PAPER

Ethical behaviour of physicians and psychologists: similarities and differences

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ABSTRACT

Objective To compare the coping patterns of physicians and clinical psychologists when confronted with clinical ethical dilemmas and to explore consistency across different dilemmas.

Population 88 clinical psychologists and 149 family physicians in Israel.

Method Six dilemmas representing different ethical domains were selected from the literature. Vignettes were composed for each dilemma, and seven possible behavioural responses for each were proposed, scaled from most to least ethical. The vignettes were presented to both family physicians and clinical psychologists.

Results Psychologists’ aggregated mean ethical intention score, as compared with the physicians, was found to be significantly higher (F(6, 232)=22.44, p<0.001, η²=0.37). Psychologists showed higher ethical intent for two dilemmas: issues of payment (they would continue treating a non-paying patient while physicians would not) and dual relationships (they would avoid treating the son of a colleague). In the other four vignettes, psychologists and physicians responded in much the same way. The highest ethical intent scores for both psychologists and physicians were for confidentiality and a colleague’s inappropriate practice due to personal problems.

Conclusions Responses to the dilemmas by physicians and psychologists can be categorised into two groups: (1) similar behaviours on the part of both professions when confronting dilemmas concerning confidentiality, inappropriate practice due to personal problems, improper professional conduct and academic issues and (2) different behaviours when confronting either payment issues or dual relationships.

INTRODUCTION

Ethical dilemmas are integral to the therapeutic process and to professional practice.1 These issues are not uncommon,2 and practitioners often have to cope with them on a daily basis. The literature suggests that the six most common dilemmas practitioners in the helping professions encounter are confidentiality, dual relationships, improper professional behaviour, inappropriate practice due to personal problems, payment issues and inadequacy of academic training.3–5 There is some limited evidence that the range of ethical dilemmas faced by physicians and clinical psychologists may be similar.6 Although these issues are common, little research has directly compared the responses in the two professions when facing ethical dilemma, but they do seem to approach ethics differently. The two professions have different ethical codes in content and style.7 For example, psychologists have been found to refer to their professional code of ethics when faced with dilemmas, while physicians related to the family context of the patient, their peers’ attitudes and their own personal values.8 9 When comparing the ethical principles that serve as the basis for the two professions, psychology and medicine, there is considerable overlap. Both demand that intervention lead to no harm and that they contribute to society by preventing harm. Nevertheless, there may be some differences in emphasis that can be attributed to their training and expertise.10 The psychologist may be more sensitive to behavioural drift, where the context of a situation is taken into account. Although it is quite likely that professionals in both areas are aware of more than just the specific symptoms that confront the patient, the psychologist is especially trained to also appreciate the background and potential consequences of a particular patient–practitioner interaction. Recently, some of the issues relating to guiding physicians in becoming more attuned to environmental influences in their practice was discussed by a group at McGill who ‘developed brief, emotionally confronting, and ethically challenging clinical scenarios based on real events reported to faculty’ as a learning tool.11 In the present study, various professionally oriented and more social/behavioural types of ethical dilemmas will be presented.

AIMS

We ask whether practitioners in these two professions have different levels of ethical sensitivity with regard to critical ethical dilemmas.3–5 Does the patient who seeks treatment meet similar ethical approaches from physicians and psychologists? Is their approach consistent across different dilemmas?

OBJECTIVES

Relating specifically to the most common ethical dilemmas faced by the healthcare professions, we tested a series of hypotheses:

1. As psychologists confront more patients with personal issues and fewer situations where the patient’s health or those surrounding them is at risk, psychologists are less likely than physicians to breach confidentiality of patients.
2. Physicians are more likely than psychologists to agree to treat their colleague’s son.
3. Considering that in Israel psychologists mostly work outside the public service, whereas most
Physicians work within it; physicians are more likely to intend to continue unfinished treatment after its allotted time has lapsed despite the patient not being able to continue payment.

4. We do not expect any differences between psychologists and physicians in relation to a colleague’s inappropriate practice due to personal problems.

5. Physicians are expected to show more concern over the adequacy of their academic training than psychologists.

**METHOD**

**Sample**

A convenience sample of 88 clinical psychologists and 149 family physicians was recruited through the internet and at professional conferences. Emails were sent to all members of the Israel Association of Psychologists and the Israel Association of Family Physicians inviting them to complete an internet-based form. MFK distributed questionnaires at national conferences of the two professional associations, which were completed anonymously. The response rate was 37% at the conferences, about the same as found in other survey studies. Respondents were asked not to reply twice, and the anonymous internet responses were screened to exclude more than one response from the same computer. In addition to the explanation on the questionnaire, participants were informed that this was a study of ethics of healthcare providers. Those who filled a manual form signed a consent paragraph, without identifying details. The internet form required pressing a consent button in order to progress from the explanation page to the questionnaire. The questionnaire took about 10 min to complete.

The two groups were broadly similar demographically, other than a preponderance of over-60 year olds among the physicians, which is 37%, as compared with the psychologists, which is 3%.

