Preventive Guidelines: Their Role in Clinical Prevention and Health Promotion

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Over the past fifteen years, the Canadian Task Force on the Periodic Health Examination has had a seminal impact on the practice of clinical preventive medicine in Canada and around the world. The Task Force has provided health professionals and health care planners with leadership and guidance on the value of preventive interventions in the practice setting.

A key finding of the Task Force was that a periodic health examination (PHE) targeted at preventing, detecting, and controlling specific conditions or risk factors for different age-, sex- and high-risk groups was likely to be more effective than a routine annual physical examination.<1> As a result of the work of the Task Force, health practitioners now have access to a comprehensive package of preventive interventions for use over the life-cycle of individuals.

This guide may be regarded as an atlas of preventive interventions. It also contributes to the systematic evaluation of preventive medicine by analyzing a number of issues including the quality of scientific data on prevention, and the efficacy, effectiveness and efficiency of preventive procedures. The rigorous scientific evaluation upon which the Task Force recommendations are based has enhanced the credibility of preventive medicine.<2>

Clinical Prevention and Health Promotion

In Canada, the leading causes of death among adults younger than 65 years of age – cardiovascular disease, some common types of cancer, and unintentional injuries – are largely preventable.<3> A number of primary and secondary preventive interventions in the clinical setting have been shown to reduce morbidity and mortality. The integration of prevention into clinical practice is recognized as an efficient, or cost effective way of providing comprehensive care and meeting current health care concerns.

In its broadest sense, clinical prevention can be defined as a clinician/patient interaction that promotes health and prevents illness or injuries. Clinical prevention includes an array of procedures ranging from counselling, screening, and immunization to chemoprophylaxis in asymptomatic individuals.

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The Periodic Health Examination incorporates primary and secondary preventive measures. Primary prevention addresses factors that lead to the onset of a disease (e.g., cigarette smoking). Secondary prevention aims at detecting latent conditions and either reducing or halting their progression (e.g., detecting and treating hypertension).

Primary prevention poses a challenge for the busy physician. This type of intervention requires an efficient and personalized patient education effort.<4> Persuading patients to quit smoking and to achieve and maintain a healthy weight requires more than merely providing information. To encourage behaviour change, the physician must assume the role of change agent.<5> It is clear that to help patients with lifestyle change, clinicians will need to expand their skills in counselling and communication. The patient must also become actively involved in his or her own health.<6>

A number of the preventive procedures recommended by the Canadian Task Force focus on counselling for behaviour-related risk factors. Clinicians' efforts to counsel patients in areas such as dietary habits, alcohol consumption, physical activity, and tobacco use may have a significant impact on cardiovascular disease and other chronic diseases.

Two out of three Canadians have one or more of the major risk factors for cardiovascular disease.<7> An appreciable proportion of Canadian adults have concomitant risk factors.<8> The clustering of risk factors is clinically significant because of their synergistic effect on risk. This suggests the need for health professionals to assess overall risk rather than focussing on single risk factors.

Clearly, there is no single strategy for improving the delivery of preventive services; multiple approaches are necessary.<9> Strategies directed towards health professionals are complemented by patient-centred approaches. Effective counselling requires an appreciation of the full spectrum of the public's perceptions, their health concerns and the factors influencing their lifestyles. Data from the two national health promotion surveys (1985, 1990) have contributed to our understanding of how people view health and how they respond to the prevention message.<10,11> These survey findings indicate that behaviour change is mainly influenced by knowledge of the risk factors, role models, support from family and friends, and advice from health professionals.

In recent years, the public's tremendous interest in health promotion and disease prevention has helped highlight the role of prevention in clinical settings. The benefit of incorporating prevention into clinical practice has become more apparent with the decline in the incidence of a number of diseases. Age-adjusted mortality from stroke has decreased by 50% in the last 20 years,<12> a trend that may be attributed, in part, to the early detection and treatment of

hypertension. Cervical cancer mortality has also fallen by 50% since Papanicolau testing of women has become widespread.<13>

