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Family doctors

Quaternary prevention

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I.The concept of quaternary prevention.

Throughout time, culture and medical customs, the human being has been confronted with change in the very concept of health. It is especially true in mental health.

Hellstrom[1] has clearly shown the dilemma of the potential patient. By integrating disease and sickness, he describes in the patient four different self-perceptions which are expressed in very distinct ways during the medical visit.

Drawing a four axis figure, he depicted it as "An effort to graphically represent the relationship between a person who is or is not sick and the fact that they have or have not developed or been afflicted by a disease.

From a similar perception one of us (MJ) proposed some years ago a similar figure[2]. Integrating the physician's knowledge i.e. science and the patient's conscience, we can determine four fields :

	Doctor's knowledge of disease	
Patient's view	Absent	Present
Healthy	**I**	**II**
Sick	**IV**	**III**

Fig. 1 : four fields of patient doctor encounter
and four fields of prevention

Those patients who truly belong to group I are not safe from the dangers of medicine. They can benefit from or are exposed to vaccinations or health promotion campaigns.

Those in group II who are picked up as positive during a screening test will join group III. Some in group I or II who are overly sensitive or who are the victims of misconceived preventive medicine will join the hypochondriacs in group IV on whom research will be needed to determine if the disease classification they fall under is accurate[3].

This group IV serves as a testimony of the excessive medicalisation of anxiety in the post-industrial society. These patients are the victims of the wild overgrowth of medical activity[4]. Patient’s anxiety meet doctor’s anxiety.

Jules Romain, the famous French writer, has pointed out already in 1924 the dangers of overmedicalisation in his play "Knock"[5]. There is a Dr. Knock in each of us.

This conflicting meeting between the « Malade imaginaire » of Moliere and the « Dr Knock » resolve itself by overproduction of superexpensive biotechnological proces.

We have so described a new and logical approach to the concepts of Primary (group I), Secondary (group II), Tertiary (group III) Prevention. It is necessary to consider the group IV to which logically the term Quaternary Prevention should be applied.

Medicine can be dangerous for patients'health and the people have to be protected against medical anxiety or 'mediconomic' agression, especially in the mental health. Quaternary Prevention should be a new, and one of the most important targets for Quality Assurance.

II. An other difference between primary and secondary care

Family doctor and specialist manage the field IV in really different way. All the professional training of the specialist push him to find the disease . He is always trying to get the patient in the field III. This disease finding proces precipitate the patient in a medical game[(6)]. No doubt he shall become sick of this 'hepatic cyst' revealed by the abdominal scanner. Patient care or Imaging care ?

Family doctor has the time to wait. Longitudinality and trust are his two tools. If he don't succeed to get the patient in the field I (no disease) he can accept to send him in the field II. In other word the GP has to be sensitive and the specialist has to be specific. This specificity has a very hight human and economic cost.

Missing the disease is the price of sensitivity but the GP can repeat the experiment. And this is clearly not the case of the specialist, by lack of time or to preserve his professional image .

On of the main problem in some country is the training of the future family doctors. Mainly all are trained in hospitals as future specialist. Nobody can accept to mis a diagnosis and nobody is trained to ear, learn to and explain.

III.Plea to introduce Prevention IV in the glossary

The International Glossary[(7)] of general practice/family medicine is now ready to be published by the Wonca Classification Committee.

Clearly, the definitions of Prevention I,II,III proposed in the glossary fit perfectly in the fields I,II and III described in fig.1.

So we attempt to define Prevention IV :

Action taken to identify patient
at risk of overmedicalisation,
to protect him from new medical invasion
and to suggest him interventions ethically acceptable.

The fig.2 shows the four definitions in their respective fields. Field I, no disease and healthy patient. Field II; the disease is present but the patient doesn't know it. Field III; the disease is present and the patient knows it. Field IV, sick patient with no disease.

I **Primary prevention**: Action taken to avoid or remove the cause of a health problem in an individual or a popula- tion before it arises (ie immunisation).	**II** **Secondary prevention**: Action taken to prevent development of a health problem from an early stage in an individual or a population, by shortening its course and duration (ie screening for hypertension).
IV **Quaternary prevention** Action taken to identify patient at risk of overmedicalisation, to protect him from new medical invasion and to suggest him interventions ethically acceptable.	**III** **Tertiary prevention**: Action taken to reduce the effect and prevalence of a chronic health problem in an individual or a population by minimizing the functional impairment consequent to acute or chronic health problem (ie prevent complications of diabetes)

Fig. 2 : The definitions of prevention I, II and II, fit perfectly in the fields I, II, III. Prevention IV is therefore proposed in field IV.

