



Care and Do Not Harm: Possible Misunderstandings With Quaternary Prevention (P4)

Comment on “Quaternary Prevention, an Answer of Family Doctors to Over Medicalization”

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Abstract

The discussion between general practitioners (GPs) and healthcare delivery organizations necessitates a common language. The presentation of the 4 types of GP's activities, opens dialogue but can lead to possible misunderstandings between the micro- and macro-level of the healthcare system. This commentary takes 4 examples: costs reduction by P4, priority of beneficence or nonmaleficence, role of evidence-based medicine (EBM) and use of a constructivist model.

Keywords: Family Medicine, Specific Training, Medical Ethics, Evidence-Based Practice, Medicalization

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Citation: Widmer D. Care and do not harm: possible misunderstandings with quaternary prevention (P4): Comment on “Quaternary prevention, an answer of family doctors to over medicalization”. *Int J Health Policy Manag.* 2015;4(8):561–563. doi:10.15171/ijhpm.2015.99

Article History:

Received: 19 April 2015

Accepted: 15 May 2015

ePublished: 17 May 2015

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Introduction

General practitioners (GPs)/family physicians are centering their activity on individuals. In the process of communication between the practitioners and the organizers, from centering on individuals to the interest for populations, from the micro- to the macro-level, goals, concepts and language are changing. It is important to highlight possible misunderstandings when GPs explain quaternary prevention to public health partners.

Quaternary Prevention Reduces Costs?

Public health managers hope quaternary prevention (P4) will reduce healthcare costs. It is certainly true for the renunciation of superfluous primary and secondary inefficient preventive activities: for example extensive check-ups or irrational use of prostatic specific antigen (PSA). But if P4 deny unnecessary actions, it does not give up caring. “Not to do is not as easy as accepting to do.”¹ It requires more time and more competencies. Time and competencies have a price. When a patient “offers”² an indeterminate, undifferentiated complaint, the doctor has a duty to answer. This answer is not necessarily a technical investigation, opening to a specific diagnosis. Understanding what is happening at different levels (biopsychosocial model) with the possibility to deepen the diagnosis (Balint's in depth diagnosis²) and giving up to immediately engage in complex laboratory or radiological tests, is certainly a difficult task, requiring a doctor's specific training. Considering the biopsychosocial determinants, changing “diagnostic level”² to help patients giving sense to their symptoms and leading to a fair “compromise”² for care, all this requires specific knowledge, skills and attitudes. It is impossible to become a reflective practitioner³ in a day. Besides specific training, the reflective practitioner needs time with the patient and also time to exchange

with colleagues (supervision and continuing professional development). The political authorities must take this fact into account when organizing care and deciding the doctor's payment mode. As Lemon and Smith⁴ stress, consultation's quality depends not only on time but first on the content. Although some authors considered how to make the best in a limited period,⁵ it remains that too short consultations can be dangerous: doctor's work may conduct to inadequate answers to symptoms, without any reflexivity. In short, if quaternary prevention is not defined as a simple renunciation to unnecessary medicine but as the proper answer to patient's demand, this will require time and P4 is not initially a method to save money by controlling the time.

First Care or Do Not Harm

We can consider the debate ethically. P4 must also question the tendency to excessively highlight the principle of nonmaleficence⁶ (Primum non nocere). If “caring and understanding patient's world is still the first duty of the family doctors”¹: the protection against to much medicine comes in second. This attitude is in agreement with the original Hippocratic text about the 2 principles of beneficence and nonmaleficence, where there is no prioritisation of nonmaleficence: “make a habit of two things – to help, or at least to do no harm,”^{7,8} said Hippocrates (Epidemics I, XI, 10-15). Nonmaleficence is here only the consequence of beneficence.⁹ The same for Pellegrino: “the primary obligation that unifies the theory of medical ethics is beneficence. The primary obligation is not nonmaleficence which is a negative obligation required even by law.”¹⁰ A good definition of the legal framework of medical activity is certainly necessary for a good functioning of health systems, from the macro-level point of view. From the point of view of the relationship

during consultation, the doctor cannot have a purely legalistic attitude. This can conduct to defensive medicine, with two pitfalls: “protective” over investigation and renunciation to understand the patient more profoundly, to simply care.

