



Primary Care Ethics

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Welcome to the ethics section of the London Journal of Primary Care.

Primary care ethics

Primary care ethics has acquired a definitive place on the 'bioethics map', now represented by a substantial body of empirical research, literary texts and critical discourse. Primary care ethics does not, on the whole, concern the dramatic or esoteric ethical issues popular in the bioethical journals and the lay press. Instead it is engaged with issues and problems that commonly confront normal individuals in the course of their everyday life. These can be subtle and complex, but are highly relevant to the practice of medicine and the business of living. In fact, much of the empirical research focuses on how primary care practitioners perceive and solve the diverse array of ethical challenges and dilemmas problems they encounter in the course of their daily work¹.

A paradigm shift in the delivery of UK primary health care – implications for professional ethics:

Primary care in the UK is undergoing a marked and rapid change. The modernisation agenda of healthcare in the UK and elsewhere can be viewed as a shift from a public service model to an industrialised market-based model of healthcare².

The emphasis is on consumer choice, accessibility and competition, combined with performance related pay. Concurrently there is a greater emphasis on population health within primary care, placing an expanded role on general practitioners and the primary health care trusts for disease prevention and health promotion. The goal of preventing disease, albeit laudable, arguably leads to a regressive move away from a person-centred biopsychosocial model to a more disease-centred biomedical utilitarian model.

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Tim van Zwanenberg summarises the challenges to General Practice under the headings of consumerism, the threat of substitution (of services by others), new demands for accountability (including changes in professional self-regulation), generational change (with changes in commitment and work patterns), and the new 'managerialism'³. Of the four broad functions primary care practitioners will need to undertake in order to meet these challenges, 'corporate management' (clinical governance, public health needs assessment, priority setting, construction of guidelines and protocols, and managed care), is undoubtedly the most ethically problematic.

Change, particularly if driven in a rapid, top-down fashion, with limited scope for timely evaluation, and in a complex organisation such as the NHS, can have multiple and often unpredictable

consequences. These can engender new and perplexing ethical challenges and dilemmas for healthcare professionals. Critical appraisal with a clear, rigorous perspective is urgently needed to identify the impact that these new healthcare policies and procedures can have on ethical principles, professional values and clinical practice. A number of empirical studies and essays from the USA alert us to the dangers of 'managed care', such as the corrosion of trust within the doctor patient relationship, and the negative impact on professional values, autonomy, morale and ethical practice⁴⁵⁶⁷. GP Fund-holding was taken up by nearly half of British GPs in the 1990's despite the problem of potential conflicts of interest and the risks to ethical practice, as highlighted by empirical research⁸. Starfield and colleagues describe primary care as effective, efficacious, and equitable, and have shown the benefits of primary care for population health⁹. They argue that these are being put at risk by the reforms¹⁰. London can be seen as the 'crucible of change' as it is often the first to experience modernisation experiments such as changes in service provision. Furthermore the tendency for a higher turnover of patients and staff and the centripetal force created by an increasingly wealthy centre make for greater difficulties in continuity of care.

New Zealand academic general practitioners take a deeply sceptical view of the UK quality outcomes framework (QOF) and see it as an external framework endorsing state-driven clinical priorities and corroding ethical practice and professionalism in a 'disempowering system of micromanagement'¹¹. Roland takes a more measured view, but can also see the risk of GPs becoming mere 'box tickers'¹². Research evidence so far, however, suggests that QOF has not acted as a threat to internal motivation or core values and is broadly aligned to GPs' view of good clinical care¹³. But this may be masked by many of the QOF tasks being delegated to practice nurses, who take a more negative view¹⁴. As the financial pressures increase, the position may change, and further evaluation and ethnographic research is needed.

Other changes not specific to primary care are also relevant for primary care ethics: these include the rise of evidence based medicine and the greater emphasis on individual autonomy in British law as exemplified by the Human Rights Act and the Mental Capacity

Act (2005). One author asks, in the light of these changes, whether we need to rethink primary care ethics¹⁵.