Most of the physicians worked only in the public sector, while most of the psychologists had a private practice in addition to their public position. About 10% of psychologists reported some academic affiliation or continuing professional development activity as compared with 20% of the physicians. In addition, more psychologists than physicians had been exposed to some sort of ethical training. In all these biographical parameters, the respondents were reasonably representative of the general population of their respective professions.13 14

**Instruments**

Paradigmatic vignettes were developed by a panel of practitioners who worked in similar contexts to the respondents. In the first stage, eight psychologists provided vignettes for each of the six most common ethical domains identified from the literature. One vignette for each domain was chosen by the senior author and an external consultant, as most representative and generalisable (table 1). Then a group of 11 professionals including family physicians, clinical psychologists, psychiatrists and attorneys, all of whom are involved with ethical boards in their specific disciplines, provided a series of possible responses for each dilemma graded on a Likert scale from 1 to 7 for ethical standards. The anchors are detailed in online supplementary appendix 1. The research instrument for the psychologists and the physicians was developed in the same way but with substitutions of content material appropriate to the different clinical context. The final version was modified after pretesting by six independent psychologists and two physicians (see table 1). Agreement as to the appropriateness of the scale items ranged from approximately 75%–85%.

The research participants rated themselves on how they would behave if confronted with each of the dilemmas in the vignettes.

**Statistical analysis**

The results for degree of ethical intent were expressed as mean scores for each professional group for each vignette and differences between professions were analysed using analysis of variance and the effect size by η².

**RESULTS**

Overall, there was a statistically significant difference in the aggregated mean scores for ethical intent of the psychologists, compared with the physicians (F(6, 232)=22.44, p<0.001, η²=0.37). The detailed results, as shown in table 2, demonstrate large, as indicated by the η² statistic, and significant differences for two of the vignettes, in favour of the psychologists, concerning dual relationships and payment issues. In the other four dilemmas, psychologists and physicians responded in much the same way. The differences in ethical sensitivity for issues of confidentiality and academic training were negligibly small. For both psychologists and physicians, the highest scoring items were confidentiality and inappropriate behaviour of a colleague impaired by mental health problems. Payment issues were scored lowest for the physicians and near the bottom for the psychologists, only academic commitment scored less.

**DISCUSSION**

Large and highly significant differences were observed for two of the vignettes—representing dilemmas concerning

<table>
<thead>
<tr>
<th>Table 1</th>
<th>The six ethical dilemmas</th>
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<tbody>
<tr>
<td>Confidentiality</td>
<td>‘If you encountered a case that requires you to breach your patient’s confidentiality, how would you behave?’</td>
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<tr>
<td>Dual relationships</td>
<td>‘If you encountered a case of dual relationships with a patient, whereby the relations diverge from clear and reasonable professional contact - for example, a colleague from work with whom you maintain close ties asks you to treat his/her son, how would you behave?’</td>
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<tr>
<td>Payment</td>
<td>‘If you encountered one of the two following cases how would you behave?: 1) A patient had undergone private treatment with you for the last half a year and his/her funds gave out. 2) In the public sector, the health insurance fund ceased to finance the treatment. In either case it is clear to you that he needs immediate continuation of the treatment.’</td>
</tr>
<tr>
<td>Improper professional conduct</td>
<td>‘If you encountered a case where a patient is in need of treatment and you know that the practitioner is not adequately trained to administer it. How would you behave?’</td>
</tr>
<tr>
<td>Academic issues</td>
<td>‘If during academic training you realize that the academic professional training you seek in order to learn new treatment methods is insufficient or superficial, how would you behave?’</td>
</tr>
<tr>
<td>Inappropriate practice due to personal problems</td>
<td>‘If you encountered a case where you face the knowledge that a colleague’s professionalism is compromised due to personal mental problems, how would you behave?’</td>
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dual relationships and payment issues. The payment dilemma described a patient in private treatment with the psychologist when his/her money ran out, or when the insurance policy ceased to reimburse for medical treatment while the patient was still in need of continued treatment. Issues of payment increasingly occupy therapists and physicians, especially when in the context of managed healthcare. The concern is that the quality of treatment may be affected by medical considerations and by financial considerations, including overuse of treatment for profit and related gains.\(^{15-17}\) While in psychology, fee-for-service is acceptable and even considered essential to the therapeutic process,\(^{18,19}\) in medicine it is seen mainly as sometimes necessary in order to compensate for the shortcomings of the public healthcare services. Either way, money becomes an ambiguous and embarrassing subject for both practitioners.\(^{20}\)

In the present study, psychologists reported they would continue treating while physicians would not. Although the psychologists showed markedly higher ethical intent than the physicians, the absolute score was low for both groups relative to the other dilemmas. Historical, political and economic factors may play a leading role here, making this a highly emotive issue, involving questions of professional identity and culture that may interfere with the exercise of independent moral judgement.\(^{15,20,21}\) Apparently, abandonment of a patient by the psychologist is perceived by the therapist as more irrevocably damaging than by the physician who views the transfer of a patient from one doctor to another as acceptable.\(^9\) We are not suggesting that physicians are necessarily less ethical than psychologists, but rather that the wider context within which they work does not provide a sufficient level of professional expectation to deal with this particular dilemma.\(^{22}\) Most of the psychologists worked primarily in the private sector, while most of the physicians were salaried. Our findings can help us to gain greater insight into the different professional worlds of physicians and psychologists at least within the local context.

