Prevention

Building on routine clinical practice

Moira G Sim

MBBS, PGDipDrugAlcAbStud, FRACGP, FAChAM, is Associate Professor, Centre for Postgraduate Medicine, Edith Cowan University, a general practitioner, Yokine, Western Australia, and Senior Medical Officer, the Drug and Alcohol Office of Western Australia.
m.sim@ecu.edu.au

Eric Khong

MBBS, GradDipPHC, GradCertHlthEcons, FRACGP, is Senior Lecturer, Centre for Postgraduate Medicine, Edith Cowan University, GP Liaison Officer, Breastscreen WA, and a general practitioner, Edgewater and Duncraig, Western Australia.

BACKGROUND
The role of general practice in preventing disease and promoting health is strongly supported by research and health policies.

OBJECTIVE
This article examines the role of general practitioners in illness prevention and health promotion activities.

DISCUSSION
Despite time and other barriers, such as competing priorities, to the implementation of preventive activities, prevention is part of routine general practice. In providing care for the whole person over a long period of time prevention and treatment are not separate entities and the line between these are necessarily blurred. From a pragmatic point of view, if a practice is to increase its activity in prevention there needs to be a driver that makes this happen and strategies to suit the structure of the individual practice. Introducing small interventions and making use of the practice team is a good place to start in a range of health promotion activities including opportunistic education, brief interventions for patients with disease risk factors, and specific interventions for a known disease.

The role of general practice in preventing disease and promoting health is strongly supported by research and health policies.[1,2] The enormous potential identified in general practice is based upon its unparalleled access to the population and the consistent evidence that general practitioner interventions can change health risk behaviour.[3,4] As captured by Ellis and Leeder[5] in 1991, 'The opportunity to introduce appropriate preventive action to 80 million health consultations a year is too good to waste.' Despite this, in routine practice, prevention activities do not always occur.[4]

Why are opportunities for prevention sometimes lost?

Commonly it is assumed that the problem is a lack of GP awareness and that the development of guidelines and the provision of GP education are required to increase intervention in specific areas such as smoking, alcohol, and other behaviours which impact on health.[6] However, such simplistic solutions do not recognise the barriers experienced and rarely result in sustained changes.[6] It has been said that: 'The problem with GPs is that they are in the ideal place to do everything'.[7] Attempts to implement screening and preventive interventions in general practice usually come from organisations focused on specific risk behaviours and diseases and these do not take into account the broad context within which general practice works. Lack of time, competing priorities, workforce shortages, lack of support systems and remuneration issues are frequently identified as barriers to preventive action.[1,8]

Yarnall et al[8] argue that it is not feasible for physicians to deliver all the services recommended by the United States Preventive Services Task Force. They point out that while individual screening recommendations may appear small, the large number of recommendations result in a substantial impact on daily workload. Furthermore, the time needed to implement recommendations is often underestimated. The authors identify the dilemma for primary care, which must balance the

need for preventive action against the requirement for the provision of ongoing care and treatment. Where time and resources are limited, there is an opportunity cost and the choice of one action denies the opportunity for another.

Russell[9] warns that an increasing focus on the prevention agenda without appreciation of the value of the individual long term relationships between primary care providers and their patients, attention to the opportunity cost, and the provision of effective practice support may unintentionally harm the goal of improving health.[9]

While there are many obstacles to establishing a comprehensive prevention action plan for the entire practice, all GPs practise prevention as part of their routine clinical practice. Prevention can be considered as primary, secondary and tertiary (*Table 1*). When prevention is viewed across this spectrum it is clear that prevention is a normal and legitimate part of general practice. Preventive actions are therefore often integrated into routine clinical care and not always identified as 'health promotion' or 'brief intervention' actions. To a GP who treats the whole patient, who brings many interconnected issues to consultations over the longitude of time, the line between prevention and treatment is and should be blurred.

