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Professional Ethics in Practice: General Practitioners' Perspectives on Ethical Demands in Clinical Work

Jokkin Jesima[1*], Bharti Goel[2]

[1] Department of Community Medicine, Kasturba Medical College (Affiliated to Manipal University), Mangalore 575001, Karnataka, India.
[2] Department of Forensic Medicine, Kasturba Medical College (Affiliated to Manipal University), Mangalore 575001, Karnataka, India.

***E-mail** ✉ jokkin.jesima@yahoo.com

Abstract

While many perspectives exist on what constitutes ideal general practice, few adequately address its ethical essence. There is limited research integrating moral theory with empirical insights into the embodied ethical knowledge of general practitioners (GPs) to inform a normative framework for good general practice. This study presents an empirically grounded model of GPs' professional morality and examines its alignment with established ethical theories to evaluate its viability as a general practice ethic. Between 2015 and 2017, we conducted observations and interviews with sixteen GPs and GP residents across healthcare centers in four Swedish regions. Using Straussian Grounded Theory, sampling began purposively and later followed theoretical guidance, with data collection, analysis, and theoretical synthesis occurring concurrently. The study's central concept was refined through multidimensional property supplementation. One of four core concepts emerging from our theory, "the voice of the profession," captures key motives influencing GPs' everyday moral decision-making. It illustrates how GPs interpret situations through three professional-moral judgments: whether to focus on immediate details or adopt a broader perspective, whether to intervene or refrain, and whether to speak up or remain silent. This framing helps narrow considerations, allowing GPs to concentrate on the morally most relevant aspects of each situation. This process can be understood as responding to Løgstrup's ethical demand, which, when filtered through a GP's professional understanding, generates moral imperatives that may conflict with patient wishes, societal norms, or the practitioner's self-interest. "The voice of the profession" elucidates how GPs morally frame complex clinical situations. It is coherent and robust enough to serve as a general practice ethic and offers an explanatory framework for understanding why GPs' intuitively justified ethical decisions may remain legitimate even in the absence of broader social validation.

Keywords: General practice, Physician–patient relationship, General practitioners, Medical ethics, Grounded theory, Sweden

Background

Does general practice possess an enduring ethical core that remains stable even as external moral expectations and circumstances shift? Amid the many voices advocating different visions of what general practice should be, it is worth asking whether a "least common denominator" exists—one that identifies moral imperatives universally recognized by GPs as central to their professional ethics, regardless of personal preferences, situational pressures, or systemic limitations.

It is not immediately clear that general practice's ethical foundation can be found within current prevailing traditions. Evidence-based medicine (EBM), despite emphasizing the role of individual clinical expertise in applying evidence to specific patients [1], has generated only cautious optimism among GPs [2]. Even those who value EBM do not view it as fully capturing the essence of good clinical practice [3]. Critics have described EBM

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as a "science of marginal gains" that prioritizes risk over illness [4], potentially promoting overtreatment [5] and adversely affecting both sick and healthy individuals [6]. Its less favorable aspects include attempts to answer fundamentally non-scientific questions [7] and a doctor-centered approach that may conflict with patient-centered care [8].

Could general practice's ethical core instead be found in abstract principles of bioethics? Respect for patients is broadly uncontested [9], and moral dilemmas are often framed in terms of value conflicts and choice [10]. Yet the emphasis contemporary bioethics places on individualistic aspects of the doctor–patient relationship may not align fully with GPs' practice. For instance, patient-centered communication in general practice often emphasizes a holistic approach, which differs from the more cognitively oriented shared decision-making model supported by bioethical norms of autonomy, preference fulfillment, and self-realization [11, 12].

Virtue ethics, which focuses on cultivating qualities through daily practice that support wise decision-making [13], including perceptual capacities to judge appropriately [14] and harmonizing reason with emotion [15], may hold particular relevance to general practice. Some evidence suggests that GPs implicitly employ virtue ethics in practice [10], yet the extent to which it is widely endorsed remains unclear [13, 15, 16].

A less frequently discussed, yet potentially influential, ethical framework is Løgstrup's phenomenological ethics [17], centered on the ethical demand—an obligation arising from the trust inherent in human interactions. Traditionally embraced by care ethicists, particularly in nursing [18], Løgstrup's ideas have also proven useful for physiotherapists [19]. Given the extensive trust patients place in GPs, this approach may be relevant to general practice as well.

