

Pogostnost etičnih dilem med zdravniki družinske medicine v Sloveniji

Prevalence of ethical dilemmas in Slovenian family practice

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Izvleček

Namen: Določiti pogostnost etičnih dilem v družinski medicini.

Metode: Vprašalnik o vnaprej določenih etičnih dilemah smo po pošti poslali naključnemu vzorcu 259 slovenskih zdravnikov družinske medicine. Glavni rezultat so bili odstotki zdravnikov družinske medicine, ki so poročali o pogostnosti določene etične dileme na 5-stopenjski lestvici.

Rezultati: Slovenski zdravniki družinske medicine so o etičnih dilemah pri svojem vsakdanjem delu poročali relativno pogosto (povprečje odgovorov (\pm standardna deviacija) 36.2 ± 12.5 od možnih 100 točk). Najpogostejše etične dileme so bile povezane z omejenimi finančnimi sredstvi (23,9 %), situacijami, kjer bolniki želijo zlorabiti zdravstvene

Abstract

Purpose: To determine the perceived prevalence of ethical dilemmas in family practice.

Methods: Self-administered questionnaire sent to a random sample of 259 Slovenian family physicians. The main outcome measure was the percentage of doctors reporting the frequency of ethical dilemmas on a 5-point scale.

Results: Ethical dilemmas were common (mean score \pm standard deviation, 36.2 ± 12.5 , out of a maximum of 100). The most common dilemmas involved decision-making regarding use of limited resources (23.9%), patient attempts to abuse the health care service (20.4%) and interfacing with the rest of the health care system (20.4%). Dealing with patients suspected of being physically

usluge (20,4 %) in situacijami, povezanimi z odnosom s sekundarno ravniyo zdravstvenega varstva (20,4 %). Najredkejše etične dileme so bile: soočanje z bolniki, kjer obstaja sum na zlorabo (<0,1 %), sporočanje slabe novice (<0,1 %) in soočanje z mladostniki (0,7 %). Starejši zdravniki in tisti z daljšo delovno dobo so o etičnih dilemah poročali manj pogosto ($32,3 \pm 11,9$ proti $40,1 \pm 11,9$, $P < 0,001$; $32,4 \pm 11,8$ proti $39,5 \pm 12,2$, $P = 0,001$). Specialisti in specializanti družinske medicine so o etičnih dilemah poročali pogosteje kot zdravniki brez specializacije, ki delajo v ambulantah družinske medicine ($37,0 \pm 12,6$ proti $30,7 \pm 10,8$, $P = 0,05$). Specializanti družinske medicine so o etičnih dilemah poročali pogosteje kot zdravniki brez specializacije, ki delajo v ambulantah družinske medicine ($39,5 \pm 12,5$ proti $30,7 \pm 10,8$, $P = 0,04$).

Zaključek: Etične dileme so relativno pogost del vsakdanjega dela slovenskih zdravnikov družinske medicine, še pogosteje pa se z njimi srečujejo specializanti družinske medicine. Ugotovitve te raziskave nam sporočajo, da je izobraževanje o etičnih dilemah v okviru specializacije iz družinske medicine nujno, verjetno pa celo potrebno izboljšav.

abused, sexually abused, or involved in other violent acts was the least common ethical dilemma (<0.1%), followed by issues involving breaking bad news (<0.1%) and special situations regarding adolescents (0.7%). Older physicians and those with more experience reported ethical dilemmas less commonly (32.3 ± 11.9 vs. 40.1 ± 11.9 , $P < 0.001$; 32.4 ± 11.8 vs. 39.5 ± 12.2 , $P = 0.001$, respectively). Specialists in family medicine and family medicine residents reported ethical dilemmas more commonly than general practitioners without specialist training (37.0 ± 12.6 vs. 30.7 ± 10.8 , $P = 0.05$ and 39.5 ± 12.5 vs. 30.7 ± 10.8 , $P = 0.04$, respectively).

Conclusions: Ethical issues are common in Slovenian family practice and are most often reported by residents in specialist training. This supports the need to continue and even improve specialist training in recognizing and comprehending ethical dilemmas.

INTRODUCTION

The main source of ethical dilemmas in medical care arises from the doctor–patient relationship, which is unique in family medicine. Family doctor and their patients develop a long-lasting personal and professional relationship that not only includes treatment of particular disease episodes but also focuses on prevention, socio-economic circumstances and family dynamics. As a consequence, family practice raises many ethical dilemmas, mostly involving a conflict between doctors' perceptions of the patients' best interest (patient welfare) and patients' moral and legal rights to direct their own lives, health and destinies (patient autonomy) (1–3).

