Prevention

We've come a long way baby...or have we?

John W. Feightner, MD, MSC, FCFP

Prevention, especially clinical prevention provided by family physicians, has developed and grown over the past 3 decades. Its profile among the general public has risen dramatically, and prevention issues are on the "radar screen" of many of our patients.

Over the same time we have developed a richer understanding of what works and what does not, allowing us to enhance patient care and increase efficiency by focusing on those preventive strategies that most benefit our patients.[1] For example, since 1994 the Canadian Task Force on Preventive Health Care has identified more than 100 clinical preventive actions of benefit across all age groups; such actions as mammography for women age 50 to 69, routine measurement of blood pressure for adults, influenza vaccination of older adults, and immunizations for children have arguably become expected standards of care. Importantly, family physicians have embraced the value of prevention and health promotion and tried to incorporate effective preventive care into their practices.

New challenges

The progress in prevention has created new challenges, primarily in management of preventive care in physicians' offices. Opportunities to provide effective preventive care often clash with ever-increasing demands of day-to-day practice, changing demographics, and the greater complexity of patient problems. Increased patient awareness of prevention and its potential benefits can add time to patient visits, and, increasingly, preventive care involves informed choice and shared decision making for interventions that carry potential benefit but known risks. Yarnall and colleagues[2] have sharpened the issue of time pressure by estimating the time required for providing effective preventive care to a practice population. Their work speaks loudly and clearly to the need to find appropriate solutions to providing effective preventive care.

Need for change

As a discipline we are only now beginning to give voice to the long-standing problem of inadequately developed and inappropriately resourced office infrastructure. In contrast to a reactive approach to care, which responds to patient symptoms and concerns, preventive care requires a proactive approach. Because most clinical preventive actions are initiated by family physicians, they need not only knowledge of what is effective for men and women in different age groups, but a way of tracking which patients need specific actions and when.

All of this suggests a need for appropriate office tools and changes in office infrastructure. Two articles (**page 40, page 48**) in this issue of *Canadian Family Physician* address one strategy to enhance infrastructure—use of prevention flow sheets. The work described in these articles reflects careful thinking and attention to existing evidence and is an important contribution to the field. But given that the original research supporting the potential effectiveness of these tools goes back at least 20 years, one cannot but wonder why we are still at a stage where the important work must focus on instrument development rather than widespread implementation.[3-7] Other studies over the last 2 decades have explored and evaluated a range of potential strategies to enhance office preventive care, including practice facilitators,[8-11] patient-targeted initiatives,[12,13] and chart-based physician reminders.[14] These initiatives have provided important evidence, but the implementation of effective management strategies has been remarkably slow, despite family physicians' interest in prevention. The challenges of managing preventive care threaten to temper this genuine enthusiasm and slow the implementation of initiatives with recognized benefits for our patients.

← FOR PRESCRIBING INFORMATION SEE PAGE 122

Where do we go from here?

There are opportunities for addressing challenges and accelerating change. Each requires a commitment on our part and enhanced support from our funding bodies. Three specific opportunities are infrastructure development, collaborative initiatives, and advocating for enhanced infrastructure resources.

Infrastructure development. If family physicians are to provide effective, efficient preventive care, office infrastructure must evolve. Proactive care requires systems capable of organizing information in a way that will enable identification of individual patients with specific preventive needs and provide reminders to patients and physicians regarding current and future preventive actions. A patient roster and the ability to identify whether there has been adequate coverage of specific age- and sex-based preventive actions also opens up important opportunities for managing preventive care. The opportunities for feedback in a rostered practice are important for providing high-quality preventive care, but they also allow physicians to derive satisfaction from knowing they have achieved their preventive care goals. Hence incorporating electronic patient records and developing rostered practices are important for enhancing preventive care.

Collaboration. Increasingly we will need to explore collaborative relationships with other colleagues to provide preventive care to our patients. These opportunities would be enriched if family practice evolved to a more team-based or collaborative model of care. This would encourage input from other disciplines and allow them to share in the task of providing effective preventive care. Opportunities for collaboration also exist at the interface between family medicine and public health. We know that implementation and behaviour change need time and multifaceted interventions. Combining and coordinating community-based strategies with office-based preventive care is an area for further exploration and evaluation.