Although prior studies have explored aspects of GPs' morality in specific contexts, few have integrated moral theory with empirical accounts of the embodied ethical knowledge of GPs to develop a normative theory of good general practice. Drawing from our emerging theory of quality in general practice [20, 21], this study examines professional morality as one of four central drivers of ethical decision-making: the voice of the situation (reflecting the problem and the patient's expressed wishes), the voice of the system (considering demands of absent stakeholders), the voice of the self (concerned with personal survival and well-being), and the voice of the profession (the focus of this article). We approach this descriptively by theorizing GPs' experiences and reflections as professional morality, framing them in moral rather than purely social or psychological terms. Finally, we discuss the implications of this model in relation to previous research and ethical frameworks, particularly principlism [22] and phenomenological ethics [17], to evaluate whether it could serve as a sustainable ethical foundation for general practice.

Methods

This study employed a Straussian grounded theory approach [23], in which data collection, analysis, and theory development occurred simultaneously. Constant comparative methods were used throughout to identify similarities and differences among data exemplars. Emerging hypotheses and questions informed subsequent rounds of data generation. Our ontological stance assumed that social concepts are sufficiently real to be investigated [24], while our epistemological stance, grounded in pragmatism, considered the purpose of inquiry to be the justification of beliefs [25].

Population and participants

The study population included general practitioners (GPs) and GP residents working in Swedish healthcare centers. GP residents were included because they share the professional ethos of their more experienced colleagues, while their relative inexperience could provide useful counterpoints. Recruitment occurred between 2015 and 2017 through personal contacts, professional conferences, and informal networks. Initial sampling sought diversity in gender, age, and professional experience; later, theoretical sampling guided inclusion toward contexts likely to yield divergent perspectives. In total, eleven GPs and five GP residents from eleven healthcare centers across four counties, ranging in size from 1,500 to 30,000 registered patients, were included. For clarity, both GPs and GP residents are collectively referred to as "GPs" throughout the text.

Sampling and data generation

Data were generated via observations and interviews. Each GP was observed for between half and a full working day, followed by an unstructured interview exploring reflections on current and past clinical encounters, particularly regarding perceptions of quality in their work (see Supplement). Observational field notes

were expanded immediately after interviews. Interviews lasted 30–60 minutes, were audio-recorded, and transcribed verbatim.

Transcripts and field notes were segmented into discrete events, each describing a central interaction and relevant contextual information. Guided by symbolic interactionism [26], attention was given to the meanings GPs attributed to their actions. For this study, these meanings represented abstract objects constituting professional morality, shaped through numerous prior interactions of which only partial observations were possible. A total of 471 events were sampled before theoretical saturation was achieved.

Analysis and theoretical integration

One concept emerging from the data was the *voice of the profession*, a theoretical construct reflecting judgments and intentions rooted in professional values rather than social or institutional pressures. Understanding this concept required simultaneous engagement in analysis and theoretical integration.

Analysis began with open coding, followed by the development of preliminary categories and processes that were iteratively refined as new insights emerged. The core category, capturing the moral demands guiding GPs' selection of practical actions, was previously described [20]. Selective coding around higher-level theoretical concepts allowed for deeper insight into circumstances influencing GPs' moral actions, which informed a subsequent study on work-related stress and its impact on moral responsiveness [21].

Exemplars of the *voice of the profession* were identified according to specific criteria: they represent moral imperatives (what ought or ought not to be done), refer to something larger than self, can be psychologically integrated independent of social expediency, and highlight potential conflicts between ideal and practical action. Variation among exemplars was addressed using multidimensional property supplementation [27], a method iterating between empirical data and abstract properties to define a parsimonious set of orthogonal characteristics. The resulting model delineates mutually exclusive subspaces that capture meaningful distinctions while accounting for all practically significant variation.

Openness, sensitivity, and quality

Observations and interviews were conducted by LJ, a GP and bioethicist, who maintained an insider perspective by empathizing with participants and co-authoring their narratives in their own voice. LJ's pre-understanding was continuously articulated through extensive exploratory, methodological, and theoretical memos. LN, a nurse with substantial experience in qualitative research, transcribed the interviews and contributed to coding. By maintaining a critical distance from the interpretations, she was well-positioned to challenge assumptions and propose novel concepts. ATH, an ethicist with expertise in bioethics, qualitative research, and gender studies, focused on scrutinizing the model and developing its links to existing descriptive and normative theories.

As the third paper in a series exploring different facets of our emerging theory, our pre-understanding is informed by earlier findings. This influenced theoretical integration: while inductive reasoning guided the analysis—particularly when informants shared professional ideals—retroduction [28] was also used to hypothesize underlying professional ideals explaining otherwise unexpected behaviors. For example, a GP might report dissatisfaction despite fulfilling patient requests within systemic constraints; such evaluations may reflect sacrifices of professional ideals rather than tangible outcomes.

The validity of the *voice of the profession* depends on its capacity to authentically represent the experiences and behaviors of GPs. The model must resonate with professional norms as understood by GPs while offering novel insights. Its distinctions should be theoretically coherent, relevant, and practically useful in differentiating actual cases. To ensure these qualities, member checking was employed to validate the model's fit and applicability [23]. Ultimately, the model's success must be evaluated by informed readers.