Sustainable professionalism

Professionalism has become increasingly disconnected from the functions central to public welfare as professionals are defined more as 'specialists' with expert knowledge and marketable skills, rather than individuals who develop and maintain mastery of their work, using it responsibly, ethically and - crucially - autonomously, in the service of others¹⁶. Freidson, in his classic and highly influential text *The Profession of Medicine* (1970), attacked the profession for its insularity, arrogance and failure to regulate itself in the public interest. In an afterword, nearly twenty years later, however, he acknowledges that the pendulum may have swung too far the other way, and conjectures that patients may well have lost more from imposed contractual limits than they have gained from the consumer movement and from legal and economic entitlements. Instead, they are transformed into 'industrial objects'.

Sustainable professional values

One thing is clear: there is a need for a solid ethical foundation when changes of structures and priorities create an environment of uncertainty. This solid foundation is often believed to be made up of core values. Values can be defined as 'deeply held views that act as guiding principles for individuals and organisations'¹⁸. Primary care's core values were articulated ten years ago in a series of illuminating essays¹⁹. These were identified as patient centredness, whole person medicine, and sustained partnership in the doctor-patient relationship. Howie and colleagues have further refined these multidimensional constructs and include empathy as an equally important concept/value in the armoury of the good physician. They question whether the rewards and incentives in the current contract promote the delivery of services based on the profession's core values²⁰. There is evidence, for example, that internal motivation can be undermined by externally imposed incentives¹³.

A recent document from the Royal College of General Practitioners restates the primacy of the doctor-patient relationship, the patient-centred clinical method, and a commitment to interpersonal care and

continuity. 'The values of general practice must be nurtured and new models of care must enhance these values'²¹. But here is the rub – how well can these values flourish in the current profit-orientated climate? For values cannot exist in isolation, hermetically sealed from what people actually do²². Values can also be seen as 'normal' i.e. assumed and central to personal and social identity, or 'aspirational' i.e. consciously sought after.²³ It is a moot point whether the core values outlined above are still 'normal' or are fast becoming 'aspirational'.

Conclusion

Perhaps the focus now should not be on *what* are the core values of general practice – the consensus appears to be clear – but rather how can they be made to be sustainable? Toon has considered the implications of incorporating a comprehensive virtue ethic as part of the moral foundation of general practice and for defining the characteristics of the virtuous practitioner.^{24,25} Others have considered the relevance of narrative and postmodern ethics in primary care^{26, 27}. It is clear that the philosophy of primary care remains a rich terrain that merits further exploration and that developing sustainability for primary care values is an urgent priority.

Further instructions for authors for the ethics section:

Word count: maximum 2000 words (excluding references) with a structured abstract of 250 words for papers (apart from case studies).

Papers: The journal welcomes ethical perspectives and experiences of other models of primary health care, essays that relate to the 'meta-issues' or philosophical basis of primary care, and discussion of a current controversy relevant to primary care ethics. Ethical insights must be underpinned by an accurate and proportionate understanding of the social and legal context, contextual realities and current clinical practice. Any work which fosters discourse and an increased understanding of the complex ethical issues confronting contemporary providers and users of health care will be considered. This includes articles that either offer a detailed critique of a recent publication or provide a comprehensive survey of work in a particular field.

Case Studies: Case studies have long been used to illustrate ethical problems in the context of clinical prac-

tice and to develop a case-based approach to ethical analysis. We welcome a clear, rigorous and nuanced discussion of the ethical (and legal) dimensions of such cases. These must be appropriately anonymised with identifiable features of the individuals concerned adequately disguised. If this is not possible, written consent must be sought by the authors. Any statement that is potentially defamatory must be avoided.

Public Policy and Law: analysis and commentary on recent legislative, legal and public policy developments and how these will affect professional practice and the ethical principles upon which health care systems are based.

Clinical Ethics: Articles on a variety of topics that reflect on the challenging issues within contemporary clinical primary ethics, including both the intellectual development and practical implementation of the discipline.

Empirical Ethics: Research reports, original articles, personal reflections on the research process, or accounts of work in progress are encouraged.

Healthcare student essay:

Original papers by students are welcomed. Editorial assistance will be offered if appropriate. The paper will be peer reviewed in the same way as all other papers, but the author will be given help to make the necessary changes if the referee reports are favourable.

Book (or media) reviews (maximum 1000 words) on appropriate ethical themes are also welcome.

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