When facing an ethical dilemma, physicians can experience a great deal of moral distress (4, 5) that, if it is not addressed properly, can cause the variety

stress-related disorders (6). The sources of the stress in family medicine are not, as one might expect, the dramatic life-and-death situations, but the more common and prosaic ones (4) that occur regularly in everyday practice (1, 7–9). They can be classified as problems in the doctor–patient relationship (allocation of time to patients, paternalism, patient autonomy, informed consent, confidentiality), financial and legal matters (lack of patient funds, financial constraints), relationships with colleagues, and special topics (contraception, abortion, chronic substance abuse) (10–14).

Ethical decision-making in family medicine appears to be based on the particular features of different clinical situations (15). An ethical decision is usually made with concern for patient welfare and according

to a personal or professional code of morality as well as institutional and legal expectations. However, the main methods of ethical decision-making in family medicine appear to be inconsistent, non-universal and individualistic and, to date, without evidence of specific models or criteria (16).

After Slovenia's independence, its health care system was transformed from a state-run system to a decentralized model (17) and higher responsibility was given to family physicians (18). Their role as "gatekeepers" produces many ethical dilemmas because of limited financial resources, unsolicited patient demands and difficulties in updating their own education.

Research in ethical problems in primary care is scarce. Some papers have focused on qualitative data (11, 19) and some have used simulated cases with closed questions (1, 15, 20–22). Few have tried to determine the prevalence of ethical dilemmas in family practice (9, 10, 12, 14, 23, 24). The only Slovenia research involved managing perceived ethical dilemmas (25).

The aim of our research was to determine the perceived prevalence of ethical dilemmas in Slovenian family practice and to reveal any possible connections with the socio-professional characteristics of the physicians. Our hypotheses were that family doctors would commonly encounter ethical dilemmas in their every day practice and that their gender, age, years of practice and specialist training in family medicine would determine their likelihood or reporting ethical dilemmas.

MATERIAL AND METHODS

Study design

We conducted a cross-sectional postal survey of a random sample of Slovenian family doctors. The study was a part of an international study that took place in several European countries.

Setting

A postal survey involving Slovenian family practices in March 2008 with a reminder sent in April 2008.

Participants

We draw a random sample of 259 doctors practicing in general/family medicine in Slovenia using random seed numbers from the membership list of the Slovene Family Medicine Society, which contains all practising family doctors in the country, aiming at a sample of 30% of the total number of 854 doctors.

Data collection

The data was obtained from a self-administered questionnaire in Slovenian. The original questionnaire was developed and validated by Altisent Trota et al. in Spanish and translated to English (26). It consists of questions on the 14 most frequent ethical dilemmas encountered in primary health care. They are answered on a 5-point response scale that ranges from "unusual" (scored 1) to "very frequent" (scored 5) for the prevalence questions. The questionnaire was rigorously translated from English to Slovenian according to proposed guidelines (27).

The socio-professional characteristics of the study sample (table 1) were collected on a separate sheet of paper, attached to the questionnaire. The materials, together with the introductory letter, were mailed to physicians in the sample. The envelope contained a prepaid and addressed return envelope. Doctors were asked to fill in the questionnaires on a voluntary and anonymous basis before returning them to the authors.

The national ethical research committee approved the study.

Statistical analysis

We used the SPSS 13.0 package (SPSS Inc, Chicago, IL, USA). Descriptive statistics were computed. We calculated the reliability coefficient (Cronbach's

Table 1: Socio-professional characteristics of the physicians who responded to the questionnaire

Physicians' characteristics	Number of physicians (%)
Sex	
Male	46 (32.4)
Female	96 (67.6)
Age (years)	
< 30	1 (0.7)
31–40	26 (18.3)
41–50	69 (48.6)
51–60	40 (28.2)
> 60	6 (4.2)
Employment period (years)	
≤ 5	5 (3.5)
6–10	17 (12.0)
11–15	18 (12.7)
16–20	36 (25.4)
21–25	26 (18.3)
26–30	26 (18.3)
31–35	10 (7.0)
>35	4 (2.8)
General/family medicine practitioner	
Yes	109 (76.7)
Resident	15 (10.6)
No	18 (12.7)
Private practice	
Yes	42 (29.6)
No	99 (69.7)
No answer	1 (0.7)
Size of community	
< 4999 habitants	20 (14.1)
5 000–24 999 habitants	73 (51.4)
25 000–99 999 habitants	25 (17.6)
100 000–249 000 habitants	7 (4.9)
> 250 000 habitants	11 (7.8)
No answer	6 (4.2)
University of graduation	
Ljubljana	115 (81.0)
Other	23 (16.2)
No answer	4 (2.8)
Optional activities/posts*	
Academic affiliation	64 (45.1)
Leading staff (director, chief of staff, quality manager)	27 (19.0)
Other (appointed physician for the National Insurance Company, member of Health Center board)	18 (12.7)
None	54 (38.0)
No answer	14 (9.9)

