Too Many Types of Prevention?

Korunma Tipleri Çok Mu Fazla?

ABSTRACT

Ever since we become Family Medicine residents, prevention becomes part of our everyday work. Different types of prevention were created years ago, being quaternary prevention the most recent one. This work aims to prevent excessive medical interventionism. In a personal perspective, this article describes what motivated this concept, taking into account the medicalization of the society, the disease mongering and the lack of health literacy. It also raises questions about the integration of academically created concepts in our clinical thinking.

Keywords: health promotion, preventive medicine, health literacy

ÖZET


Anahtar kelimeler: sağlığın geliştirilmesi, koruyucu hekimlik, sağlık okuryazarlığı

During medical education, future doctors are academically directed towards organizing their scientific knowledge in brain “drawers” in order to facilitate their capacity to memorize, achieve learning objectives and perform clinical thinking.

After entering Family Medicine specialization programme, included in its definition and core competencies described by WONCA and WHO, there is an important place for a comprehensive approach or integrated care involving health promotion and disease prevention (1,2). In fact, the change of the curative paradigm into a more preventing one really changed our speciality but, originally, the concept was created to help people being more responsible for their own health. In this way, Family Doctors could adapt their needs and adapt guidelines to their specific context as they know their patients and their main difficulties.

Nowadays, health promotion and disease prevention are multidisciplinary and have deserved more and more attention because of its financial viability and cost-effectiveness - as Benjamin Franklin’s said “an ounce of prevention is worth a pound of cure”. However it does not produce immediate results (3,4).

The role and gains of implementing preventive measures are undeniable (5), but how ready and well informed about the effectiveness of these interventions are we? Has one model been proved to be better than another? And how interested are the patients in engaging with this and many times going against the paternalistic medical culture that lasted for centuries? These are some of the questions that I put myself

SPECIAL COMMUNICATION / ÖZEL RAPOR

AUTHORS / YAZARLAR

Maria Margarida Alves Moreira
Department of Family Medicine, USF das Ondas, Póvoa de Varzim, Portugal

Corresponding Author / İletişim için
Maria Margarida Alves Moreira
Rua da Praia, n.º 186 - Fieiro – Aguçadoura, 4495-031 Póvoa de Varzim
E-mail: mmargmoreira@gmail.com
Date of submission: 20.06.2015 / Date of acceptance: 03.11.2015
Moreover, because they help us organize our brain “closets”, we all know the created concepts of the different types of prevention that emerged some decades ago:

- Primordial – includes political promotion programmes of positive health determinants like laws prohibiting smoking in public areas, etc.
- Primary – represents activities to avoid or remove exposure of the individual to a risk factor before disease is installed, this way reducing its incidence. Immunization against infectious diseases is an example.
- Secondary – consists in detecting and treating disease as soon as possible (through screenings for instance) to halt or slow its progress, encouraging strategies to prevent recurrence, and implementing programs to return people to their original health and function in order to prevent long-term problems.
- Tertiary – has the objective of soften the impact of an ongoing illness or injury that has lasting effects at both individual and populational levels (the latter by reducing the economical and social burden). It includes early rehabilitation and reintegration to enable patients to recover their function and improve their quality of life and life expectancy.
- Quaternary – results from the need to prevent the excess of medical intervencionism or, in other words, the iatrogenic unbalance between harms and benefits of exams or treatments.
- Some may even suggest a new type of prevention, an informal “quinquenary prevention” that would prevent damage in patient by taking action concerning the doctor, preventing his burnout and thus the probability of error.

And this must be a matter of reflection: why do we need to have types of prevention? The concept of prevention should mean all this: that we want to maintain our patients health, prevent the emergency of diseases and manage chronic disease in the best way possible, free from overwhelming pressures at our workplace.

However, it is because we feel the need to intervene to prevent that we had to create the most recent recognized one: quaternary prevention. But preventive medicine is not consensual and has raised other issues:

- We may be recommending vaccines with questionable impact in locations where the incidence of the disease they mean to prevent is low (as in the case of the new meningococcal serogroup B vaccine) and we may be using controversial measures, like the use of acetilsalicilic acid to prevent primary cardiovascular events, that probably have more risks than benefits.
- We are surely enlarging the number of screenable diagnoses creating a “risk epidemic” because we are not just looking for diseases anymore, we are one step ahead by looking for risk factors like arterial hypertension and dyslipidemia and we treat them.
- We may be acting too demandingly in achieving goals in the management of chronic diseases where many times “less is more”.

And these are only some examples. For these reasons, some authors refer the medicalization of the society as a consequence of preventive medicine. The same happens with the “everyday” created diseases and for that you just need to observe the difference in the number of mental disorders described in Diagnostic and Statistical Manual of Mental Disorder (DSM)-I and in DSM-V which increased substantially, surely we all fit in one of the descriptions, so are we mentally ill? We are overdiagnosing, setting too many “drawers”, and overdiagnosis can be troublesome: it does not simplify decisions or protect the patient.

That’s why there was a need to introduce the terms “quaternary prevention”. But didn’t we all agree with the Hippocratic Oath and the “Primum non nocere” principle when we entered our profession? So this shouldn’t be needed. The problem is that we face a new era of mediatization of diseases and disease mongering by the pharmaceutical companies. In developed countries we live the paradox between living more time with more quality and the increase of the sense of disease and dependence on the health system. A lot of people seek for the medical doctor just to be sure that they don’t suffer from what’s popular (and proffitable for some) at the moment or just to check if the newest and best claimed treatment for a disorder is the one.
they are receiving.

This means that despite the great improvement in education level, health literacy is far from what is desirable. This parameter includes functional (ability to read, understand and interpret a written text and write), interactive (ability to speak, listen and communicate about health-related information), critical (ability to make appropriate health decisions) and numeracy (ability to use numeric information for tasks such as interpreting doses) skills (10,11).

Reduced health literacy is recognized as one of the strongest predictors of a person’s health (12).

So, before implementing curative treatments or preventive advices one must understand the patient and his health literacy, otherwise we will never get the opportunity to properly empower the patient and make well informed shared-decisions with him. That’s the safest way to deal well with uncertainty and not be afraid of our joint decisions.

References


