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Opportunistic Prevention in Family Medicine: Anticipatory Care, Case-Finding and Continuity of Care

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Abstract

The concept of "prevention" is important in medicine, especially in family medicine, and it includes specific tasks of primary care. The conceptual basis of these tasks is “opportunistic prevention”, because every contact with patients provides opportunities for the prevention of illness and the encouragement of people to adopt more healthy life-styles, even when the patient has come for an apparently unrelated problem which has to be dealt with first. The emphasis is on taking the opportunities offered by patients. Family medicine presents a unique position to do “opportunistic prevention", which includes at least: Anticipatory care, Case-finding, and Continuity of Care. But, these concepts have important, different, and specific connotations, and its implications have not been sufficiently systematized conceptually. These tasks can be difficult to explain and understand. So, these concepts are presented based on a fable or tale. The fable is an adult education method which can serve to intuitively understand abstract concepts, by linking them to specific situations, and so to facilitate their assimilation. The essence of family medicine is to assist individuals in families and communities and this implies, to be a "doctor lark" - who arrives early: with a good Continuity of Care, Anticipatory Care, and “Case Finding”. The challenge is to combine these anticipatory care, case finding and continuity of care, addressing the heterogeneity of needs and achieving individual and contextualized solutions.

Keywords: Family medicine; General practitioner; Preventive medicine; Preventive care; Preventive health care; Health promotion; Anticipatory care; Fable; Significant learning

Introduction

No longer is it necessary to defend the importance of prevention in health care. Successive international and local reports, from many sources, have recognised the importance of promoting health and preventing disease. Neither is there much dispute about the value of most basic statutory methods to improve public health. However, some differential conceptual subjects about the role and tasks of the family doctor in preventing the disease and in relation with how to deal with asymptomatic and undiagnosed problems have not been sufficiently clarified. The conceptual basis for these tasks lies in "opportunistic prevention", because every contact with patients provides opportunities for the prevention of illness and the encouragement of people to adopt more healthy life-styles, even when the patient has come for an apparently unrelated problem which has to be dealt with first. The emphasis in opportunistic care is on taking the opportunities offered by patients [1,2]. The prevention and delay of chronic disease is an increasing priority in all advanced health-care systems, but sustainable, effective and equitable approaches remain elusive.

Conceptual systematization in the specialty of family medicine/general medicine has not matched with practice. However, it is not until that the conceptual heritage of family medicine, is ordered, systematized and fully clarified when it can begin the real practical work [3-5]. Therefore, it is necessary to achieve more meaningful representations of the fundamental concepts of family medicine, and facilitate the transfer of these to clinical practice. One of these main concepts is “prevention” in primary health care [6]. Although, we can have several examples, including especially the famous pioneering example in the UK, of Julian Tudor Hart who combined reactive and anticipatory care within routine consultations in primary medical care [2,7], this concept can be difficult to understand and explain, even for experienced physicians in the specialty [8,9].

On the other hand, regarding this explanation, data are important, of course, but numbers sometimes imply an order to what is happening that can be misleading. Stories, tales, and metaphors are better at capturing a different type of “big picture” [10] so, we will present this concept of “prevention” in family medicine by a fable [11]. Fables and metaphors can simplify the expert knowledge, not by ignoring or reducing the inherent complexity, but by providing a point of entry for its comprehension. They are a means of generating ideas, promoting creativity, and constructing concepts and theories [12,13]. The fable is an adult education method that can serve to intuitively understand abstract concepts by linking them to specific situations, for facilitating their assimilation. The fable is a fictional story which is presented as real. In the fable it can be distinguished two parts: one is the story itself and the other the moral [14,15].

The fable of the lark and the owl

Once upon a time a lark and an owl which consulted the family doctor.

Mrs Lark came early at medical office.

-"Doctor, I have some symptoms...they are very mild, but I perceive them: thirstier than usual, polyuria, blurred vision and weight loss. I imagine it is not serious but as soon as I have noticed them I come..." said Mrs. Lark.

After, Mr. Owl entered the office. He was late.

-"I bring you this discharge report from the hospital. I did not

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want to come. That is why you do not know me; I had not consulted before...But now I have had to go to the hospital. There they found me retinopathy and I am told that it could lead to blindness, nephropathy that could lead to kidney failure, neuropathy that could produce plantar ulcers or even have to amputate..." said Mr. Owl.

The doctor thought: "Diabetes mellitus can present with characteristic symptoms, such as thirst, polyuria, blurred vision and weight loss. Often the symptoms are not severe or are not appreciated. Mrs. Lark is an early riser and the fact of consulting us early should help the treatment and improve the results. Mr. Owl gets up late and he come late. Hyperglycemia can cause functional and pathological changes for a long time before diagnosis. Chronic complications of diabetes mellitus include the progressive development of retinopathy, with potential blindness; nephropathy that can lead to renal failure; peripheral neuropathy at risk of plantar ulcers, amputation or foot of Charcot; certain infections; odontological alterations, autonomic neuropathy; and cardiovascular diseases, such as ischemic heart disease, stroke or peripheral artery disease."