Ethical considerations

Observing doctor–patient interactions carries inherent intrusiveness, potentially affecting dynamics beyond issues of confidentiality. Patients were given the option to decline participation without providing justification. GPs were also allowed to veto the researcher's presence to protect patient interests. Field notes avoided direct or indirect patient identifiers, and health information was recorded only sparingly as an aid to recollection.

Although interviews focused on professional experiences, participants could share deeply personal reflections. No participant was pressured to disclose beyond their comfort level. Recordings were stored

securely, identifiers were removed from transcripts, and all participants provided both oral and written informed consent.

Results

The *voice of the profession* is one of four key concepts that capture the different motives influencing GPs' everyday moral decision-making. It is distinctive in framing concrete situations through a specific professional–moral lens. This process highlights some moral values while subordinating others, shaping how GPs interpret and act within clinical encounters **(Figure 1)**.

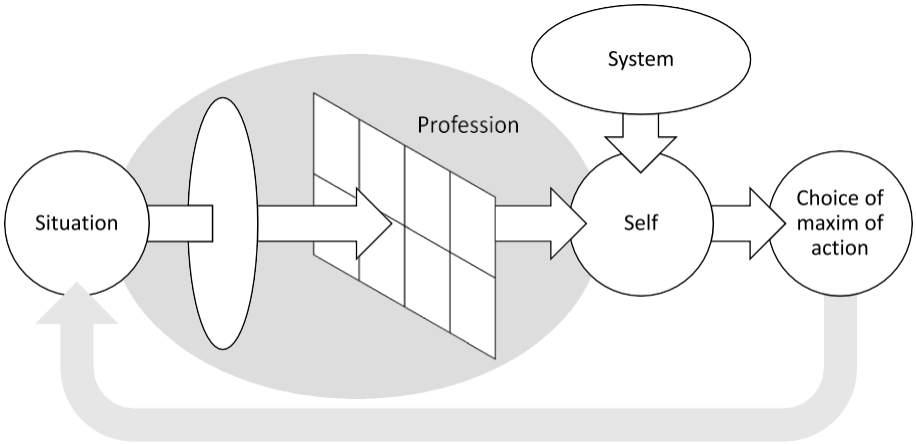

Figure 1. Ethical Decision-Making in General Practice

The GP's ethical decision-making is shaped by the interplay of four "voices": the situation, the profession, the system, and the self. The *voice of the situation* reflects the problem as presented by the patient or other immediate parties; the *voice of the profession* embodies the moral values and principles inherent to the professional role; the *voice of the system* accounts for demands from people not currently present, including institutional or organizational expectations; and the *voice of the self* concerns the GP's own well-being and ability to function effectively within their work environment. The circular nature of the process illustrates the iterative dynamics of problem identification, intervention, and human interaction. Within this framework, the *voice of the profession* represents a sub-process through which the GP identifies the moral values at stake, framing the situation from a professional perspective.

Three moral judgments framing the problem

A GP's professional understanding of a situation is guided by three core moral judgments, each requiring a choice between two opposing options: (1) Should I attend to what is immediately before me, or adopt a broader, bird's-eye view that considers absent stakeholders? (2) Should I intervene, or allow events to unfold without interference? (3) Should I speak up to influence others, or remain silent, observing and reflecting?

Attending to immediate needs or taking a bird's-eye view

When facing a patient, the imperative to address what is immediately before them often requires temporarily setting aside broader concerns. From this perspective, abstract or hypothetical needs may seem less pressing: *"I order those tests that I need … but I don't carry out unnecessary investigations because that is not good for the patient … I don't see it as an economic problem."* (Senior GP, male)

Conversely, adopting a bird's-eye view positions the current patient within a broader context of care, prompting attention to overall patterns and systemic considerations:

"I'm strict about sticking to my schedule. Consultations should be a maximum of thirty minutes … anything beyond that requires a follow-up to respect the next patient." (Junior GP, female)

Both perspectives recognize the need to balance competing values, though the scope differs: the former is narrowly focused on the immediate encounter, while the latter integrates wider contextual concerns.

Intervening or staying one's hand

The imperative to intervene is common, reflecting the GP's role in alleviating suffering and meeting patient expectations. Sometimes interventions are chosen to build trust rather than strictly for medical reasons: *"He didn't present diabetes symptoms, but I saw this as a way to create trust … I need his trust for my model of explanation."* (GP resident, male)

Equally important is knowing when to refrain from action, particularly in situations where intervention might be harmful or when the GP's capacity to influence is limited. Learning to withhold action with confidence is crucial:

"It is dangerous to take it personally … thinking 'I'm a bad doctor' leads to depression about your work." (Senior GP, male)

This judgment metaphorically reflects decisions about whether to act or hold back—what to do with one's hands.