Advocacy. Finally, our funding bodies must decide whether or not they truly believe effective clinical prevention is an important component of health and health care. Without a commitment that is supported by appropriate resources, continued evolution and effective change will be extraordinarily difficult. Resources are required to provide infrastructure support for family practices, including support for proven practice management strategies. Providing effective preventive care needs to be properly compensated.

Given the burgeoning evidence for prevention and the time pressures this brings to everyday practice, stable funding to support careful systematic reviews and relevant, trusted recommendations is absolutely essential. Many questions regarding the effectiveness of selective preventive strategies remain unanswered and require appropriately designed research. Resources to support high-quality primary studies of clinical prevention as well as studies to evaluate effective strategies for knowledge transfer and implementation must continue to grow. Some early gains in research funding are promising, but achieving appropriate funding will require a concerted effort in the face of funding programs that more often focus on therapeutic issues, and are increasingly driven by funding bodies whose primary interests rarely include prevention.

Despite the challenges, family physicians need to continue to play a key role in clinical prevention. We understand the value of prevention and the concerns our patients have for preventive care. Our discipline must embrace its responsibility both in clinical care and in providing leadership for change. We must be prepared to explore new strategies for providing preventive care, advocate for enhanced infrastructure resources and development, and embrace the range of collaborative opportunities. We have much to offer and, above all, we owe it to our patients.

Dr Feightner *was Chair of the Canadian Task Force on Preventive Health Care and is a Professor in the Department of Family Medicine at the University of Western Ontario in London.*

***Correspondence to*: Dr John W. Feightner,** *Schulich School of Medicine and Dentistry, University of Western Ontario, Rix Clinical Skills Learning Bldg, 2nd floor,*

London, ON N6A 5C1; telephone (519) 850-2511, extension 86010; fax (519) 850-2522

The opinions expressed *in editorials are those of the authors and do not imply endorsement by the College of Family Physicians of Canada.*

References

1. Canadian Task Force on Preventive Health Examination. *The Canadian guide to clinical preventive health care.* Ottawa, Ont: Health Canada; 1994.
2. Yarnall KS, Pollak KI, Ostbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? *Am J Public Health* 2003;93(4):635-41.
3. Cheney C, Ramsdell JW. Effect of medical records' checklists on implementation of periodic health measures. *Am J Med* 1987;83:129-36.
4. McDonald CJ, Hui SL, Smith DM. Reminders to physicians from an introspective computer medical record: a two-year randomized trial. *Ann Intern Med* 1984;100:130-8.
5. Cohen DI, Littenberg B, Wetzel C. Improving physician compliance with preventive medicine guidelines. *Med Care* 1982;20:1040-5.
6. McPhee SJ, Bird JA, Fordham D, Rodnic JE, Osborn EH. Promoting cancer prevention activities by primary care physicians. *JAMA* 1991;266:538-44.
7. Bird JA, McPhee SJ, Jenkins C, Fordham D. Three strategies to promote cancer screening: how feasible is wide-scale implementation? *Med Care* 1990;28:1005-12.
8. Fullard E, Fowler G, Gray M. Promoting prevention in primary care: controlled trial of low technology, low cost approach. *BMJ* 1987;294:1080-2.
9. Fullard E, Fowler G, Gray M. Facilitating prevention in primary care. *BMJ* 1984;289:1585-92.
10. Lemelin J, Hogg W, Baskerville N. Evidence to action: a tailored multifaceted approach to changing family physician practice patterns and improving preventive care. *CMAJ* 2001;164(6):757-63.
11. Hogg W, Baskerville N, Lemelin J. Cost savings associated with improving appropriate and reducing inappropriate preventive care: cost-consequences analysis. *BMC Health Serv Res* 2005;5(1):20.
12. Dickey LL, Petitti D. A patient-held minirecord to promote adult preventive care. *J Fam Pract* 1992;34:457-63.
13. Schapira DV, Jumar NB, Clark RA, Yag C. Mammography screening credit card and compliance. *Cancer* 1992;70:509-12.
14. Hulscher ME, Wensing M, van Der Weijden T, Grol R. Interventions to implement prevention in primary care. *Cochrane Database Syst Rev* 2001;(1):CD000362.