* Numbers do not add up because some physicians have multiple optional activities/posts

alpha) of the questionnaire. Total scores (0–100 points) from the 14 items in the prevalence part of the questionnaire were computed, using the following equation: $((\sum \text{questions 1–14}) \times 100 / (5 \times 14)) \times 1.25 - 25$. To identify statistically significant differ-

ences between different variables, independent samples t-test and one-way ANOVA were performed. In order to split the continuous variables into two groups, medians were used. To reveal correlations between different variables, linear correlation was

Table 2: Number and percentage of physicians answering the items of the frequency part of the questionnaire

Item	Unusual	Not very frequent	Frequent	Quite frequent	Very frequent	No answer
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
1. Patients' temporary inability to work	23 (16.2)	72 (50.7)	28 (19.7)	12 (8.5)	7 (4.9)	0 (0)
2. Relationship with specialized health care	4 (2.8)	24 (16.9)	38 (26.8)	47 (33.1)	29 (20.4)	0 (0)
3. Usage of limited resources	4 (2.8)	28 (19.7)	38 (26.8)	38 (26.8)	34 (23.9)	0 (0)
4. Patients trying to abuse the health care services	1 (0.7)	19 (13.4)	49 (34.5)	44 (31.0)	29 (20.4)	0 (0)
5. Confidentiality	36 (25.4)	71 (50.0)	22 (15.5)	10 (7.0)	3 (2.1)	0 (0)
6. Abandoned, unattended, or patients with not enough means of support	21 (14.8)	73 (51.4)	28 (19.7)	14 (9.9)	6 (4.2)	0 (0)
7. Communication of bad news to patients	39 (27.5)	79 (55.6)	17 (12.0)	7 (4.9)	0 (0)	0 (0)
8. Disputes within the clinic team	73 (51.4)	44 (31.0)	12 (8.5)	8 (5.6)	5 (3.5)	0 (0)
9. Patients requesting prescription	2 (1.4)	62 (43.7)	44 (31.0)	24 (16.9)	8 (5.6)	2 (1.4)
10. Difficulties in updating physicians' education	40 (28.2)	40 (28.2)	36 (25.4)	13 (9.2)	13 (9.2)	0 (0)
11. Controversial situation regarding pharmaceutical industry	46 (32.4)	41 (28.9)	29 (20.4)	19 (13.4)	7 (4.9)	0 (0)
12. Suspicions of physical abuse, sexual abuse or other crime	77 (54.2)	58 (40.8)	5 (3.5)	1 (0.7)	0 (0)	1 (0.7)
13. Seeing adolescents	59 (41.5)	49 (34.5)	20 (14.1)	9 (6.3)	1 (0.7)	4 (2.8)
14. Seeing immigrants	55 (38.7)	50 (35.2)	17 (12.0)	9 (6.3)	8 (5.6)	3 (2.1)

performed. To develop a possible explanatory model for the differences, multivariate linear regression analysis was performed.

RESULTS

A total of 142 questionnaires were returned (55.0% response rate) and all were used in the final analysis. The respondents represented 16.6% of the whole population of Slovenian family doctors. The distribution of age and gender did not differ substantially from that of the whole population of Slovenian fam-

ily doctors (29). 46 respondents (32.4%) were male. Ages ranged from 30 to 68 years, with a mean of 47.5 ± 7.4 years. Years of practice ranged from 2 to 45 years, with a mean employment period of 20.3 ± 8.5 years. The distributions of age and employment period were normal. The population size of the location of the practices ranged from 1,500 to 450,000 citizens, with a median of 150,000 citizens and mode of 20,000 citizens. Other socio-professional characteristics of the physicians are presented in Table 1.

Family physicians in Slovenia reported ethical dilemmas as occurring relatively commonly in their

everyday practice (2.4 ± 1.0 , out of maximum 5). The reliability of the questionnaire was acceptable (Cronbach's alpha 0.763). A composite score for the prevalence scale was 36.2 ± 12.5 , out of a maximum of 100. Decision-making regarding the use of limited resources was reported as the most frequent ethical dilemma (23.9% very frequent vs. 2.8% unusual), followed by patient attempts to abuse the health care service (20.4% very frequent vs. 0.7% unusual) and situations regarding the interface between primary and secondary health care (20.4% very frequent vs. 2.8% unusual). Doctors' suspicions of possible physical abuse, sexual abuse, or other violent acts were reported as less frequent ethical dilemmas (54.2% unusual vs. 0% very frequent), followed by disputes within the clinic team (51.4% unusual vs. 3.5% very frequent) and specific situations regarding the care of adolescents (41.5% unusual vs. 0.7 very frequent) (table 2). When the statements "unusual" and "not very frequent" were summed, communication of bad news to patients also emerged as one of the less frequent items. Mean scores of the items of the prevalence part of the questionnaire ranged from 1.5 to 3.6.