Speaking up or remaining silent

The imperative to speak up arises when the GP can influence others' decisions for beneficial outcomes, such as advising against unnecessary procedures:

"When there is a history of substance abuse, once you've decided, you need to be adamant … you can't change your mind." (Senior GP, male)

Conversely, choosing to remain silent can be crucial when careful observation offers greater insight than immediate intervention, such as when a patient's narrative reveals important therapeutic or diagnostic information:

"Back in the old days, critically ill patients made a stopover … everything else had to be put on hold until you were done." (Senior GP, male)

This judgment highlights the close relationship between ethical decision-making and communication skills, demonstrating how professional ethics intersect with practical strategies in patient interaction.

The eight frames of GP ethics

By responding to the three core moral questions, a GP establishes a perspective that clarifies which professionally endorsed values are at stake. The binary structure of these questions allows for a straightforward yet comprehensive model, designed to encompass the full range of moral imperatives that GPs encounter in practice. Each of the $2^3 = 8$ possible combinations of responses corresponds to a distinct ethical frame. Examining each frame in the context of the events it encompasses enables their identification and definition in ways that are both meaningful to GPs and theoretically robust.

A summary of the voice of the profession model is presented in **Table 1**, with further elaboration provided in the following sections.

Table 1. Framing professional moral judgments in general practice. By making three foundational judgments, the GP situates the problem in professional terms. The selected frame determines which morally relevant aspects of the situation receive attention.

	See what is before me	**Take a bird's-eye view**
Shut up	**Intervene:** The patient is my primary focus. I must develop the skills and relationships necessary to understand and address their issues. **Stay my hand:** I observe attentively, avoid rushing, and carefully weigh my words. I object to interventions that could cause disproportionate harm. I maintain a self-image independent of others' approval and safeguard the integrity of general practice.	**Intervene:** I act with discretion, applying myself judiciously. **Stay my hand:** I advocate for a better working environment while protecting professional boundaries and avoiding unnecessary responsibilities.
Speak up	**Intervene:** I communicate clearly and candidly, expressing what is necessary to bring about positive change, even if uncomfortable. **Stay my hand:** I refrain from causing harm while appreciating being "good enough" and celebrating achievements without destructive self-critique.	**Intervene:** I address broader systemic concerns with professionalism and discretion. **Stay my hand:** I uphold the integrity of my profession while stepping back to consider long-term implications and maintain balance across multiple responsibilities.

The patient is my first concern

When no cues indicate a need to persuade others, avoid harm, or consider factors beyond the consultation, the GP is free to focus fully on making a difference for the patient at hand in an active, concentrated, and verbally minimalistic manner. Conscious of the importance of understanding the patient's condition to provide appropriate care, GPs strive to acquire the necessary tools, mainly through honing their consultation skills and cultivating the doctor–patient relationship:

"Skilled surgeons operate, they spend time in the wound. … Re list of patients is our wound, and that is what we should work on—learn to know our individuals and their diseases. And that is the preeminent condition of quality in primary care, to achieve doctor–patient continuity." (Senior GP, male)

Several GPs highlighted the importance of postponing or abandoning pre-planned agendas to address the patient's concerns. This approach, far from cutting corners, was considered a worthwhile sacrifice when no immediate danger was present:

"… she had done a lot of reading on the web and had lots of symptoms and ideas of what it could be, and somehow we ended up with a plan … Twenty minutes for a whole lot of things, so we didn't do a physical examination but … she was calm when she left …" (Junior GP, female)

These examples are united by the GP's responses to the three framing questions. First, the scope is narrow: the GP prioritizes the person before them. Second, intervention is necessary, either by providing a solution or shaping the problem toward resolution. Third, the GP "shuts up," performing much of the ethical reasoning internally. Since this frame aligns naturally with the GP's instincts, it is often experienced as the most relaxed.

I speak frankly and clearly

When achieving a beneficial outcome requires influencing someone else, GPs see it as their duty to speak up rather than remain silent, even if the situation is awkward. Sometimes, this involves persuading a third party for the patient's benefit:

"… if I've made up my mind about putting a patient on sick leave for a month, then I'd better write a certificate that holds up to scrutiny." (Senior GP, male)

More frequently, the goal is to evoke change directly in the patient, whether in beliefs, emotions, or behaviors:

"… they went to the ER but were redirected here because they did not have a myocardial infarction … Some patients who get no help get more anxious. Rat chain will then be harder to break … Rat's why I use a lot of pictures when explaining …" (Senior GP, female)

Like the previous frame, the focus is narrow and interventionist. However, the GP achieves change by speaking up, integrating reasoning into interpersonal communication rather than keeping it private. While more demanding, many GPs find this frame rewarding.

