International Journal of Integrated Care – ISSN 1568-4156
Volume 10, 29 January 2010
URL: http://www.ijic.org
Publisher: Igitur, Utrecht Publishing & Archiving Services

Section on Person-centered Public Health

Person-centered prevention and health promotion

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Since at least the time of Hippocrates in the 5th century AD, doctors have sought to prevent diseases, as well as to offer treatments and cures, and consideration of preventive advice remains an essential element of every medical encounter. In 1979, Stott and Davies listed four possible components of each consultation in primary care [1]. The last of these was opportunistic health promotion, advice made more effective by being directly linked to the content of the preceding consultation. For example, advice to stop smoking is proportionately more powerful when it is linked to an episode of acute bronchitis or a first presentation of angina. In contrast, the blanket application of preventive imperatives poses a grave threat to authentically person-centered medicine.

Fear is present to a greater or lesser extent in every medical encounter—fear of serious disease or chronic pain or disability or premature death—and, even when this scale of fear proves unwarranted, it can be easily replaced by the fear of embarrassment. One of the many tasks for the doctor in this situation is to locate and acknowledge the fear, to calm inappropriate fear and, for well-founded fear, to find some measure of hope in the identification of alternative better futures. The doctor is in a position, because of his or her particular professional knowledge, to envisage possibilities which can be offered to the patient but should never be imposed. A better and more hopeful future might result from changes in life circumstance, or from giving up smoking or drinking, or from the effects of medication or more complex medical treatments.

The prevention of disease is a noble aspiration but it causes harm as well as good and the certainty of death places limits on its effectiveness that are not sufficiently acknowledged [2]. When the prevention of disease begins to assume greater priority than the relief of suffering, something very fundamental begins to go awry.

With the development of increasingly sophisticated methods of biometric measurement, the definition of disease has shifted and has become increasingly dependent on number and on an assessment of the deviance of an individual's measurement from the statistical norm. This has begun an apparently inexorable process by which an ever greater proportion of the population is classified as being in some way abnormal. The classification of disease has become detached from the experience of suffering. This is happening with the definitions of diseases and even more with the identification of risk factors for disease.

Linn Getz and colleagues [3] applied the thresholds recommended in the 2003 European guidelines on cardiovascular disease prevention to the entire adult population of the Norwegian county of Nord-Tröndelag. They discovered that half of the population are considered to be at risk by the early age of 24 years. By the age of 49, this proportion rises to 90% and as much as 76% of the total adult population are found to be at 'increased risk.' Yet the current life expectancy at birth in Norway is 78.9 years, making it one of the longest living populations ever. Something appears to be going very wrong—it is simply not possible for three quarters of one of the longest living populations in history to be at increased risk of early death and yet, fear is sewn in every preventive health consultation which follows these guidelines and fear itself throws a shadow across life and undermines health [4].

These huge prevalences of designated risk are driving rapid increases in the rates of prescribing of pharmaceuticals aimed at minimising the risk factors. In whose interests do these trends operate? Many commercial and professional interests are well served by them but clearly the pharmaceutical industry is first in line and seeks to consolidate its advantage by providing support to those who write the guidelines. Every single one of the authors of the 2003 European guidelines on cardiovascular disease prevention has a significant connection with the pharmaceutical industry [5].

These disturbing trends pose huge threats to the viability of healthcare systems funded through taxation and based on social solidarity. The treatment of disease and the relief of pain and suffering do not demand limitless resources and can be achieved by such a system. However, primary prevention involving the wholesale treatment of all known risk factors for serious disease has the capacity to bankrupt any healthcare system funded through taxation [6].

Allowing the imperatives of primary preventive public health medicine to run contrary to the concept of person-centered medicine has the potential to damage healthcare [7]:

> Doctors with a public health orientation can be quick to say what general practitioners should be doing on the basis of population data. Yet doctors and nurses in general practice face the frustration of being bribed or bullied by governments to achieve targets that many patients are not ready to accept for personal and social reasons. Nothing is more likely to reduce the likelihood of long-term 'success'. Coercion may in the short-term achieve apparent health gain targets, but at what cost to relationships and the professionals' feelings of integrity and self respect? The opportunity costs are still unevaluated.

This is the recurring problem of utilitarianism [8]:

> In the name of taking each person's pain seriously—the noblest motivation in the birth of utilitarianism—we have a view that cannot adequately fathom any person's pain in its social context or see it as the pain of a separate person.

In his *Groundwork of the Metaphysic of Morals* of 1788, Immanuel Kant laid out his categorical imperative:

> Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end.

For doctors, Kant's imperative becomes that we treat our patients always at the same time as an end, whatever else we seek to achieve. And also that we treat ourselves, ourselves as doctors, as an end and do not allow ourselves to be treated simply as a means.

Contemporary healthcare systems, perhaps themselves increasingly subservient to multinational commercial interests [9], have a worrying tendency to treat both patients and doctors as the means to some other greater purpose and neglect to treat them, at the same time, as ends in themselves. The greater purpose might be something very worthy, such as a cure, or a longer life or something rather vaguer like 'the public health' or 'the public interest' but, however, worthy the end, turning humanity into simply the means to achieve it, is to undermine what it is to be human in a very fundamental way and this holds even if those who are used as the means stand to benefit directly.

In order to treat someone as an end in him or herself, one is obliged to pay a very particular attention to each individual and there can be nothing cursory. Philip Roth [10] sees this very clearly:

> Keeping the particular alive in a simplifying, generalizing world—that's where the battle is joined.

Like writers, and perhaps even more so, doctors must keep the particular alive. Biomedicine is an intensely simplifying and generalising world. We make generalisations about people and categorise them all the time—and we have to, but, as we do so, we simplify, censor and devalue individual experience, values and aspirations.

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