Quaternary prevention: an explicit task of the family physician.

Interview conducted by Julien Nève with Marc Jamoulle

Abstract

In health care, it is generally believed that prevention defines itself according to a chronological model from primary, to secondary and tertiary prevention. With his extensive experience in the field of family practice, Marc Jamoulle questions this model but also expands it with a relational dimension. By questioning his family physician status, he is defining what could be termed quaternary prevention: the prevention of non-required medicine, or the prevention of overmedicalization

I know you have questioned your role as a family physician. What does this role mean to you?

The central issue is about my relationship with the patient. This particular meeting is between two human beings, each filled with different knowledge; one demanding care and the other offering it. I am willing to understand what makes people come to me, to choose me as a discussion partner to talk about what can sometimes be extremely personal subjects. What is the legitimacy of this label of a physician who, under the pretext of my body of knowledge, gives me the right to intrude into someone's private life? It's surprising to see that fields like mental health or sexuality have been entirely absorbed by medicine. Many family physicians have become psychotherapists without thinking or questioning it. They have granted themselves the right of inspection into people's lives without having an ethical reference guide. Now, nothing escapes medicine; from birth to death you can no longer exist without a doctor. This medical priority in the name of health is astonishing from a sociological point of view, or even an anthropological one. What can be stranger than being in consultation with someone, in front of me, who considers it a legitimate situation that I hold the power of telling or defining normality?

It's on the basis of this thought that you've built your relational model of prevention?

A long time ago during a public health lecture, I amused myself by using the "chi-square" tool and, putting the patient into abscissa and the doctor in ordinate. Doing so, I realized we could build a typology of relations that bind patient and doctor.

If we draw a cross in the middle of the square, we obtain four different situations in the relationship between patient-doctor.

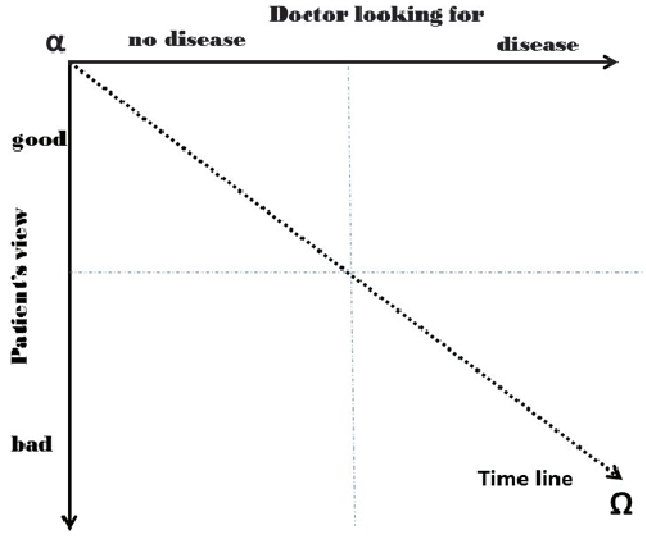

Figure 1 : on the nature of P 4 (Courtesy Marc Jamoulle 1986

The definitions of the first three situations already exist. You just have to think about the chronological model of prevention: primary, secondary and tertiary. The first situation corresponds to what is meant by primary prevention: the illness is absent, and seeing that the illness can't be found by the doctor, he tells the patient about potential problems or some other nonsense about what should be done or not, and what is dangerous or not. The whole education to health can be found in that box, as well as immunizations. In the second box, doctors are looking for an illness that the patient doesn't have. For example, you come to me and I announce to you that I want to perform a rectal examination because I am looking for a cancer and I was trained to do that. That's the exact definition of screening. The doctor "bets" on the illness being there. The third box corresponds to the situation where people are actually sick. The doctor knows it and so we try to avoid complications. That's the tertiary prevention.

What is the situation regarding the fourth box?

The fourth box needs to be defined as patients or future dependents of medicine who are coming to consult the doctor.