I apply myself with discretion

Maximizing one's skills and resources requires setting and sometimes adjusting priorities. GPs must occasionally shift focus from the current patient to other urgent matters or decline requests that interfere with their work.

Given time constraints, several GPs described strategies to manage long patient agendas efficiently. Some "listen with half an ear," reacting only to the most critical issues, while others structure consultations more formally: "You have to find out … Someone might be bringing a long list … 'Well, this seems to be a lot … What do you find most important? … Can you name two things that you would like us to work on today?' You have to put it like that sometimes …" (Senior GP, female)

Even when patient-centered, GPs do not follow the patient blindly; they remain alert for signs of significant health risks. Unexpected events outside the consultation may require interruptions or early endings. Protecting a safe environment for junior colleagues is a high priority: "… I think it's imperative that they feel comfortable asking … not erecting barriers that keep them outside … Rey are, after all, my future colleagues." (Senior GP, female)

This frame differs from the first in that it temporarily looks away from the patient to adopt a bird's-eye view of one's responsibilities. Actions taken to address other priorities constitute active intervention, and because change is enacted through deeds rather than words, the GP generally "shuts up" while performing ethical deliberation internally.

I demand a better work environment

When GPs encounter obstacles that prevent them from achieving meaningful goals, they feel obligated to address these barriers actively. Because routine or less impactful tasks must be completed before attending to the

work that truly matters, the solution cannot rely solely on prioritization; instead, GPs need to enlist the cooperation of others.

Requesting help with procedures or administrative tasks carries the risk of friction in the workplace. Many GPs expressed frustration at time spent cleaning or searching for equipment but rarely took steps to change these circumstances. Even when falling behind schedule, few voiced complaints:

"I oversee 75 patients in home health care. Now, some diagnosis must be removed … it's an administrative thing. … I would be better off seeing a patient or something." (Junior GP, female)

GPs also recognized, but did not always act upon, their right and duty to pursue continuing education—a crucial professional investment often delayed by staff shortages:

"… the intention of management is, I suppose, that everyone should get time off and educate themselves, stay up to date, but for the past year it hasn't … We've not received much continuing education because we've been understaffed …" (Junior GP, female)

This frame involves a bird's-eye view of the work environment and calls for intervention to improve it, primarily by speaking up about unmet professional needs. Observed GPs, however, often struggled to live up to these ideals.

I stand back and observe when there is time

Ethical competence requires GPs to be aware of their capacity for both harm and good. This awareness often leads to minimalistic intervention, stepping in only when necessary.

Forgoing medications for self-limiting conditions is a common form of minimalism. More complex forms involve limiting communication, balancing the need to avoid unnecessary interventions with maintaining the therapeutic relationship. One GP described the value of taking the long-term perspective rather than seeking short-term wins:

"… to some degree, you have to adapt and approach the patient in the way that they expect health care to be. … some people are used to … always having samples taken. … you might have to take some samples … next time, when I say, 'I do not think that will be necessary,' then, 'Ok.'" (Senior GP, male)

Some GPs emphasized careful observation even during seemingly simple appointments, using a "dormant vigilance" to remain relaxed yet alert for signs of serious illness. Quiet observation could also reveal critical diagnostic insights through spontaneously offered patient information:

"… for the past couple of days, her shoulder had been drooping. 'Have you been in an accident?' 'No, I just noticed it in the mirror a few days ago.' … Completely inexplicable. … And then her husband says, 'And there was this other thing, about her short-term memory.' … And then it all made sense …" (Senior GP, female)

Like the first frame, this one emphasizes attention to the immediate situation and "shutting up," but it differs by prescribing restraint in action, allowing events to unfold before intervening. By blending into the background, the GP gains understanding and trust, even if it means temporarily ceding control.

I refuse to do harm

Occasionally, GPs are asked to take actions they believe might harm the patient. In such cases, passive resistance is insufficient; they must actively oppose the harmful intervention.

Common examples include avoiding prescribing medications with serious side effects or overstating limitations on sick-leave certificates:

"… I ramped up her work ratio a little. She seemed a bit reserved about that, perhaps not completely satisfied, but I think she can make it … You might falter somewhat and, like, drag out the sick leave full time for a bit too long." (Senior GP, male)

Other forms of refusal require confronting systemic requirements, such as mandatory interventions that may be counterproductive or harmful:

"… we are supposed to ask everyone about suicidal ideations … Rose are questions that need to be asked in the right context … You can hardly prevent all suicides in that manner. … I think there are many who would be put off or even insulted …" (Senior GP, male)

Refusal can also relate to competence; when lacking the skills to safely manage a condition, GPs feel morally obligated to acknowledge their limitations.

