Do family doctors have an obligation to facilitate research?

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In the third of a series of articles examining ethical issues in primary care research, we argue that family doctors, when considering what they ought to do in relation to research, have a positive obligation to participate in research and that one means of discharging this obligation is to collaborate in research studies by aiding recruitment. We offer three arguments in support of this obligation—arguments from fairness, reason and utility. We then go on to specify a series of conditions on this obligation which take into account that doctors have many other obligations. These are the conditions of financial remuneration, reciprocity and ability.

Keywords. Research, obligation to participate, research collaboration, reciprocity.

Introduction

This article is the third in a series examining some of the ethical aspects of research in a primary care setting. The first of these articles explored the question of whether family doctors should be permitted to recruit their own patients into research during the primary care consultation,1 and the second looked at the issue of offering financial incentives to both patients and family doctors (to encourage them to participate in, and recruit into, research).2 This third paper asks what moral obligation family doctors have when considering participation in research. We will argue that family doctors are under a moral obligation to participate in research and that one means of discharging this obligation is to facilitate recruitment. However, while this obligation is prima facie inescapable, we argue that the extent to which family doctors should be required to discharge it is conditional upon a number of factors, such as reimbursement of expenses, reciprocity and ability (which takes into account both research expertise and other competing and pressing obligations).

Accurate and consistent figures on how many family doctors in the UK are participating in research are hard to come by. One study, conducted in the West Midlands region of the UK (n = 1351) suggests that 75% of family doctors were involved in research or audit during the late 1990s and that 48% of those who were research active were participating in research that was initiated by others. However, almost half the responders stated they had no interest in undertaking research.3 Another UK-based study (n = 249) of the attitudes of family doctors towards research, published in the same year, found that although 13% of responders reported ongoing involvement in research, 39% of responders had no interest in research. Just over a third (38%) of responders had training in research (30% at undergraduate level), with only 8% having undergone research training in the previous 3 years.4 The generalizability of these findings is uncertain, and it is likely that the number of family doctors who are research active will vary significantly both within and between regions and countries. If these studies are at all representative, they suggest that although many family doctors are participating in research or audit in some way, a significant proportion of family doctors are not research active, have no interest in being research active and of those who are research active, a high proportion have had little research training.

The obligation to participate

All doctors have a duty of care to their patients5,6 and, arguably, this duty of care extends to providing the best treatment available. This will be determined partly by the patient’s interests and needs and partly by economic and social factors. The best treatment
‘available’ will not, therefore, necessarily be the best treatment ‘possible’. Their duty of care also requires doctors to seek out the most effective treatments and to keep their medical knowledge and training up to date, as the General Medical Council (GMC) states:

You must keep your knowledge and skills up to date throughout your working life. You should be familiar with relevant guidelines and developments that affect your work. You should regularly take part in educational activities that maintain and further develop your competence and performance.5

The GMC also requires doctors to provide effective treatments based on the ‘best available evidence’,4 while the American Medical Association (AMA) states that ‘[a] physician shall continue to . . . advance scientific knowledge’.6 The obligation to practice according to ‘the best available evidence’ and to keep knowledge and skills ‘up-to-date’ arguably only requires doctors to take account of what is currently known and does not extend to furthering the evidence base. This interpretation, however, is a narrow one and does not take into account the fact that the practice of ‘keeping up to date’ requires new research to keep up to date with. There could be no requirement to keep up to date with current medical science if there was no advancement of medical science through research and the requirement to keep up to date pre-supposes such advancement. An explicitly broader interpretation of the obligation to ‘keep up to date’, which seems to acknowledge this codependence, is found in the AMA’s formulation of the obligation to ‘advance scientific knowledge’. This not only requires doctors to keep up to date with advances in medical knowledge but also requires them to contribute to its advancement. This paper offers three arguments in support of this broader reading: the arguments from fairness, from reason and from utility. It then examines some practical limitations to this obligation.