The total score of the frequency of ethical dilemmas (presented in brackets as a mean plus the standard deviation and P value) did not differ according to physicians' gender, university of graduation, years of experience in private practice, functions within their organization, and size of their community. Physicians aged 48 years or older and those with an employment period of 21 years or more reported ethical dilemmas less frequently (32.3 ± 11.9 vs. 40.1 ± 11.9 , $P < 0.001$; 32.4 ± 11.8 vs. 39.5 ± 12.2 , $P = 0.001$, respectively). Specialists in family medicine and residents of family medicine programs (the scores of both groups were summed together) reported ethical dilemmas more frequently than general practitioners without specialization (37.0 ± 12.6 vs. 30.7 ± 10.8 , $P = 0.05$). Residents of family medicine reported ethical dilemmas more frequently than general practitioners without specialization (39.5 ± 12.5 vs. 30.7 ± 10.8 , $P = 0.04$), but no significant difference was found between specialists in family medicine and general

practitioners without specialization. Multivariate regression analysis of doctor and practice characteristics did not yield any statistically significant model to explain the differences in reporting of ethical dilemmas.

Analysis of the individual items revealed some differences regarding sex, age, working period, working in private practice, university of graduation and size of the community. Female physicians reported issues involving interfacing with the secondary health care (3.7 ± 1.1 vs. 3.2 ± 1.0 , $P = 0.02$), difficulties in updating their own education (2.3 ± 1.2 vs. 2.7 ± 1.3 , $P = 0.04$) and controversial situations involving the pharmaceutical industry (2.2 ± 1.2 vs. 2.6 ± 1.2 , $P = 0.04$) more frequently than male physicians did. Younger physicians had more disputes within the clinic team (2.1 ± 1.2 vs. 1.5 ± 0.7 , $P = 0.001$), reported more controversial situations with pharmaceutical industry (2.6 ± 1.1 vs. 2.0 ± 1.2 , $P = 0.01$) and reported more difficulties when seeing immigrants (2.4 ± 1.3 vs. 1.7 ± 0.9 , $P = 0.001$).

Physicians with less work experience reported the following ethical issues more often: issues with confidentiality (2.2 ± 1.0 vs. 1.9 ± 0.8 , $P = 0.058$), abandoned or unattended patients or patients without sufficient means of support (2.5 ± 1.0 vs. 2.2 ± 0.9 , $P = 0.05$), communicating bad news (2.1 ± 0.8 vs. 1.8 ± 0.7 , $P = 0.02$), disputes within the clinic team (2.0 ± 1.2 vs. 1.5 ± 0.8 , $P = 0.006$), controversial situations regarding the pharmaceutical industry (2.5 ± 1.2 vs. 2.1 ± 1.1 , $P = 0.04$) and seeing immigrants (2.4 ± 1.3 vs. 1.6 ± 0.8 , $P < 0.001$). Family physicians in private practice reported issues regarding immigrants less often than those in public practice (1.6 ± 0.8 vs. 2.2 ± 1.2 , $P = 0.01$).

Family physicians working in small-sized communities reported issues regarding suspicions of physical abuse, sexual abuse or other crimes and special situations arising when seeing adolescents more often than those working in larger communities (1.6 ± 0.7 vs. 1.4 ± 0.5 , $P = 0.03$; 2.1 ± 0.9 vs. 1.8 ± 0.9 , $P = 0.02$, respectively). On the other

hand, those working in small-sized practices experienced issues regarding patients' temporary inability to work less often than those working in larger practices (2.1 ± 0.8 vs. 2.5 ± 1.1 , $P = 0.04$). Physicians who graduated from the only Slovenian medical faculty, in Ljubljana, reported difficulties in updating their own education less frequently than those who graduated from other universities (3.0 ± 1.5 vs. 2.3 ± 1.2 , $P = 0.01$).