This frame is defined by two key imperatives: maintaining focused attention on the immediate situation and refraining from harmful actions, which involves staying one's hand while speaking up to defend decisions to potentially critical observers.

I enjoy being good enough

Although prioritizing the patient's wellbeing is central to GP ethics, this aim is moderated—particularly among senior GPs—by the recognition that some illnesses cannot be cured, some suffering is difficult to relieve, and some systemic shortcomings cannot be fully addressed. Being able to accept one's limitations and feel satisfied with "good enough" appears crucial for sustaining a professional career.

Senior GPs noted that younger doctors often have a tendency to "listen for zebras," ordering extensive tests to be "safe," which can sometimes inadvertently disadvantage the patient. A key motivation for tempering this tendency is concern for professional development:

"… you have to accept that … you don't know everything and that you will make mistakes. If you … can't make up your mind, if you become anxious … you can't stay in this field." (Senior GP, male)

Alongside accepting their limitations, GPs also allowed themselves to quietly celebrate near-misses that ultimately ended successfully. A stable professional role does not mean rigidity; one GP highlighted the importance of revising decisions based on new evidence—or even a gut feeling—despite exposing personal imperfections:

"Once I had made up my mind, I used to be rather unflexible … After a while, I realised that … it made me feel bad and it was dangerous. … I could make things much easier for myself by … doing that extra checkup, seeing the patient again …" (Senior GP, male)

This frame emphasizes a bird's-eye view, coupled with shutting up and staying one's hand, rather than futilely attempting to improve situations already deemed "good enough."

I uphold the integrity of my profession

The final frame concerns the boundaries of the GP role—essentially, the preservation of general practice itself. It captures the duty to protect the profession from demands that, if consistently met, could dilute its legitimacy.

GPs viewed many external demands as questionable, often stemming from trends toward patient emancipation and medicalization of everyday life. Upholding the profession's integrity required clarity about the limits of patient rights—based on health needs and justice considerations—and the ability to enforce those limits, ideally with tact:

"Usually, I try to say to the patient, 'Begin by describing your problem and then we … will try to help you find the right way …'" (Senior GP, male)

Several GPs reported experiencing subtle disregard from hospital colleagues, who expected them to perform ancillary tasks like ordering specific tests. Some even developed defensive principles to counteract these expectations:

"… it's reasonable that the one who wants an examination to be carried out also will be the one to order it, isn't it …" (Senior GP, male)

Hospital colleagues often maintained strict boundaries around their own responsibilities while expecting GPs to stretch theirs. Despite external critique—whether overt or implicit—GPs drew strength from professional norms, particularly when criticism seemed unfair or irrelevant:

"… what we are assessed by are usually these simplistic parameters, like … how many patients with atrial fibrillation are on warfarin, for example … for individual patients, other things may be much more important." (Senior GP, male)

This frame calls for taking a bird's-eye view of professional practice and speaking up to defend decisions to refrain from intervention when appropriate. Being one of the most confrontational frames, it can place considerable strain on GPs who commit to fulfilling its obligations.

Discussion

GPs are subject to multiple sources of moral and practical demands. The voice of the situation represents explicit demands present in the encounter itself; the voice of the system supports or discourages certain actions; the voice of the self-accounts for stress arising from threats to personal needs [21]; **and the** voice of the profession reflects a professional moral perspective that is not directly dependent on the immediate situation or context. Our findings suggest that the work of GPs can easily become overwhelmingly complex, yet GPs appear to have strategies to reduce this complexity. By selecting a "frame" that highlights a set of actions aligned with the most morally relevant values at that moment, GPs can narrow the range of ethical considerations. This form of framing can be seen as a type of problem setting [29], where the professional converts a challenging situation into a manageable problem.

The voice of the profession in a wider context

By attending closely to concrete details, the voice of the profession provides a broad perspective on GP morality, in which principles commonly assumed to be central to general practice occupy only a small space. For example, patient-centeredness [8] is evident in the frame *The patient is my first concern*, which emphasizes knowing patients as individuals [30]. Another aspect, avoiding doctor-centeredness, aligns with *I stand back and observe when there is time*. However, in the remaining six frames, patient-centeredness is largely silent.

In contrast, virtue ethics is closely intertwined with the voice of the profession. Traits such as perceptual capacity [14] are essential for framing decisions, while character virtues like justice, courage, and truthfulness [31] are critical to responding to professional moral demands. Although virtue ethics provides insight into desirable ends and proper means, the pervasiveness of these virtues limits their analytical utility in this context.

Next, we examine how our findings relate to two moral frameworks: principlism [22] and phenomenological ethics [17].

