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Putting prevention into practice: how can you do it ethically, effectively and efficiently?

Summary

Preventive care needs to be justifiable ethically and delivered in an evidence-based manner. This Wonca Europe workshop provided both an outline of a number of ethical issues and an evidence-based framework for implementation.

Associate Professor Litt and Professor Weingarten led a 60 minute workshop at the European meeting of Wonca in Basel, in September 2009. Both presented some of the key issues that surround implementation of prevention. Associate Professor Litt outlined an evidence-based framework for the implementation of prevention in the general practice setting. Professor Weingarten covered the ethical issues. To provide focus to the session, both speakers related these issues to the topic of hazardous drinking and the general practitioner's (GPs) role.

The aim of this paper is to highlight the prevention implementation framework and to summarise some of the ethical issues. It is beyond the scope of this article to cover specifically how the prevention framework can be used to assess whether and how GPs tackle hazardous drinkers in their practice. This will be addressed in a separate article.

Over the past two decades, governments and health care providers have become increasingly concerned about the steady increase in demand for health care and the capacity of a nation to provide quality services to meet that demand. Prevention strategies have the potential to reduce the burden of morbidity in the community. While prevention has evolved to be a fundamental part of the GPs role, performance is variable.

Ethical issues

A prevention program or activity is only valuable if the benefits outweigh the harms. This is encapsulated in the guidelines for screening that were first developed by the WHO which are used by most professional guidelines groups. Most of these groups recommend that adult patients be screened for hazardous alcohol use as the benefit/cost ratio is seen as high. For example, in Australia, alcohol costs the Australian community about $15.3 billion in 2004–05. Despite these guidelines, many would argue that there has been considerable inertia in their implementation.

There is considerable debate about whether we should indeed regard this as clinical inertia or not. Some would say that doctors cross the boundary of privacy when they ask about health-related behaviours that are seen by patients as personal choices. Such enquiry may be justifiable only when the health-related behaviour can be linked to the patient's presenting complaint. Thus, GPs are reluctant to intervene if patients do not see their drinking as a problem. As most patients who are drinking at hazardous levels do not seek care, it is not surprising that most of this group are not being offered treatment.

Many would argue that individuals should be allowed to make unhealthy lifestyle choices. Victim blaming and stigmatization are both potentially unfair consequences of labeling individuals as hazardous drinkers. It can be hard to determine which of those factors leading to the behaviour are under a person's control and which are outside it. Thus, Cappelen and colleagues suggest that in medicine, individuals should not be held responsible for the consequences of their choices.

To what extent may society impose its vision of what is in the best interest of its members upon those who do not share this vision? The answer that currently prevails is the one given by John Stuart Mill in 1859: *"[t]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant."* At any rate, doctors should not be the agent of the exercise of power on behalf of society – that is the function of the police force.

In so far as doctors should be the agents of society, this should be aimed at reducing health gaps, such as the gap between the rich and the poor. The most vulnerable individuals in society are those least likely to respond to GP-based health promotion initiatives, which may thus produce the unwanted side-effect of widening the health gap. Alonzo suggests that we should *"address issues of response-ability in terms of reducing structural barriers to health behavior"*.

Finally, health promotion activities in general practice must justify themselves in terms of cost-effectiveness vis-à-vis the more traditional activities of diagnosis and treatment of acute and chronic disease. One must inevitably come at the expense of the other.

A framework for prevention implementation

While the development of clinical guidelines has rapidly progressed, their implementation has evolved in a more ad hoc manner. Effective implementation is more likely if there is: (a) a clear framework; (b) consideration and utilization of a range of change processes, and (c) a strategic combination of evidence-based implementation activities.

The Royal Australian College of General Practitioners, through its National Standing committee on Quality, has developed evidence-based guidelines for the implementation of preventive activities provided by GPs. The components of effective implementation are similar to those required for making good music. An orchestra needs three elements to perform good music: a conductor, a musical score and musicians. The equivalent components for implementation include: (a) a coordinator (conductor), (b) a mix of effective and agreed strategies and processes musical score, and (c) use of specific implementation activities that have an evidence base.