The argument from fairness
It has been argued that there is a general obligation to participate in research because it is unfair for those of us who do not participate to ‘freeride’ on those who do.7,8 ‘Free riding’ occurs when one benefits from the efforts of others while simultaneously and inexcusably avoiding contributing to this effort oneself. Harris argues that free riding is unfair because if we accept the benefits of medical advances ‘there is an obligation in justice to contribute to the social practice which produces them’.9 Because we always have a moral reason not to act unfairly we must have a moral obligation to participate in medical research. This is a general obligation on everyone and therefore includes family doctors. Family doctors, then, who are able to keep up to date by relying on the research efforts of others, while unreasonably failing to contribute to that research effort, are free riding on those who do contribute.

The arguments from reason and utility
The practice of evidence-based medicine requires an evidence base and this requires high quality research.9,10 If modern medicine is dependent upon research, so too are family doctors as practitioners of medicine. Practice without research may become stale and outdated—to the detriment of patients11—and consequently to the detriment of doctors themselves. The legitimacy of medicine, as a science that can be relied upon and trusted, arguably depends upon the profession taking a critically reflexive approach to itself. Medicine can be trusted precisely because it challenges its existing norms and practices and strives to increase its knowledge base and the clinical application of that knowledge. It is, therefore, in the interests of all doctors to contribute to the process of research that gives their profession its legitimacy. Both deontological (Kantian) ethics and consequentialist (utilitarian) ethics, two of the most commonly referred to theories in biomedical ethics, suggest that this interest gives rise to an obligation to participate in research.

The Kantian argument (the argument from reason)
Kantian ethics are based on the view that ethical conduct is both rational and universal (if there is an ethical rule, it is a rule that everyone must follow, regardless of circumstances or consequences).12 If ethical rules are universal, they apply as equally to ourselves as they do to others and we must never, therefore, make ourselves exceptions to these rules. Furthermore, any rule for moral conduct that one chooses to follow must be the kind of rule that can be followed by everyone and not just by oneself. If a doctor, when considering whether or not she or he ‘ought’ to participate in research, decides to follow the rule ‘do not participate in research’, we can see that this rule could not be followed by all doctors without the entire practice of medicine losing its legitimacy. This is for the reasons offered above, namely that the practice of medicine would lose its legitimacy if it ceased to be critically reflexive and ceased to strive to increase its knowledge base and improve its practice. If no family doctor participated in research, research in primary care would grind to a halt, which would in turn undermine primary care medicine. The ‘rule’ of non-participation is, therefore, irrational and unethical. The rule that doctors ought to participate in research is, for the same reasons, rational and ethical.

If all doctors have the same obligation to participate in research, but some do not participate, those who do are arguably exploited by those who do not. Exploitation, as we discussed in our previous paper,2 is wrong for a variety of reasons. In that paper, we looked at exploitation in terms of unfair distribution of benefits.
and burdens. However, an action may also be regarded as exploitative because it uses people as mere means to the ends of others. Doctors who do not participate in research might be considered to be using those who do participate as a means to the end of retaining their own professional legitimacy. However, because Kantian ethics requires that any rules can be universalized, it is not just the doctors doing the exploiting who are to be criticized. Doctors who allow themselves to be so exploited are also behaving unethically—they should stand up against their own exploitation as vigorously as they would the exploitation of others. Accordingly, family doctors who fulfill their own obligation to participate in research should also expect and promote the participation of other family doctors in research.

The utilitarian argument (the argument from utility)
In utilitarianism, actions are judged by their outcomes: good outcomes are those that maximize good and/or minimize harm. Any action that does not promote good (or minimize harm) is de facto unethical. If we accept that medical advances act to maximize good and minimize harm (for patients and the wider population), and if we accept further that the de-legitimization of the institution of medicine would be a very great harm (both to society and to medical practitioners), then family doctors are obliged by utilitarianism to participate in research. Although not every act of research participation would lead to substantial benefits, ‘good’ will nonetheless be maximized if everyone always participated in research where possible. The good would be both direct therapeutic benefits to patients from successful research and also the continued legitimacy of medicine as described above (Table 1).