It's the box of imaginary illness as described by Molière, the box of somatic symptoms and of the Medically Unexplained Symptoms (MUS). Doctors tend to create those kinds of persons, being encouraged in this by the model of capitalistic production dominating our health system. It's no mystery that those who produce medications or scanners aren't doing it for the great good of the people but to make profits. As a result, we create inflation, a constant overproduction in order to fill in the fourth box. By making the choice to prescribe a scanner for every headache or illness, we've come to over determining the anxiety expressed by the patient who is facing death. And by investing this symbolic but specific function to human beings, we make a

huge amount of profits but we also see the spending for health care explode in all countries without anyone who can control them. Interestingly, according to the timeline of the relational world, doctors and patients meet at the end point (Ω) that faces both illness and death.

In specific terms, what do you recommend?

First, sit and think about it because those questions can't be solved by books or in conferences but, rather, by day-to-day, one-on-one consultations, one after another.

When a patient tells me they'd like to have a scan, am I going to take the time to explore their hidden anxiety? Or am I going to get rid of them by signing a paper without caring about the financial cost, the radiation risks, or knowing if it gets them further into undue medicalization?

There is no recipe. It's a question of attitude and we need to be pragmatic in every single consultation. For example, it is estimated that in a local hospital a million consultations are made per year. That's a million occasions to question the right that medicine has to investigate all the fields that exist. But considering the actors involved, are they trained enough to think through this kind of question?

You advocate for the doctors to be more trained. What should they be trained to do? Can you give me an example?

Future doctors are being trained as medical experts, not as listeners. Let us take the case of a Moroccan mother who was expatriated in Belgium for being married to a cousin who was born in Belgium. She gave birth to her first baby but, seeing that it is impossible for her to go back to Morocco in order to be with her family, and above all her mother, she can't stop crying. A typical doctor would tell her that it's the consequence of her baby blues. But most of them don't know that, in the culture the north-African countries, the relationship between a daughter and her mother during the experience of childbirth is crucial. Instead of prescribing an antidepressant for her to feel better, it would be sufficient to give her the option to take a plane ticket to visit her mother for 40 days. At present, we diagnose a depression or postpartum without really questioning the reason for this depression. We make the decision to choose the medicalization instead of choosing the development of an approach based on the link between the young mother's distress and the cultural extraction from which she suffered.

Is this still about avoiding medicalization?

Not necessarily. In the case of a patient who is affected by a multi-disease with severe immunological problems, my role has been to help them get a clear understanding from the specialized doctors.

The aim of our program is to build, in the long run, an online library for the GP trainers that can be used individually but also during joint training sessions to respond to the bottom-up needs of the GP trainers.

For example, I had to control and manage the information so I didn't do too much and miss problems in order to determine that her epileptic seizure was caused by a new medicine. Here, my role consists of telling her that she is indeed sick and that she had nothing to do in the Box 4 of imaginary illness, but she had to join the Box 3 where people are really ill. In the end, and against the advice of officials of Social Welfare who had denied her illness and had refused her a pension supplement, I helped her recognize her rights.

To you, is it that state of mind which seems to be lacking among doctors?

Medicine is focused on the doctor and not the patient. The motive which made the patient get in touch with the healthcare system is not really of interest to them. What really matters is the results their healthcare produces. The position of the doctor is vertical and dominant. He is not in a horizontal relationship with the patient. The patient's underlying need in itself is not considered. Naturally, that's not the case with every doctor. Nobody wants to make bad medical

Patient's feeling	Doctor's knowledge Disease natural evolution Absent ——————————————————> Present	
Well being feeling	I Primary prevention Action taken to avoid or remove the cause of a health problem in an individual or a population before it arises. Includes health promotion and specific protection (e.g. immunization)	II Secondary prevention Action taken to detect a health problem at an early stage in an individual or a population, thereby facilitating cure, or reducing or preventing it spreading or its long-term effects (e.g. methods, screening, case finding and early diagnosis)
Sick feeling	IV Quaternary Prevention Action taken to identify patient at risk of overmedicalisation, to protect him from new medical invasion, and to suggest to him interventions, which are ethically acceptable.	III Tertiary prevention Action taken to reduce the chronic effects of a health problem in an individual or a population by minimizing the functional impairment consequent to the acute or chronic health problem (e.g. prevent complications of diabetes). Includes rehabilitation.

Figure 2: Definitions according to WICC/ WONCA

decisions but there are few who think about the medicine they practice.