Principlism

The four-principle framework of Beauchamp & Childress [22]—respect for autonomy, non-maleficence, beneficence, and justice—is widely used in medical ethics and is thought to encompass most relevant concerns in medical moral dilemmas.

When considering how the voice of the profession aligns with principlism, all four principles can be semantically identified within our model. *Seeing what is before me* reflects beneficence, while taking a bird's-eye view draws on utility and justice. *Staying one's hand* aligns with non-maleficence. Autonomy is more complex: *shutting up while seeing what is before me* could reflect negative respect for autonomy, but *speaking up* addresses positive obligations, such as ensuring the patient is adequately informed.

However, when evaluating ethical deliberation as a process, some discrepancies emerge. Principlism emphasizes abstract reasoning and balancing principles, whereas GPs often handle moral problems in practice through situational framing and context-sensitive judgment. These differences suggest that principlism may be limited in explaining how GPs navigate everyday ethical challenges.

1. **Limited prominence of principles.** Within some frames, a single principle tends to dominate, overshadowing the others. For instance, in *I speak frankly and clearly*, beneficence can potentially override autonomy; in *I refuse to do harm*, non-maleficence clearly takes precedence over both beneficence and autonomy; and *I apply myself with discretion* primarily emphasizes procedural or comparative notions of distributive justice. Once a GP frames the problem in one of these ways, questions about what is morally right or wrong are largely settled. This highlights that, because principlism focuses on moral decision-making, it must be supplemented with skills in value negotiation and reflection to be useful for the arguably more critical task of moral problem setting.

2. **Limited practical guidance.** In frames where multiple principles are relevant, relying on them alone may not provide actionable guidance. For example, *The patient is my first concern* reflects beneficence, but it also acknowledges that careless speech can cause harm, and its insistence on sincere presence aligns with positive aspects of autonomy. Yet, simply knowing the four principles does not equip GPs with the insight needed to act effectively. Moral rules always require contextual specification [22], and in the case of GPs, the skills needed—attending carefully to the specifics of each situation—lie outside the scope of principlism. Effective moral action depends on practical, situational knowledge rather than abstract principles alone.

3. **Limited scope.** Some frames address issues that fall outside the reach of principlism. In *I enjoy being good enough*, the GP is guided to temper self-criticism, focusing on their own sustainable professional life rather than the patient's immediate welfare. Likewise, *I demand a better work environment* and *I uphold the integrity of my profession* concern morally relevant aspects of the GP's working conditions and professional boundaries, which are not addressed by the four principles.

Implications of this lack of alignment. Given that principlism is intended as a normative framework, one might argue that, when disagreement occurs, the voice of the profession may lack normative authority. However, placing ethical deliberation within the framing process does not absolve the GP from weighing moral principles against each other. Empirical evidence from this study suggests that this weighing happens during framing, rather than as a separate, later stage.

The assumption that ethical deliberation must conform to principlism may be unnecessary. Previous authors have noted that a "quandary ethics" approach often overlooks the everyday, practical moral reasoning central to

professional life [32, 33]. GP training is largely experiential, requiring constant responses to challenging situations through judgment and problem construction. It is reasonable to expect that a motivated GP will develop strong competence in this practical ethical reasoning. If a theoretical model—whether principlism or another—does not align with this process, imposing it may be of little benefit. Therefore, proponents of principlism bear the responsibility of justifying why its logic should override the natural deliberative processes of GPs.

While principlism has value in addressing specific moral dilemmas, the analysis here suggests that it is insufficient as a comprehensive framework for understanding the everyday morality of general practitioners. Readers are thus encouraged to consider alternative theoretical perspectives that better capture the nuances of daily GP ethical practice.

Phenomenological ethics

Løgstrup's phenomenological ethics frames the ethical demand as a responsibility to care for another person's life as it has been entrusted to one [17]. At first glance, this seems most directly aligned with frames of the voice of the profession that emphasize caring relationships, such as *The patient is my first concern*. However, a deeper alignment exists that may clarify the broader intentionality underlying the voice of the profession.

First, the concept of conflicting voices resonates with Løgstrup's view that the ethical demand remains constant even as social norms shift, while still being sensitive to specific relational and situational factors. The demand itself does not change; instead, it is refracted through the lenses of the relationship, the situation, and the self. We argue that the voice of the profession represents a specialized application of Løgstrup's relational lens, shaped by the unique dynamics of the doctor–patient relationship. In this sense, framing is the GP's professionally informed way of determining how the other person can be best served.

