



# Quaternary Prevention and the Challenges to Develop a Good Practice



## Comment on “Quaternary Prevention, an Answer of Family Doctors to Overmedicalization”

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### Abstract

The article analyzes literature problems using as a parameter the quaternary prevention concept, introducing guidelines to have good shared decisions that avoid overdiagnosis and overtreatment and improve the quality of life. The author proposes a four-step approach: reliable evidence, awareness about populations profile, independent research analysis, and an understandable format by ordinary people.

**Keywords:** Quaternary Prevention, Literature Problems, Practice

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### Introduction

In 1986 a family physician, Marc Jamouille, coined the concept of quaternary prevention. At the time, the perspective was that we could offer good care without the harm of excessive intervention to our patients. The issue remains nowadays, and the challenges we face are even bigger.<sup>1</sup>

We are dealing with two new situations. First, the patients are over informed about healthcare and influenced by the media – but the quality of this information is doubtful at best. Second, there are safety issues with medical research, frequently developed in a way that inhibits independent analysis.

It is time to reflect how to develop an approach to medical practice considering the principles of quaternary prevention in the present scenario. There should be new ways to talk to patients, to challenge their distorted perception and to share decisions with them.

The concept of quaternary prevention is nothing more than the systematization of the concept of “primum non nocere” in our modern medical practice, an ethical approach to practice better clinical care and to protect people of excess of medicine.<sup>2</sup>

This problem appeared to have been solved when Sackett<sup>3</sup> devised the concept of evidence-based medicine, which claims that good research evidence and expert physicians would take good care of patients. However, the practice is different from the theory. There are many misconducts in medical research and practice, influenced by the biased health industry, much more interested in their bottom-line. Researches funded by health industry have to respond to their stockholders, but physicians must respond to patients. Many authors have published papers on this issues<sup>4-11</sup> and it is time to reflect what is important to a good medical practice. In order to reach a shared decision, it is important to know the literature, but it is also fundamental to consider that even

documents like AGREE II<sup>12</sup> and GRRADE<sup>13</sup> were still under a lot of pressure to take in consideration practices that do not embrace the concepts of quaternary prevention. We are still developing medical interventions that are not in benefit of the patients, but on the interest of the health industry.<sup>4,5</sup>

### A New Approach

The challenge to run medical care with shared decisions is to have an information that could be comprehensive and suitable for both the physician and the patient. This is not possible with the use of the traditional medical language and evidence-based medicine.

The first step in this movement is to define what could be an evidence that we can trust. The research protocol should always be public, with information on where the study was conducted. The health industry has many times used secondary results to write papers, with no protocol information and no possibility of peer review. This practice is harmful to patients.

The second step is to identify the population on the study, and to understand if this is applicable to the scenario of each patient. To reach shared decisions, we must understand how each person lives and what the feeling of being well is.<sup>14</sup> The concept of health is a perception of the individual, not a lack of illnesses, and this is crucial to define the treatment. In a shared decision, both patient and physician should understand what is available and what could happen with each choice.

The third step is to have an independent analysis of the research data. The commercial interest of the health industry has frequently overshadowed the interest of the population, and this is unacceptable. Even if many efforts have been done to correct this (AGREE II<sup>12</sup>, GRRADE<sup>13</sup>, and many other initiatives), we still have a huge influence of that industry

in regulation organizations and in political boards, leading to unacceptable misconduct. Even when there is a genuine interest in the promotion of proper recommendations, it is compromised by the poor quality or lack of transparency of the research we have today.

The fourth step is to bring the available information to a more understandable format. Terms of significance are not suitable for a complete understanding of the information. It is necessary to talk in terms of numbers needed to treat (NNT) or to harm (NNH). This will allow both the health team and the community to reach a shared decision together and to improve their relationship.

### Conclusion

When we put the patient and the community first in our medical practice, it is clear that quaternary prevention is a path to good practice and the development of good care that increases the quality of life of both the patients and the healthcare team.

We have a population that has access to a large amount of information, and it is our role to organize all that knowledge in a way that we may reach shared decisions together.

### Ethical issues

Not applicable.

### Competing interests

Author declares that he has no competing interests.

### Author's contribution

HW is the single author of the manuscript.

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