Table 1. Types of prevention

Prevention	Examples
Primary Health promotion and prevention of disease in healthy people	• Advice on healthy diet, physical activity and lifestyle • Immunisation • Advice on folate consumption before pregnancy
Secondary Screening for early disease and risk factors	• Infant and mother postpartum check • Blood pressure examination • Cholesterol and blood sugar examination • Pap tests and mammograms • Identification of risk factors for disease • Advice on healthy diet, physical activity and lifestyle
Tertiary Preventing progression to complications of disease	Chronic disease management or treatment of whole patient when disease is identified, including lifestyle advice, medication and monitoring of disease state, and liaison with other care providers (eg. in diabetes this includes education on disease management, advice on diet, physical activity, smoking, monitoring of blood pressure, lipids, end organ effects, and medications to stabilise the disease and reduce risks)

Table 2. Factors to consider in choosing interventions

What	**Consider**	**Examples**
	Major attributable risk factors for disease in the population	A high prevalence of diabetics from a particular cultural group in the practice
	Specific practice characteristics	A high prevalence of Muslim women who do not access mammograms
	Choose	**Examples**
	A common risk factor for which there is evidence of effect for the intervention	Smoking and lack of exercise has been identified in this population
How	**Consider**	**Examples**
	The current strengths, resources and staffing in the practice Available resources already developed elsewhere and implementation advice and local assistance from organisations such as divisions of general practice	Intervention can range from the availability of health promotion posters relevant to the population and pamphlets in the waiting room to a more comprehensive audit and GP intervention Use the lifestyle scripts available through the Australian government website (www.health.gov.au)
	Choose	**Examples**
	An intervention that is easy to do and can be part of every day practice	Checklists and reminders within the patient paper or electronic records Referring patients to other providers and services that support healthy lifestyle choices
	Who in the practice can assist?	The practice nurse is keen to be involved in health promotion activities as part of chronic disease management or a receptionist who would like to ensure that waiting room messages are up-to-date and relevant

Increasing prevention – is it possible?

Is increasing the role of prevention in general practice worthwhile and possible? In the face of health workforce demand that continues to outstrip supply, the aging population, and increasing expectations of health and quality of life signal a need to focus on preventive health care to reduce the risk of disease and its complications. The question for general practice is whether it is to increase its responsibility in prevention or if this is to be taken up by other health professionals who seek a greater role in the provision of primary care. If general practice is to take up this challenge and its resources remain limited, how can it do more? Is general practice making sufficient use of the members of the practice team and other services in the community?

Preventive interventions in general practice can be targeted at primary, secondary or tertiary levels (*Table 1*). The major risk factors to which the burden of disease in Australia is attributed are tobacco, physical activity, hypertension, alcohol, obesity, lack of fruit and vegetable consumption, hyperlipidaemia, illicit drugs, occupation and unsafe sex.[10] These risk factors are relevant to all levels of prevention. The major causes of mortality in Australia are also relevant in determining priorities in tertiary prevention. These include vascular disease, chronic obstructive pulmonary disease, cancer, diabetes and dementia. Other important contributors to the disease burden include mental illness and musculoskeletal conditions. In the first half of life, injury, suicide and poisoning play a major role in morbidity and mortality.[11]

The importance of these for each practice will be determined by characteristics such as the age and cultural composition of the practice. For greatest effect, highly prevalent risk factors that can be changed with minimally intensive interventions should be chosen. For example, the effect of GP advice to change behaviour in smoking, alcohol and exercise is well documented and it is known that the addition of written materials provided by the GP to reinforce the message increases the effect.[1] In a busy general practice the availability of pamphlets can increase the effectiveness of GP advice for minimal effort.

The driver

From a pragmatic point of view, if a practice is to increase its activity in prevention there needs to be a driver that makes this happen. With so many external and internal issues to consider in running a practice, without a system and identified people who can lead changes, any actions are likely to be short lived. Strategies must be tailored to suit the structure of individual practices. For example, in a medium size practice with regular practice team meetings, if prevention priorities are identified at these meetings together with small easily implemented interventions, some of these can become part of the long term routine of the practice. Some questions to consider in defining where to start are outlined in *Table 2*. *Examples 1–3* demonstrate how implementation can occur in routine practice.

Each of the examples can be implemented in routine practice. However, for prevention activities to remain relevant and for the impetus to continue, reviewing the effect is important. Small changes which can be measured, such as those measured by the practice nurse in *Example 3* can confirm that a positive effect has occurred and can encourage continued action.

Example 1. Exercise – primary prevention

Dr X is a solo practitioner who has recently developed angina. His personal health journey has brought to his attention the importance of primary prevention. As a solo practitioner he has a receptionist with no formal training in health and does not have the same access to the resources available to larger practices. However he has learned about the resources available during his health experience as a patient, and wants to use this for the benefit of his patients. He asks his receptionist to call his local population health unit and after some redirection to various sources, she gets some posters and pamphlets about the importance of a healthy diet and exercise. These are to be used in the waiting room and also to be handed out by Dr X whenever the opportunity arises. He also asks his receptionist to call the local council to find out about exercise classes that can be advertised in the surgery. Later Dr X comes across the Lifescripts resources developed by the Australian government and starts using the waiting room poster, the patient flyer and the prescriptions for exercise (www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pubhlth-strateg-lifescripts-index.htm). Over time he becomes familiar with the other resource material such as the *Lifescripts practice manual* and the prescriptions for smoking, nutrition, alcohol and weight management, and these become part of his routine practice.