A prima facie duty with a broad scope
While these arguments establish a prima facie obligation for family doctors to participate in research, they nonetheless fail to stipulate what this participation must entail. The obligation is to participate in research ‘somehow’ and how family doctors choose to do this is a matter of personal judgement. Here, it is useful to draw a distinction between two kinds of duty. In moral philosophy, a ‘perfect’ duty is a moral duty that we have to perform in a particular way—such as a duty not to lie. There is no leeway in how we choose to discharge this duty; we cannot lie ‘just a little bit’. Alternatively, an ‘imperfect’ duty is one in which there is room for discretion as to its discharge. A duty, for example, to help others can be performed in a number of ways. It is not possible to help everybody in every way, and so we are at liberty to choose who we help, how and when. The duty to participate in research is, in this sense, an ‘imperfect duty’. Family doctors could, for example, become participants in a clinical trial themselves, conduct their own research or become members of research ethics committees. Alternatively, they could act as collaborators in research that is led by others and facilitate the recruitment of their patients into research studies.

Facilitating recruitment as a means of discharging the duty to participate
There are several ways in which doctors can discharge the obligation to participate in research. When considering becoming research participants themselves, family doctors operate under the same constraints as other potential participants; their ability to do so depends upon being able to meet the eligibility criteria. Further, there are only limited places on research ethics committees or other committees that support the development and conduct of high quality research. There are significant barriers to doctors conducting research themselves, including a lack of training, funding and time. Few doctors have either the expertise or the resources to carry out their own research. If and when the opportunity arises, all the activities mentioned above are legitimate ways to discharge the obligation to participate in research. Another way to

<table>
<thead>
<tr>
<th>Argument</th>
<th>Key points</th>
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<tr>
<td>The argument from fairness</td>
<td>Free riding occurs when one person benefits from the efforts of others</td>
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<td></td>
<td>whilst simultaneously and inexorably avoiding contributing to this effort him/herself.</td>
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<td>Free riding is wrong because it is unfair.</td>
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<td>All family doctors benefit from medical research in some way.</td>
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<td></td>
<td>Family doctors who benefit from research without contributing to the research effort are free riding.</td>
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<td></td>
<td>Therefore, it is wrong (because it is unfair) for family doctors not to participate in research.</td>
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<td>The argument from reason (a Kantian argument)</td>
<td>Medicine, as a legitimate scientific practice, requires ongoing, high quality research to be conducted.</td>
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<td>If all doctors refused to take part in research, medicine would lose its legitimacy.</td>
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<td></td>
<td>No family doctor would reasonably wish for medicine to lose its legitimacy.</td>
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<td></td>
<td>Therefore, no family doctor should refuse to participate in research.</td>
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<td>The argument from utility (a utilitarian argument)</td>
<td>We all have an obligation to maximize goods and minimize harms, including family doctors.</td>
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<td></td>
<td>The aim of medical research is to maximize good and minimize harms.</td>
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<td></td>
<td>Overall, participating in research will maximize goods and minimize harms.</td>
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<td>Therefore, family doctors should participate in research.</td>
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Legitimate limitations to the duty to participate

So far, we have argued that family doctors have a *prima facie* obligation to participate in research and that it is not unreasonable for them to discharge this obligation by collaborating with external researchers in facilitating recruitment of patients into studies. It should be acknowledged, however, that there are a number of barriers that must be negotiated prior to any legitimate expectation that a family doctor should discharge this obligation on a given occasion. Family doctors may be legitimately reluctant to discharge their obligation for a number of reasons, including where there is lack of timely and quality feedback about their patients and study outcomes; the amount of extra work poses an unreasonable burden and there are unrealistic expectations on family practices stemming from a lack of understanding, on the part of the researchers, about the culture and priorities of primary care. Lack of financial remuneration for resources expended; lack of training in research methods and conduct; clinical workload; and scepticism about the gap between theoretical research and practical work are all used to justify a refusal to participate in, or collaborate with, a research project. Clearly, family doctors are not the only parties to research collaborations who have obligations; so do the researchers who come to them for help.