The P.R.A.C.T.I.C.E framework incorporates all three elements and provides a set of questions and issues that could be considered (fig. 1).

	Components	Issue
•	P → Principles	*What underpins the process?*
•	R → Receptive	*What's in it for me?*
•	A → Ability and capacity	*Can I do it?*
•	C → Coordination	*Who will organise it?*
•	T → Targeted	*Who needs it?*
•	I → Iterative cycles	*How can I ensure that it happens?*
•	C → Collaboration	*Who can help me?*
•	E → Effectiveness and efficiency	*What works to put it in to practice? How can I make it a part of the routine?*

Figure 1
P.R.A.C.T.I.C.E – an evidence-based framework for implementation.

The first component, principles, relates to the need to define key values. Strategies that are compatible with the values, norms and perceived needs of the practice are more readily adopted. Prevention activities will also need to have a strong commitment to being patient/consumer centred and using a population approach. At the same time, implementation should use a framework, processes and strategies that acknowledge the context and complexity of general practice. Finally implementation should be evidence-based, outcome-focused and both efficient and sustainable.
The second component relates to receptivity; change is difficult. Why is change needed? What's in it for the GP and the practice? What's in it for patients? It is important to check that the benefits exceed the costs. Receptivity is improved when: (a) prevention programs are congruent with the values/goals of the practice; (b) there are adequate rewards, incentives and feedback; (c) the process can be incorporated into the practice routine; and (d) there is sufficient support for implementation. In a nutshell, implementation needs to be tailored to the context/setting.
The third component needed is the factors that facilitate the ability and capacity of the practice to provide preventive care. These include the knowledge, attitudes and beliefs, skills of GPs and their staff; their motivation to be involved and the presence of a supportive organisational infrastructure. For busy clinicians, strategies that provide a reasonable return on effort and are not too time consuming are also more likely to be implemented.
The fourth component necessary for effective implementation is coordination. Ehrlich defines coordinated care in the primary healthcare setting as the '*delivery of systematic, responsive and supportive care to people with complex chronic care needs.*' Complex tasks require: (a) someone to coordinate them, and (b) an active planning process that fosters involvement and teamwork with clearly defined roles and responsibilities.

The next component required is targeting. Prevention activities should be based upon need. While perceived need can reflect the burden of illness, there is increasing evidence of the value of establishing both subjective and objective need. Grol and colleagues have highlighted the importance of targeting barriers to implementation, both evident and anticipated.
The sixth component of P.R.A.C.T.I.C.E follows on from targeting. Complex interventions are rarely implemented in the first pass. Measurement and evaluation are essential to determine that the implementation processes have been carried out, barriers to implementation have been identified, and the intervention strategies have been effective. This process creates a learning cycle, hopefully leading to more effective strategies being developed and/or to discarding ineffective strategies. Hence, an iterative process should be established. This involves measurement of need followed by implementing an intervention and then re-measuring to see if change has been achieved. This plan, do, study, act cycle stems from a number of sources including community orientated primary care and continuous quality improvement.
The seventh component is collaboration. If all the recommended activities are performed for both chronic illness and prevention, then the average consulting day for a typical GP is lengthened by 3–4 hours and 7–8 hours respectively. Clearly this is not feasible without the clinician being more collaborative. GPs need to actively engage patients in self care and involvement in decision making. Similarly, GPs need to develop better collaboration with practice staff and other health care professionals to share the load.
The eighth and final component of P.R.A.C.T.I.C.E is the need to use interventions that have good evidence of effectiveness. Both effective processes and specific intervention activities are needed and should be combined in a strategic manner as utilization of more implementation strategies is not necessarily better.

References
The references to this article are published on www.primary-care.ch.

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