If I understand you right, quaternary prevention is a form of resistance in relation to a position of overmedicalization?

In some ways, yes. However, there are as many risks rushing someone into Box 4 through overmedicalization by making them believe they are sick, when they actually are not, than by filling this box with people who don't believe they should be in it because they are actually sick. I also think about this patient because of a blunder by the radiologist who missed the diagnosis of a multiple sclerosis condition that was rather evident. The patient was told that the loss of the use of her arm was due to a psychological problem. Believing that she had made her illness up, she thought she belonged in Box 4 and she imagined that she needed a psychotherapist.

That kind of bad medicalization could be avoided by the construction of a transmission device for quality control which medicine doesn't presently have in Belgium. Of course, the very expensive campaign that is aimed to encourage doctors to prescribe fewer antibiotics has very well worked. After 2 years, however, bad habits have taken over again. Why? Because, this campaign ignores the influences that pharmaceutical companies have relating to the doctors, and this is precisely the essential point. If we would dare to denounce that practice of medical representation, we would seriously disrupt the provision of prescriptions being put forward as useless, dangerous and inadequate products, but we'd be killed by the pharmaceutical industry for saying that

Your relational approach of prevention is, in a way, a transposition of your practice?

I think the relational prevention model could replace, with great use, the chronological model where prevention boils down to the view of the doctor about a task to be done before the events occur. In this chronological vision, quaternary prevention corresponds to the palliative care. The originality of the model that I suggest is not about having this new definition of quaternary prevention, but about developing a relational vision of prevention, more qualitative and also more individual. I am obviously interested in public health care but I am first of all a clinician of individual patients and a family physician. "What should I do, doctor?" That is the question that attracts me in the first place. And it's up to me to help the patient find what to do for him to survive. Because in the end, the central question that remains is still the same. How to survive socially, politically, economically and mentally?

Further readings

1. *Kuehlein T, Sghedoni D, Visentin G, Gérvas J, Jamoulle M., 'Quaternary Prevention: a Task of the General Practitioner.', Primary Care, 2010* http://www.primary-care.ch/pdf_f/2010/2010-18/2010-18-368_ELPS_engl.pdf
2. *Marc Jamoulle's web page on Quaternary Prevention* http://docpatient.net/mj/P4_citations.htm

Literature review

Self-efficacy revisited

Reviewer: Jan Degryse

Artino AR (2012) Academic self-efficacy: from educational theory to instructional practice. Perspect Med Educ 1:76-82

The Dutch society for Medical Education has been editing for many years its own journal in Dutch, but has decided recently to move further an to enter on the international scene with a new Journal : Perspectives in Medical Education. In the first issue of this journal a interesting review on "academic self-efficacy" caught our attention.
Self-efficacy is a personal belief in one's capability to organize and execute courses of action required to attain designated types of performances. Often described as task-specific self-confidence, self-efficacy has been a key component in theories of motivation and learning in varied contexts
The purpose of this article is to describe the nature and structure of self-efficacy, a key component of social-cognitive theory, and to provide a brief overview of several potential instructional implications for medical education.

Bandura defined self-efficacy as: 'People's judgments of their capabilities to organize and execute courses of action required to designated types of performances.'

Two important aspects of this definition warrant further explanation. First, self-efficacy is a *belief* about one's capability, and as such, does not necessarily match one's actual capability in a specific domain. A second aspect of Bandura's definition of self-efficacy is the idea that individuals make use of their efficacy judgments in reference to some *goal* ('attain designated types of performances'), which reflects both the task- and situation-specific nature of efficacy beliefs.

Results from a meta-analysis of more than 100 empirical studies conducted over the last 20 years found that of nine commonly researched psychosocial constructs, academic self-efficacy was the strongest single predictor of college students' academic achievement and performance It seems, then, that cultivating students' academic self-efficacy is a worthwhile goal for any educator

Ultimately, by explicating Bandura's theory of self-efficacy, this article encourages medical educators to consider and explicitly address their students' academic self efficacy beliefs in an effort to provide more engaging and effective instruction.

I must admit that this paper induced a "aha-erlebnis". However more research is needed in order to find out what specific interventions can improve self-efficacy of medical trainees and student.