Another point of compatibility is the notion of the ethical demand as both unnegotiable and silent. No mandate can be set before the situation arises; rather, it is the responsibility of the caregiver to discern, through their understanding of life and circumstances, how best to serve the other. This may at times conflict with the explicit wishes of the patient, since simply being "nice" when denying a request may be necessary for their well-being. This explains why the voice of the profession can occasionally clash with the voice of the situation. Even when the two align, following the voice of the profession requires that the GP make a careful judgment about the relevant values and act on it, regardless of potential conflicts.

Despite its strengths, phenomenological ethics has been criticized for focusing so heavily on the immediate needs of "the other" that it risks neglecting obligations to "the third" [18]. Questions remain about whether it can meaningfully address broader issues, such as priority-setting or protecting professional integrity. While a detailed exploration is beyond the scope of this article, one potential approach is to incorporate a conception of justice.

Løgstrup's distinction between caring for and pandering to the other implies that denying certain requests may sometimes be morally necessary. This is a foundational step for any reasonable notion of justice, but it does not fully explain how denying a request for the sake of a third party could simultaneously serve the original patient. The apparent problem may be resolved by considering the third person as concrete rather than abstract. For GPs, who encounter many patients daily, the needs of one patient cannot be fully understood in isolation from previous or anticipated patients. In this way, the third party also deserves care, and ethical decision-making can account for both. Although further theoretical development is needed, it seems plausible to extend Løgstrup's phenomenological ethics to include obligations toward third parties.

Finally, the GP's responsibilities to the profession itself merit attention. Frames such as *I demand a better work environment* align partially with the voice of the self, but the professional perspective adds an important dimension: certain actions are necessary to ensure sustainable practice. Professional autonomy is thus not merely about personal freedom, and professional integrity is not simply about feeling satisfied with one's work; both are essential for the GP's ability to respond effectively to current and future patients.

Strengths and limitations

A high-quality grounded theory should help readers understand the dilemmas experienced by specific groups and, ideally, explain their actions in relation to a phenomenon. A key strength of this study lies in the relevance of the voice of the profession within our emerging theory on GPs' moral decision-making. The

concept may also serve as a practical tool for GPs reflecting on their day-to-day ethical choices. For instance, they could analyze their approach to challenging cases by considering which frame they adopted and whether an alternative frame might have been more effective.

Several methodological choices strengthened this study. Using constant comparison allowed us to identify patterns and differences across numerous examples. Sampling was both purposeful—drawing from the relevant population—and theoretically guided, and triangulation helped minimize the risk of misinterpretation. The application of multidimensional property supplementation [27] enhanced the robustness and comprehensiveness of the focal concept. Additionally, the differing preunderstandings of the three authors reduced the likelihood of biased interpretations.

However, given the complexity of the focal concept, some aspects were only superficially addressed. For example, the potential conflicts between the voice of the profession and the other three voices were not fully explored. Although one can imagine that acting in alignment with professional ideals versus pragmatic considerations may appear differently depending on context, a full discussion of all possible implications was beyond the scope of this study.

Although grounded theories typically have limited normative ambitions, we propose that the voice of the profession should also be seen as normative. This claim may raise concerns, especially among readers deeply grounded in normative ethics. Nevertheless, our empirically derived theory should not be dismissed as purely descriptive: professional morality, shaped through the shared engagement of many practitioners, is likely effective. Moreover, it does not rely on a specific social context or set of norms and, when abstracted sufficiently, may be applicable across cultures and time periods.

Conclusions

The voice of the profession captures key elements of GPs' moral decision-making. By framing an initially complex situation in moral terms, GPs can focus on the ethically most relevant aspects and narrow the range of considerations. The moral imperatives arising from the voice of the profession sometimes conflict with the patient's expressed wishes, social norms, or the GP's own self-interest.

Principlism, with its strictly deductive focus on "moral quandaries," can overlook the nuances of individual situations. It may fail to account for the tensions among the expectations of the patient, institution, and profession, and can misrepresent the actual decision-making process, where much of the deliberation involves judging what the situation demands in terms of observation, action, and communication.

Viewing our findings through Løgstrup's phenomenological ethics, however, highlights framing as a professional–relational refraction of a fundamental ethical demand. This perspective clarifies why, even when the GP understands what is morally at stake, pressures from other sources—such as patient needs or institutional demands—remain influential. Overall, the voice of the profession is coherent and sustainable as a model for general practice ethics. It can explain why certain decisions, intuitively judged by GPs as ethically justified, may be legitimate even in the absence of external social support.

Abbreviations

EBM Evidence Based Medicine
GP General Practitioner

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Ethics Statement: Each informant was informed orally and in writing about the study's purpose and methodology, what kind of information might be generated, and our intention to publish the results. They were promised confidentiality and data security. Informed consent was obtained orally and in writing. The

study was exempted from review by the regional ethics committee in Uppsala (Dnr 2015/030). Data were generated and subsequently handled in accordance with relevant guidelines and regulations.

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