Example 2. Mammograms – secondary prevention

Dr Y works in an area where there is a strong Muslim population. As one of the few women doctors in the area she has attracted many Muslim women to her practice. The majority of them speak Arabic and little English, and rarely go out without their husbands. While their uptake of Pap screening in the population that attend her practice is high (as she offers the service within the surgery) their uptake of screening mammography is low. Dr Y contacts her state BreastScreen service and discovers they have pamphlets about mammograms in Arabic. In addition to handing these out to the women, Dr Y decides to speak with the young English speaking daughters of these women, who agree to recruit their mothers.

Example 3. Diabetes – tertiary prevention

A six doctor practice with a practice nurse identifies the need to better manage the growing number of diabetic patients in the practice. The practice is aware of the recent changes in the Enhanced Primary Care items as well as the previous changes to Medicare. The doctors at the practice are aware of good practice in treating diabetes and do their best to ensure that diabetics who attend get comprehensive and preventive care, but do not have a system for recalling patients who do not attend for review.

As the practice has electronic records, it is easy for the practice nurse to identify all the patients with diabetes as a diagnosis on their records and to check if height and weight, blood pressure and HbA1C have been recorded in the past year. This is presented at a team meeting, and the doctors are surprised to find that many patients have not returned for routine review or have frequently attended for other reasons and have not had all their routine checks related to diabetes. As the practice is very busy it is often the case that other issues distract from the issue of diabetes.

The practice makes a decision to use an electronic checklist that is imported as a template into the medical software and the practice nurse ensures that routine diabetes reviews occur in accordance with the Medicare requirements for a Service Incentive Payment. The practice nurse also finds information for patients on managing diabetes from the local division of general practice and this is given out to patients to reinforce the importance of prevention and maintaining health in diabetes.

Conclusion

The range of health promotion activities described in this article show that prevention is part of general practice and it is possible to incorporate one or more of the following into routine clinical care:

- the provision of appropriate opportunistic health education
- brief interventions for patients with risk factors for a disease, and
- specific interventions for a known disease.

Summary of important points

- Prevention is part of routine general practice.
- In providing care for the whole person over a long period of time prevention and treatment are not separate entities in general practice and the line between these are necessarily blurred.
- General practice can increase preventive care by introducing small interventions and making use of the practice team.

Conflict of interest: none declared.

References

1. National Preventive and Community Medicine Committee. Putting prevention into practice: a guide for the implementation of prevention in the general practice setting. Melbourne, Victoria: RACGP, 1998.
2. Powell-Davies G, Fry D. 2005. General practice in the health system. In: General Practice in Australia. Canberra: Department of Health and Ageing, 2004;440–1.
3. Heywood A, Firman D, Sanson-Fisher R, Mudge P, Ring I. Correlates of physician counseling associated with obesity and smoking. Prev Med 1996;25:268–76.
4. Grol R, Wensing M. What drives change? Barriers to and incentives for achieving evidence based practice. Med J Aust 2002;180(6 Suppl): S57–60.
5. Ellis N, Leeder S. General practitioners and disease prevention: their role and remuneration, Better Health Program, Canberra. In: O'Connor-Fleming ML, Parker E. Health Promotion. Sydney: Allen & Unwin, 2001.
6. Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. Lancet 2003;362:1225–30.
7. Attributed to Malcolm Battersby, Flinders University. In: McCabe D, Holmwood C. Comorbidity in general practice: the provision of care for people with coexisting mental health problems and substance use by general practitioners. Adelaide: Primary Mental Health Care Australian Resource Centre, 2002, revised report, p7.
8. Yarnall KSH, Pollak KI, Ostbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? Am J Public Health 2003;93:635–41.
9. Russell GM. Is prevention unbalancing general practice? Med J Aust 2005;183:104–5.
10. Mathers CD, Vos ET, Stevenson CE, Begg SJ. The burden of disease and injury in Australia. Bulletin of the World Health Organisation, 2001;79:1076–84.
11. Australian Institute of Health and Welfare. Australia's health 2004. Canberra: AIHW, 2004.

afp **CORRESPONDENCE** email: afp@racgp.org.au