

ETHICAL ISSUES IN PRIMARY CARE

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INTRODUCTION

This issue of *Current Allergy and Clinical Immunology* is dedicated to childhood atopic eczema in primary care and for this reason it is appropriate to address some of the ethical issues related to primary healthcare.

Primary healthcare (PHC) is regarded as the basis of the healthcare system, as it is intended to provide 'most care for most people, for most conditions, most of the time'.¹ Gilson et al describe it as follows:

'Primary health care aims to promote health and prevent disease, using education as one of its main tools. It aims to cure sick people and help people with disabilities to improve the quality of their lives. It follows the approach that health is linked to a country's social, economic and political development. It sees health as dependent on the environment in which people live, the services to which they have access and the extent to which they are able to take responsibility for their health.'²

Van Rensburg emphasises that PHC is the portal of first entry into the healthcare system, that its remit is broader than simply primary medical or curative care, and that it may lead to referral to secondary and tertiary care, as appropriate. It is 'not cheap, simple or second-class care: comprehensive PHC implies interventions firmly based on scientific research and on broad-based planning, implementation and coordination of such care'.³

Well-developed PHC is an essential component of South Africa's health policy as it is frequently the first point of contact of the patient with the healthcare system. It also provides promotive and preventive care to the population. The prevention and control of chronic diseases such as asthma and allergy constitutes one of the core PHC programmes in South Africa. The goal of PHC is to diagnose chronic disease early, to manage it and to reduce the harm it can cause, together with its prevention and the promotion of healthy behaviour.

For this article, I use Humphreys' explication of PHC as being 'the location for, and the activity of, the clinical management of self-presenting non-emergency conditions'.⁴ Primary-care practitioners include general and family practitioners (medically qualified clinicians providing the initial point of access to the healthcare system), doctors

and nurses working in primary-care clinics or community health centres and allied health professionals. Humphreys explains that, in the case of the National Health Service in the United Kingdom, the aim is for the vast majority of healthcare to be situated in primary care. It also implies a move away from the biomedical model of healthcare to the biopsychosocial one in which the individual's psychological and social circumstances are taken into account in addition to the biological component.⁴ The focus of primary care in South Africa is similar and becomes even more important in relation to the planned National Health Insurance scheme.

PRINCIPLES AND ATTRIBUTES OF PRIMARY CARE

The principles underlying PHC include:

'equity; community participation; social and economic development; interventions focused on the determinants of poor health, health promotion, prevention, cure and rehabilitation; an integrated referral system to facilitate a continuum of care; teams of health professionals with specific and sophisticated biomedical and social skills; adequate resources; and a client centred approach'.⁵

The important attributes of primary care are accessibility, patient-centredness, and the provision of continuous and comprehensive care. Access to and the *accessibility* of appropriate PHC are essential to ensuring the well-being of the population. *Patient-centred care* incorporates the notion of patients being seen as partners in making decisions with regard to their own healthcare. This shows respect for them as people and takes into account their values, wishes and preferences. It may present an ethical dilemma for the primary-care practitioner if the patient decides not to adhere to the prescribed treatment or has a different point of view. *Continuous care* refers to an ongoing clinician-patient relationship, whereas *comprehensive care* includes preventive care as well as attention to physical and psychosocial problems.¹

Primary care emphasises the importance of the individual in the healthcare system, whereas secondary and tertiary care concentrate on the disease.⁴

ETHICAL ISSUES IN PRIMARY HEALTHCARE

Many of the high-level ethics debates in tertiary healthcare settings focus on end-of-life issues such as euthanasia and physician-assisted suicide, withholding and withdrawing

life-sustaining treatment and do-not-resuscitate orders, termination of pregnancy and genetic testing. However, it is everyday clinical encounters that raise many ethical issues in primary care. Examples of these include requests for treatment that the clinician deems inappropriate; the professional and therapeutic relationship between the health professional and the patient; access to special investigations and treatment; a lack of resources and issues of confidentiality and consent.^{1,4} The complexity of the relationship between the primary-care practitioner and the patient is increased as the whole family may be patients of the practitioner and the model of care delivery is a longitudinal one. This, together with the large number of patients that have to be seen, adds to the likelihood of encountering ethical problems in primary-care practice.