The vignette representing dual relationships used the case of the appropriateness of treating the son of a colleague. Situations of dual relationships pose a common dilemma in both professions, which has destructive potential for both the therapist and the patient.\(^4\) This dilemma focuses on interactions beyond the therapist–patient relationship such that the therapist may be involved in two roles simultaneously (eg, therapist and friend). It has been found that while the psychologists are more concerned about incompletely worked-through countertransference processes damaging the patient, and therefore will avoid dual relationships,\(^{23,24}\) physicians might not be so troubled, for example, when prescribing treatment without going through all the necessary precautionary stages.\(^2,25\)

In this study, significant differences were found between the two professions. The psychologists’ intent was to avoid treating the son of the friend, while physicians tended to treat. Again, it is the cultural norm that may influence whether physicians are likely to comply with such requests. With the increased exposure to managed care programmes, the ethical dilemmas of dual relationships facing physicians have increased. Thus, undertreatment may be a response to overt pressures from management or for financial incentives,\(^{25}\) representing a conflict between the patients’ interests and that of the physician.\(^{15-17}\) Additionally, there is a fundamental difference with regard to who is the focus of the treatment. While psychologists see the individual patient and his/her needs as paramount,\(^{26}\) the physicians seem to be more affected by the social context and the health needs of the community within which they work and thus more responsive to its various demands.\(^{22}\) The family physicians and the psychologists may simply be following their particular codes and standards, whereby dual relationships are specifically forbidden for psychologists but not for physicians. The difference here may not be in ethical intent as much as it is in the profession’s local standards and expectations.

The aims and the content of educational programmes for physicians and psychologists are fundamentally different. While the professional culture of psychology has been to produce therapists, physicians have traditionally been trained simultaneously for the role of physician and scientific investigator.\(^8\) Clinical psychology, as compared with family medicine in particular, has been slow in developing continuing professional education.\(^{20}\)

In the academic dilemma, physicians showed slightly greater ethical sensitivity than the psychologists and perhaps this difference expresses differences in the nature of their training and education, essentially the difference between training towards practice and scientific inquiry for the physicians and training for practice alone for psychologists.\(^7,8\) These differences in professional culture may diminish over time as more psychologists start doing research. Because the differences that were found were not large, future study is needed with different samples, perhaps stratified by age so as to determine if the professions are indeed converging on this issue.\(^4,5,10\) For both professions, the highest scores on ethical intent were reported for the dilemmas of confidentiality and a colleague’s inappropriate behaviour due to personal problems. The confidentiality dilemma deals with the practitioner transferring information regarding the patient to a third party outside the treatment. Psychologists and physicians both reported they would not break secrecy, unless required to do so by the court. The dilemma of inappropriate behaviour deals with the case of the practitioner being informed of a colleague’s impairment by mental health problems. Both psychologists and physicians reported they would ask him/her to stop practicing and get help, or to stop practising temporarily, and if the behaviour continues, both groups of professionals would report this fact to their professional organisation. In

### Table 2 Comparison of the physicians’ and psychologists’ intentions in ethical dilemmas

<table>
<thead>
<tr>
<th></th>
<th>Physicians</th>
<th>Psychologists</th>
<th>η²</th>
<th>F(1, 237)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>6.45</td>
<td>0.89</td>
<td>6.52</td>
<td>0.85</td>
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<tr>
<td>Dual relationships</td>
<td>4.26</td>
<td>2.10</td>
<td>4.63</td>
<td>0.95</td>
</tr>
<tr>
<td>Payment</td>
<td>4.07</td>
<td>2.30</td>
<td>5.69</td>
<td>1.40</td>
</tr>
<tr>
<td>Improper professional conduct</td>
<td>5.41</td>
<td>1.40</td>
<td>5.87</td>
<td>1.27</td>
</tr>
<tr>
<td>Academic issues</td>
<td>5.77</td>
<td>1.31</td>
<td>5.38</td>
<td>1.21</td>
</tr>
<tr>
<td>Inappropriate practice due to personal problems</td>
<td>5.99</td>
<td>1.43</td>
<td>5.91</td>
<td>1.40</td>
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*p <.05; ***p<0.001.
Patient preference in the choice between consulting a psychologist or a doctor seems to be based on their level of education rather than age, sex and race of the provider. However, within the health profession, some are more likely to be engaged in intimate and psychosocial health problems, for example, gynaecologists and general practitioners, which may affect patient choice of practitioner. Patients tend to choose physicians of the same age, race and religion, and to a certain extent the preference relates to gender differences in communication style. Since our findings indicate that when a patient enters treatment, and there are dilemmas concerning dual relationships, or payment issues he or she may meet different responses from physicians or psychologists, the practitioner’s position on ethical issues in general may also reasonably contribute to determining the patient’s choice of practitioner.

Competing interests None declared.

Patient consent Obtained.

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REFERENCES