DISCUSSION

Family physicians in Slovenia reported that encountering ethical issues was relatively common, and this is consistent with the available data (10, 12, 14, 24). Relatively frequent ethical dilemmas arose from problems in interfacing with the secondary care system, cost containment issues imposed by the health insurance bodies, and unsolicited patient demands. This is similar to the findings of Robillard et al (10) and Saarni et al (14), and consistent with the characteristics of the Slovenian health care system. The Slovenian National Health Insurance Company is constantly faced with a growing financial burden, resulting in progressive cutting of insured persons' rights. The majority of patients are used to a former state-run health care system, where voluntary insurance was not possible and health care was supposed to be available to everyone, regardless of the cost, with a marginal co-payment in some instances (28).

Surprisingly, the most difficult ethical issues, such as breaking bad news and suspicions of patients' abuse, were reported less frequently than more mundane, everyday issues. In contrast, Dayringer et al (12) found communicating truth to be a relatively common ethical issue. It seems that the continuous undergraduate and postgraduate education in communication that is nowadays a part of family medicine curricula in Slovenia results in better communication skills, so these issues emerge less often.

Several issues, such as the relationship with the secondary health care system, difficulties in updating

physician education and controversial situations involving the pharmaceutical industry, have not often been reported in previous studies but were reported as being relatively frequent in Slovenian general practice. This highlights the differences between family practice and other branches of medicine, indicating that situations not directly connected to treatment decisions are still an important source of ethical conflict and, as such, a potential source of stress for family physicians.

Our study and several others (1, 14, 20–24) reported age and employment period as important variables in the reporting of ethical dilemmas. Longer experience and higher age seemed to contribute to fewer perceived ethical dilemmas. Not surprisingly, younger physicians and those with shorter employment periods emphasized the most difficult ethical issues in primary health care, such as abandoned or unattended patients, communicating bad news and seeing immigrants. It also seemed that younger physicians and those with shorter employment periods had more problems communicating with patients and co-workers. The findings that physicians without any specialist training in family medicine were less likely to report ethical dilemmas while physicians in training were more likely are relatively new but are to some point consistent with the findings of Lo et al (29), who found that specialists reported fewer ethical dilemmas than residents.

To date, all of the studies (including this one) have failed to provide a clear pattern regarding the influences of different variables. This accords with the findings of Christie et al (15) that ethical decision-making does not depend significantly on the socio-professional characteristics of physicians, but rather relates to special features of individual clinical situations.

As our findings suggest, the paucity of research into ethics in family medicine does not mean that there are no ethical problems or that they are rare and without special importance. It is clear that ethical

dilemmas in family practice occur in everyday work and therefore are an important part of the decision-making process. The lack of professional experience in young physicians and in physicians without specialist training should be compensated for by appropriate education during undergraduate and post-graduate training. Although one could argue that education would not change the actual prevalence of ethical dilemmas, it could alter the ability of physicians to the presence of ethical dilemmas. Physicians who do not recognize ethical dilemmas cannot report their prevalence and cannot successfully resolve them, so education is vital.

The prevalence of ethical dilemmas in family medicine practice may indicate the need for ethics consultation services, involving experts in this field. However, previous studies have shown that doctors use them rarely (30). As our research has shown, ethical dilemmas are usually triggered by concrete factors and as such demand prompt solutions. Although there can be a moderate benefit in seeking professional advice from experts in medical ethics, continuous education remains the core method for helping doctors resolve ethical dilemmas in family practice.

The questionnaire used here proved to be a reliable instrument. It could be used as a measurement tool of the frequency of perceived ethical dilemmas in family practice settings as well as an assessment tool for detecting the effectiveness of education in recognizing and resolving ethical dilemmas.

The main strength of this study is the use of a randomly selected study group. The characteristics of the respondents did not differ substantially from those of Slovenian family doctors (31) and thus the study may be generalizable to the whole population

of Slovenian family doctors. A limitation is a possible selection bias created by the non-respondents: they could face more ethical dilemmas or report different ones and, if so, the study may underestimate the prevalence of the ethical dilemmas in family practice. Other possible limitations are the cross sectional nature of the study and the response rate, which was not high (but was what would be expected for this type of a study). Several issues make it difficult to research the prevalence of ethical dilemmas in family practice. One of the most important is what causes physicians to label an ethical issue as being common or uncommon. This depends largely upon the physicians' perceptions of the seriousness of the situation and their own moral and ethical principles. It is therefore not completely clear whether the reported prevalence reflects the actual one or rather the physicians' perceptions of the actual one, which are not necessarily the same. The decreased reporting of ethical dilemmas by more experienced physicians in our study points to the latter.

Some questions remain to be answered by further studies. The effects of other possibly significant variables, such as the length of the doctor-patient relationship, remain to be determined. The management of ethical dilemmas in family practice should be assessed and evaluated and the effects of education should be determined.

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