In the South African context, issues of justice, inequity and inequality are important ethical considerations in primary care, in both urban and rural areas. Particularly in rural areas, access to healthcare services is limited and therefore it is essential that what is provided is not only of a high standard but also has seamless linkages to higher levels of healthcare. At the same time, the gatekeeping role of the primary-care practitioner is to prevent unnecessary wastage of scarce resources by ensuring that referrals are appropriate.

Humphreys argues that utilitarianism, or consequence-based ethics, should not be an important consideration in PHC as the focus is on caring for the individual rather than on the disease.⁴ He believes that it is the ethical duty of the primary-care practitioner to uphold the autonomy of the patient, ensuring the best treatment for the individual while respecting his/her choices. In order for the patient to make an informed decision, the primary-care practitioner needs to share the information with the patient and make a recommendation regarding further management. This shared decision-making is often neglected in the PHC setting, because time constraints impose limits on consultations.⁶

Another important ethical consideration in PHC is the rise of evidence-based medicine and its influence on the relationship between the primary-care practitioner and the patient. Guidelines are becoming increasingly evidence-based and funders may refuse to pay for treatment that they do not consider to be based on available evidence. This could undermine the role of the doctor in caring for the patient and may negatively affect the doctor–patient relationship.⁴ In addition, the emphasis in evidence-based medicine is on the findings derived mainly from randomised controlled trials, while it disregards the experience of patients and clinical judgement as important aspects of evidence.⁷ According to Slowther et al,

‘The complexity of disease presentation and management in primary care does not fit easily into this limited view of evidence based medicine, and if this is not recognised there is a danger that patient autonomy and

good patient care may be diminished.’⁷

In the primary-care setting, support for clinical ethical decision-making may be lacking, and therefore the primary-care practitioner should develop an approach to deal with the most common ethical issues.

A CASE STUDY IN PRIMARY-CARE ETHICS: THE CASE OF BABY B

Baby B, aged three months, presents to his local primary-care clinic with moderately severe generalised atopic dermatitis. The primary-care nurse practitioner, Sr D, counsels the mother regarding Baby B’s skin care, advising the use of a non-perfumed emollient cleaner and the application of regular emollient therapy. She also advises topical corticosteroid (TCS) therapy and suggests that Baby B be referred to the allergy clinic at the tertiary hospital – 100 km away – for allergy testing and specialist management. As part of her counselling, Sr D discusses the latest research regarding the optimal time to introduce solids, and explains which solids should be introduced between four to six months of age.

Baby B’s mother is reluctant to go to the tertiary hospital as it involves a full day trip, requiring her to leave home very early in the morning and spend the whole day at the hospital. She has also heard that TCS therapy may cause thinning of the skin and she was given a natural remedy by a friend whose baby had a skin rash. The friend’s baby’s rash had responded dramatically to this remedy. Furthermore, she reacts with disbelief to Sr D’s advice to start her four-month-old baby on solids such as egg and peanut-containing food rather than on baby cereal. How should Sr D approach this ethical problem?

There are several frameworks that can be used to resolve such ethical dilemmas. For this discussion, I use the step-wise approach as set out in Professor Moodley’s book, *Medical ethics, law and human rights: A South African perspective*.⁸ (See Table I.)

STEP 1: IDENTIFY AND ARTICULATE THE MORAL DILEMMA

In the case of Baby B, the alternative actions would be either to respect the mother’s autonomy and permit her to continue to use a topical treatment that may well be ineffective or to act in Baby B’s best interests and convince her that her baby needs to be seen by a specialist and be given TCS therapy for his atopic eczema. Here the principle of respect for autonomy is in conflict with beneficence. The ‘natural’ remedy may well cause harm to the baby and Sr D would be promoting the principle of non-maleficence – that is avoiding harm to Baby B – if she advises against it. At the same time, she will have to consider the benefits and potential harms of using potent TCS therapy in a very young baby (beneficence vs non-maleficence).