Evidence-Based Medicine as a Solution?

Is EBM the better solution to choose good medicine? It seems that in recent years, “evidence” became doctor’s (or nurse’s) supreme argument to convince public health authorities of the merits of their activity. Always doctors had to prove to society the legitimacy of their actions. Gadamer¹¹ described this phenomenon as “doctor’s apologetic discourse.” Since ancient times, according Gadamer, doctors had to defend medicine as an art: “an art is not practical application of theoretical knowledge but own form of practical knowledge.”¹¹ This part of medicine is certainly the most complex matter to explain simply and clearly to our public health partners. EBM can give us probabilistic decision-making tools, such as number needed to treat (NNT) or medical scores. But the final decision can be very different according different professionals¹² and different kind of relationships with the patient. Clinical decision-making is not simply a probabilistic or mathematical reasoning. Sackett¹³ himself, EBM’s father said the same: “*Good doctors use both individual clinical expertise and the best available external evidence and neither alone is enough.*”

If we think that P4’s consequence is the refusal of any action in presence of doubt (*in dubio absterne*), or in the absence of evidence, we must also consider the risk of therapeutic nihilism⁹: to let the patient without support. Inadequacy or insufficiency of care can be as dangerous as over medicalization. Questioning the potential harms of therapeutic nihilism is also the role of P4.

For the “artistic” part of his activity, the doctor needs to get out of EBM’s positivism, and open his reflection to other epistemologies, as suggested by Thomas¹⁴: critical theory and constructivism. The position of P4 is certainly that of a well-conducted skepticism who needs alternative tools than those of biomedicine. Medical psychology, sociology and anthropology allow P4 to adopt a critical position.

Paradigm Shift to a Constructivist Model

P4’s concept goes beyond the patient-centered medicine, tending to a constructivist approach based on the patient-doctor’s relationship. We can speak of a relationship centered medicine. Launer¹⁵ considers the consultation as a co-construction process, when different stories are meeting together, leading to a new common narrative (narrative-based primary care). For example the establishment of therapeutic priorities in the case of a patient with multiple chronic diseases, necessitates a process of common construction to grant different agendas. When promoting the participation of GPs to the debate on the organization of healthcare delivery, we must use such a co-construction model. GPs should be able to present their disagreement for any system that impedes the therapeutic relationship. For example, an organization of care based on multiple and maximal targets can be excessive for the patient. Such organization must be criticized, who can lead to what is called a disruptive medicine,¹⁶ when the patient is deprived of his daily life in favor of medicine. Disruptive

Table. Macro- and Micro-Level Points of View

Healthcare Delivery Organizations	GP
P4 reduces costs	P4 implies time and specific training
Importance of nonmaleficence for legal issues	Beneficence as the first principle
EBM as the gold standard for decisions	EBM as one epistemological tool within others
Citizen centredness	Relationship centredness

Abbreviations: GP, general practitioner; P4, quaternary prevention; EBM, evidence-based medicine.

medicine is also too much medicine. For this reason GPs have to defend horizontal organizations of care centered on primary care rather than vertical organizations of multiple juxtaposed specialized silos.¹⁷

Conclusion

My intention was to show the possible sources of misunderstanding between interlocutors, practitioners and managers, hoping having not added confusion. Partners have to clarify the concepts used and try to construct a common language. A shift in research agenda from disease specific research to research based on global impact in overall health (functional impairment), seems necessary with the increase of multimorbidity.¹⁸ This research should not be based only on biomedical or numerical indices (such as hospitalization rate¹⁹). A special emphasis should be left to qualitative research²⁰ to assess the impact of health policies, evaluating the lived experience of practitioners and users (for example anthropological studies after implementation of a new payment system^{21,22}) (Table).

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author’s contribution

DW is the single author of the manuscript.

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