Negotiating the ethical constraints

Alongside the obligation to participate in research, family doctors also have obligations to care for their patients and obligations to the staff they employ. Many also have obligations outside of work e.g. to their families. These may entail being, for instance, an active and present parent, giving support to a partner or participating in the wider life of a community, all of which legitimately justify placing reasonable limits on the amount of time spent working. A reluctance to participate in research is not necessarily an ethical failure to recognize an obligation to do so. Rather it may result from being unable to reconcile conflicting or competing obligations. The obligation to spend extra time with a particular patient or to keep the practice financially solvent may be more ethically urgent than the obligation to participate in research. At the same time, however, it is reasonable to expect family doctors to try to make time for research or to prioritize research where doing so does not impact negatively and unreasonably on their other duties. What counts as ‘reasonable’ depends upon the circumstances. It is, however, possible to stipulate some conditions that must be met for participation to be morally obligatory.

Financial remuneration

There is a widely recognized obligation on researchers to offer to cover the expenses incurred by research participants. We have argued that this obligation extends to family doctors who collaborate in research projects. It may not always be appropriate and neither may it be necessary, however, to pay family doctors additional sums of money to facilitate research. Family doctors should not expect financial incentives to discharge their moral obligation to participate in research. On the other hand, the discharge of moral obligations can be consistent with payment. For example, family doctors—like all of us—have a duty to help others if they can, but they are not expected to discharge this duty during the course of their professional practice for no payment. Accordingly, it is not unreasonable for family doctors to refuse to participate in research if doing so would cause them to lose out financially. Similarly, like other (professional) researchers, they can sell their specialist research skills where this is consistent with the fair discharge of their other contractual and professional duties. However, the expectation of fair pay for a fair day’s work does not justify a refusal to participate in research solely on the grounds that there is no financial ‘incentive’ to do so. If, for instance, participation merely required the family doctor to do what s/he normally does and is paid for, a refusal to participate on the grounds that no ‘additional’ financial reward is on offer would be unreasonable.
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Reciprocity
Reciprocity not only requires just acknowledgement and recompense for expenditure of resources but also that researchers involve and listen to their collaborators. If a family doctor is asked to spend time recruiting patients into a study, then that doctor has a stake in the outcomes of that research and should, therefore, have a voice in how the research is conducted. Family doctors are entitled to expect adequate training and should be willing to accept training, for example, in taking consent for research or in any other role they are reasonably asked to play. It is likewise reasonable for family doctors to expect to be supported in the event of some adverse reaction not due to their negligence and to be credited for any successes to which they have contributed. Reciprocity guards against any tendency to use others merely as a means to our own ends and serves to remind other parties to the research of their own duties. Although doctors have an obligation to participate in research, like any other participant they ought not to be exploited for the purposes of research. They must be free to choose to align themselves with the aims of another researcher or to choose to place their skills at the disposal of a research project. They cannot be obliged to act as the passive instrument of either an individual researcher or the society for whose benefit the research is being performed.