TABLE I: AN APPROACH TO ETHICAL DECISION-MAKING⁸

Step 1: Identify the moral dilemma: What are the conflicting values?
Step 2: Establish all the necessary information – medical, legal, ethical, socio-political norms; patient preferences; practitioner's personal value system.
Step 3: Analyse the information obtained.
Step 4: Formulate possible solutions and make recommendations or take action.
Step 5: Implement the necessary policies in institutions/private practice.

From Moodley, 8 p 163. Original source Dr Eugene Bereza, Department of Family Medicine, McGill University, Canada.

STEP 2: ESTABLISH ALL THE NECESSARY INFORMATION

It is essential to establish all the scientific and medical information relating to the case, together with the values of the treating team and all the social, ethical and legal information. A useful tool to analyse the information is the four-quadrant approach described by Jonsen et al explained in an article by Daniel Sokol.^{9,10} The four-quadrant approach uses the following in each of the four quadrants: clinical indications, patient's (or parent's) preferences, quality of life and contextual features.

The clinical information required includes: the scientific evidence for the use of TCS therapy in babies with atopic eczema; the available data regarding the side-effects of TCS therapy; the evidence for recommending that the introduction of solids should occur between four to six months of age in high-risk babies and more information regarding the 'natural' remedy and what it contains. The evidence for recommending the early introduction of allergenic foods when weaning high risk young babies should also be examined.

The mother's preferences are clear, but Sr D should explore the reasons for her steroid phobia and why she is reluctant to go to the tertiary hospital. At the same time, Sr D should consider how important it is for Baby B to be referred to the tertiary hospital, and whether additional tests are in fact clinically indicated.

If Baby B's eczema can be controlled, it will significantly improve his quality of life. The appropriate therapy would therefore be in his best interests (principle of beneficence). The contextual features in this case may include financial considerations that might make it difficult for Baby B's mother to travel the distance to the tertiary hospital.

STEP 3: ANALYSE THE INFORMATION

The information from step 2 should be weighed and analysed carefully, and there should be discussion regarding which principles should weigh more heavily in the particular case. Moral arguments for each approach to resolving the problem should be mounted and carefully analysed.

STEP 4: FORMULATE SOLUTIONS, MAKE RECOMMENDATIONS, THEN ACT

Possible solutions in this case are to accede to the mother's request and prescribe very mild TCS therapy only, while negotiating for a review if there is no response;

or to override her and indicate that she is not acting in Baby B's best interests. Sr D may postpone referral to the tertiary centre and follow Baby B up to gauge his response to the treatment. She may also decide to refer Baby B to the doctor at the primary-care facility for an opinion. The introduction of solids and its timing constitutes a more difficult problem. Does a randomised controlled trial on peanut allergy prevention done in the United Kingdom apply to an individual such as Baby B, who lives in South Africa? Sr D should provide Baby B's mother with information and the latest guidelines, and encourage her to consider the options carefully. The alternative would be to remove Baby B from his mother's care, but that would be an extreme action, and really not in his interests. I do not believe that any social agency or court would countenance that either.

STEP 5: IMPLEMENT POLICY

If appropriate, guidelines and a policy may have to be drawn up to address similar ethical dilemmas in the primary-care clinic.

CONCLUSION

PHC ethics is a developing field within bioethics, and ethical problems in primary care are different from those in secondary and tertiary care. The emphasis in primary care is on the individual patient rather than on the disease, and issues regarding the healthcare professional's relationship with the patient and the patient's family frequently pose ethical dilemmas. I have illustrated some of these dilemmas in this article and discussed a framework for resolving them in practice in relation to a hypothetical case.

DECLARATION OF CONFLICT OF INTEREST

The author declares no conflict of interest with respect to the contents of this article.

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