internationally is necessitated by issues of geography and population distribution and it might never be practical in isolated rural communities, for example, to employ more than one doctor. In such cases, the relevance of this paper is to highlight the need to reduce peer isolation as much as possible, and to encourage through undergraduate and continuing medical education, the value of peer discussion. It is also suggested that there is an urgent need to undertake research that directly explores the ethical problems and decision-making of solo doctors, to enhance understanding in this area of practice.

[ii]This may be contrasted with the actions of another fictional doctor working alone—that of Dr Wilbur Larch in John Irving's *The Cider House Rules*.

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