Ability
In moral philosophy ‘ought implies can’. This means that a person cannot be obliged to do that which they are incapable of doing. For one to have an obligation, it must be possible for one to discharge it. No single doctor has a moral obligation to save the life of every cancer patient in the world, for instance. Similarly, family doctors can only be obliged to participate/collaborate in research insofar as they have the requisite skills, ability and resources. We have already suggested ways in which family doctors might be better enabled to discharge their obligations to participate. Some of these ought properly to be thought of as the obligations of researchers seeking collaborators. For example, offering training or ensuring research expenses are met. There may, however, be constraints to ability that cannot be mitigated by the researchers and which money, equipment and training cannot resolve. These might include constraints on the doctor’s time or availability of suitable participants. We have argued above that the obligation to participate in research might require a family doctor to do what he/she can to enhance ability in order to enable research collaboration; but where ability is genuinely lacking, for reasons that cannot be reasonably mitigated, there is no obligation to participate. Indeed, it would be unethical for researchers to pursue collaborations with family doctors who lack the skills, or capacity, to appropriately participate in a specific research study (Table 2).

A brief caveat
In the above, we have focussed narrowly on the obligation to participate in research; we have not considered how family doctors can, and do, balance the need to discharge different obligations, for instance to their profession and to society. Clearly, the obligation to participate in research is only one of the many obligations that family doctors have. We have not argued that family doctors have an ‘overriding’ obligation to participate in research, but rather that there is a prima facie obligation to do so. The fact that doctors discharge many other obligations admirably does not necessarily mean that they are not also bound by an obligation to participate in research. The active discharge of other obligations might, however, excuse them from discharging it when the obligation to participate in research is incompatible with other, more pressing duties. This paper has not extensively discussed the obligations that researchers have to provide

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**Table 2** Summary of constraints and the obligations of family doctors and researchers

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<tr>
<th>Constraints and barriers to participation</th>
<th>The obligations of family doctors and researchers</th>
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<tr>
<td>A general unwillingness to participate</td>
<td>Family doctors should say yes to reasonable requests to help with ethical research projects. Researchers should do all that they can to remove barriers to participation in research collaborations but accept that some barriers are insurmountable. Family doctors are no different to the rest of the population when it comes to participating in research as a patient or volunteer. We all have an obligation not to freeride on the willingness of others to participate.</td>
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<tr>
<td>Family doctors feel uninvolved in the research process</td>
<td>Researchers should involve family doctors in the development of protocols and take their views and judgements into account when executing protocols.</td>
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<tr>
<td>Family doctors feel inadequately prepared/experienced</td>
<td>Family doctors should be prepared to undertake reasonable requests for training.</td>
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<tr>
<td>Participating in research puts family doctors out of pocket (in terms of money or time)</td>
<td>Family doctors participating in research should expect and receive remuneration for expenses incurred, but should not expect financial incentives to exercise their obligation to participate.</td>
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appropriate support, training, information and feedback to collaborating practitioners and patients. Our focus on the obligation on family practitioners to participate in research should not be taken to imply that this obligation is of greater importance than the obligations on researchers nor that this obligation is weightier than the other obligations family doctors have.

Conclusion

We have outlined three arguments to support the claim that family doctors have an obligation to participate in research: fairness, reason and utility. We have also noted that, given certain practical restrictions, collaborating as recruitment sites is probably the simplest and most readily available way for family doctors to discharge this obligation. We isolated some limitations to this obligation—namely financial remuneration, reciprocity and ability.

In summary, we are not suggesting that family doctors should be compelled to collaborate with researchers against their will. We do, however, suggest that it is important for family doctors to recognize that collaboration in research is not something they should exempt themselves from lightly. Nor is absence of financial incentive a valid excuse. Rather, participation in research is a moral and professional obligation, where the burden of proof must be on the individual family doctors to demonstrate that they lack the ability to discharge it. If this lack of ability is the result of some deficit of skill, there may be an obligation to address this deficit, all things being equal. Lack of ability can also arise from a lack of personal resources generated by the fulfilment of other obligations that can legitimately be regarded as more pressing. Family doctors, and indeed any health care professionals, who refuse to participate or collaborate in research ‘for no good reason’ are guilty of free riding, of perpetuating a lack of evidence base in practice and of failing in an aspect of their duty of care to their patients.

Declaration

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Conflict of interest: None.

References