In field IV we find two concepts in one. From the patient's point of view it is the place of the 'Malade imaginaire' and from the medical point of view Dr Knock's triumphal science.

A.Prevention IV and the patient encounter

So the patient at risk of overmedicalisation has to be identified.
Many ways to do that : the identification of the reason for encounter is the first step in quaternary prevention. Ask the patient what he/she thinks about this particular problem is the next step (patient expectative).

With the social, cultural and intellectual patients'background in mind (family physicians'job), the next step would be to explain carefully what's going on and the stages and the reasons of diagnosis and therapeutic processes.

Be aware of the projected anxiety of a patient helps to consider the type and form (letter, phone call) and the reason (for all results, only for problems) before contacting the patient when the tests and results are ready to be transmitted.

Visiting patient in hospital, explaining what's going on, who is responsible for his/her care or cure is another way to prevent patients'anxiety.

B.Prevention IV, humanity and medical ethics

To be aware that the medical view is one and only one of the multiple views used by the human being might give the family physician a touch of humanity.

To have in mind that medicine can be dangerous for patients'health is a key for quality assurance. That's the way of explaining why the physician doesn't agree to prescribe neither an Xray nor a Headscan as first procedure for a headache.

Prevalence, sensitivity, sensibility, negative and positive predictive values teach us that a scanner is not the first step to investigate headache. The patient doesn't know it and is really anxious since his relative died from brain tumor.

How to manage this dilemma in an ethically acceptable way. How to circumscribe the prehistorical patients'pulsion for magic medicine and the 'scientifically' based medical agression ? Nor direct nor clear answer to this fundamental question but identifying the question as such is already the beginning of an answer.

C.Prevention IV in health education programs

Any experienced physician knows that Monday is the heart day if there was a television show on cardiopathy the Saturday before.

Leaflets or videoshows are often anxiogenic and need to be carefully studied from this point of view.

The health education language is often a battle language with strategic issues. Nobody has the right to withdraw. Nobody has the right to say that one day the fight will stop by lack of combatant. You are not allowed to speak about death. Nobody is prepared neither to suffer nor to die. Everything is going well with low cholesterol. "You can't beat the feeling".

D.Prevention IV through medical record (chart or screen)

The game is to do something without sending the patient into field IV. Seeing a patient in field I, missing the explanation of rubeola immunisations'principles to a pregnant woman sends this patient into field IV with a terrific anxiety to have a deaf baby.

A medical record can help you remember that this particular patient is very sensitive to medical advice, that you have already done the pap smear this year to this woman, that you have already made the breast palpation this year. So you control your preventive productions and you avoid to this woman to fall in cancerophobia. Indeed, repeating the procedure is anxiogenic. The woman might think that "You have seen that she has a cancer and you hide it "

IV. Humanism

Reading the glossary of general practice, one can have the impression that general practice /family medicine is now determined by health economy, public health and management. Philosophy is lost.

General practice/family medicine is an encounter place between science and conscience and a crossing for medical ethics. Family physician is also a local ethnologist and a multiethnic multicultural mediator. Prevention IV requires ethical, cultural and communicational approach of the patient.

Medical ethics, patient doctor communication and patient doctor relationship are central issues in medical care. Economy, management, public health and quality assurance don't have to take the pre-eminence.

Introducing Preventon IV is also a plea for a more humanistic view, more patient oriented thinking in medical care.

References

1 Hellstrom O W. Health promotion in general practice.
Europ. J. Public Health. 1994;4:119-124
2 Jamoulle M. Information et informatisation en médecine générale. [Computer and computerisation in general practice] in: Les informa-g-iciens.: Presses Universitaires de Namur; 1986:193-209.
3 Noyes R; Kathol R G; Fisher M M et al. The validity of DSM-III-R Hypochondriasis.
Arch Gen Psychiatry. 1993;50:961-970
4 Lebrun JP. La Maladie Médicale [The Medical Sickness].
De Boeck Université. Bruxelles. 1993.
5 Romain Jules, Knock, Editions Gallimard, Paris, 1924.
6 Carpentier J, Medical Flipper, Edition de la Découverte, Paris, 1989
7 Wonca Classification Committee, An International Glossary for general/family practice, Bentsen N.(ed.), draft, feb.1995