In Canada, the primary care setting offers an excellent opportunity for implementing prevention. Over 50 percent of physicians are either general practitioners or family physicians. They can play a pivotal role in prevention. Physicians are also perceived by the general public as a reliable and credible source of health information. They have the opportunity to take advantage of the "teachable" moment when patients are concerned about their health. They have contact with a large percentage of the population each year. It is estimated that 80 percent of Canadian adults see a physician at least once a year.<14> Among those who see a doctor, the average number of visits per year is about four.<14>

A number of studies have shown that the provision of preventive services by physicians is far from optimal.<15,16> This has been attributed to a variety of factors including time constraints, practice organization issues, patient non-compliance, a lack of counselling skills, and gaps in knowledge about which interventions to provide. Contradictory recommendations and a lack of consensus contribute to clinicians' confusion and skepticism concerning the value of prevention.

Implementation of preventive activities in clinical practice continues to be a challenge. To address this issue, Health Canada established a National Coalition of Health Professional Organizations in 1989. The purpose was to develop a strategy to enhance the preventive practices of health professionals. Two national workshops were held. The first focused on strengthening the provision of preventive services by Canadian physicians. The second addressed the need for collaboration among all health professionals. This process led to the development of a framework or "blueprint for action" for strengthening the delivery of preventive services in Canada.<17> It is a milestone for professional associations and one that will have a major impact on the development of preventive policies in this country.

In practice, preventive interventions of health professionals do not take place in a vacuum. Clinical prevention must be seen in the broader context of public health and healthy public policy. Preventive interventions occur in combination with health promotion efforts implemented through a variety of channels including the media, the workplace, and schools. A comprehensive approach to prevention involves the coordination of these individual efforts with those of the community. The one-to-one doctor/patient relationship serves to reinforce large-scale public education and community wide health promotion efforts. It is well recognized that it is the interplay among multiple reinforcing approaches and the collaboration of numerous partners in both the public and private sectors that ultimately lead to a change in individuals' behaviour.

Practice Guidelines and Quality of Care

Practice guidelines have been defined as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."<18> They are becoming an integral part of the clinical decision-making process. There is growing interest in using guidelines as a means of reducing inappropriate care, assessing geographic variations in practice patterns, and using health care resources more effectively. With the current attention being given to quality of care, practice guidelines should play an increasingly prominent role in medical care policy.

Over the years, professional, scientific, and voluntary organizations, as well as government health agencies and licensing authorities, have attempted to resolve clinical uncertainty by issuing guidelines on effective interventions. In Canada, forty organizations are involved in developing practice guidelines.<19> The guidelines issued by the Canadian Task Force on the Periodic Health Examination are the most comprehensive recommendations available on preventive care.

The process developed by the Task Force to evaluate effectiveness may be as important a contribution to clinical policy making as the recommendations themselves. The techniques developed and used by the Task Force to review evidence and develop recommendations are applicable far beyond the sphere of prevention. They are particularly relevant at this time when increasing attention is being paid to evaluating the effectiveness of clinical diagnostic and therapeutic interventions.

In 1991 the Canadian Medical Association spearheaded the creation of a National Partnership for Quality in Health to coordinate the development and implementation of practice guidelines in Canada.<20> This partnership includes the following: the Association of Canadian Medical Colleges, the College of Family Physicians of Canada, the Federation of Medical Licensing Authorities of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Council on Health Facilities Accreditation, and the Canadian Medical Association.

The existence of guidelines is no guarantee they will be used. The dissemination and diffusion of guidelines is a critical task and requires innovative approaches and concerted effort on the part of professional associations and health care professionals. Continuing education is one avenue for the dissemination of guidelines. Local physician leaders, educational outreach programs, and computerized reminder systems may complement more traditional methods such as lectures and written materials.

Public education programs should also support the process of guideline dissemination. In this context, rapidly expanding information

technology, such as interactive video or computerized information systems with telephone voice output, presents opportunities for innovative patient education. The media may also be allies in the communication of some relevant aspects of guidelines to the public. All of these technologies should be evaluated.

The implementation of multiple strategies for promoting the use of practice guidelines requires marshalling the efforts of governments, administrators, and health professionals at national, provincial and local levels. It is up to physicians and other health professionals to adopt approaches for the implementation of guidelines in clinical practice and to support research efforts in this direction.

The compilation of preventive guidelines in this book is a significant step toward making health promotion and disease prevention a reality.

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