And he continued: "The family doctor is a doctor 'lark': an early bird, who performs early interventions. Thanks to the longitudinal or chronological continuity - which refers to the fact that health care takes place in the same place, with the same medical record, and with the same professional-, there is an increasing knowledge of the patient by those who provide assistance, and it allows to family doctor for anticipatory care and "case finding". Longitudinal continuity implies the knowledge of a certain pattern of visits, and it has clinical advantages: it increases the knowledge about the patient and facilitates the diagnosis and the treatment; allows to see that the presence of a problem can be a marker of a more serious transforms; facilitates the implementation of opportunistic preventive elements; and finally save costs to the health system (better use of services, fewer hospitalizations, etc.). The hospital doctor is an 'owl' doctor; usually he 'arrives late' and this forces him to complex, expensive interventions that only achieve partial results. His activity is episodic, it is not continuous. The family doctor is ahead of the events because of his continuous knowledge and anticipatory work; the hospital specialist has to deal with cases late..."

In order for doctor "owl" to be able to work better in his night-time emergency service, doctor "lark" must maintain the continuity of care and anticipate events. The family doctor performs "anticipatory prevention": he or she is a caregiver with eyes on the future. This can involve primary, secondary, tertiary and quaternary prevention [avoiding iatrogenic], as well as identifying factors in an individual that may affect others in their family or community.

Discussion

In family medicine, "opportunistic prevention" includes, at least: 1) Anticipatory care; 2) "Case-finding", and 3) Continuity of Care.

Anticipatory care

Anticipatory care, in practical terms, are both about adopting a "thinking ahead" philosophy of care that allows practitioners and their teams to work with people and those close to them to set and achieve common goals that will ensure the right thing is being done at the right time by the right person(s) with the right outcome. Anticipatory care is more commonly applied to support those living with a long term condition to plan for an expected change in health or social status.

Family doctor is in a unique position within the health care system with regard to clinical health promotion. An essential feature is the integration of diseases prevention and health promotion in the regular consultation. The concept of anticipatory care seems fit to understand this integration. Because of the family doctor (anticipatory) knowledge of the patient's medical history, lifestyle, risk factors, living conditions, health perceptions and family context, he has the opportunity to include during the consultation, aspects of health promotion and disease prevention [16,17].

Triggers for Anticipatory Care are practical opportunities that can be used to prompt conversations with people about their condition and to discuss the potential benefits from developing their own Anticipatory Care Plan. Useful triggers may include: Situation (for example, following discharge from an unscheduled admission to hospital, or when the person has frequent contacts with Out of Hours services), Condition (for example, COPD in receipt of domiciliary oxygen), Clinical assessment (e.g. patients recognised as vulnerable by primary or community care services due to change in health, function, psychological state or carer situation, or patients receiving poly-pharmacy or on certain categories of drugs, e.g. opioids) [18].

Case finding

The primary purpose of screening tests is to detect early disease or risk factors for disease in large numbers of apparently healthy individuals. The purpose of a diagnostic test is to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals (confirmatory test). Case finding is a strategy for targeting resources at individuals who are suspected to be at risk for a particular disease. It involves actively searching systematically for at risk people, rather than waiting for them to present with symptoms or signs of active disease. Note the similarities to screening - both seek to risk stratify the population for further investigation-but note also the special characteristics of this screening own of family medicine. "Case-finding" taking advantage of patient visits [19-22]. The screening activities as a method of cohort where the service is offered to a selected group of the population, is replaced in "Case finding" by that of taking advantage of the contact with patients to offer screening to those who need them. It requires organization and proper medical history. Family medicine is the ideal framework for screening activities because of providing access to the entire population; even those less motivated by prevention come to the family doctor when they feel sick (75% of patients assigned to a family physician attend at least once every 5 years). This situation makes it possible of determining the biological onset (presymptomatic) of disease, allows the integration of preventive and curative activities, and finally, the problems of health are followed until its solution [5]. Examples of case-finding can be: sexual partner ascertainment in syphilis outbreaks, or household/work contacts in food-borne outbreaks, or the two-question case-finding instrument for detecting depression in primary care [23]. The purpose is to identify at-risk individuals and offer them screening and treatment if necessary.

Continuity of care

Natural history of disease refers to the progression of a disease process in an individual over time, in the absence of treatment. Natural history of disease represents the course of biological events between the sequential action of component causes (etiology) until the disease develops and the outcome occurs (healing, passing to chronicity or death). For example, untreated infection with HIV causes a spectrum of clinical problems beginning at the time of seroconversion (primary HIV) and terminating with AIDS and eventually death. In this example, it is now recognized that it may take 10 years or more for AIDS to develop after seroconversion. Many, if not most, diseases have a characteristic natural history, although the time frame and specific manifestations of disease may vary from individual to individual and are influenced by preventive and therapeutic measures [24].

The continuity of care is considered as a defining characteristic of family medicine and primary health care [10,25-28]. Family medicine presents a unique opportunity to study the natural history of disease and allows the establishment of patient-physician-family-community relationships [29]. Family doctor work includes the natural history of disease and the human life cycle, and so, no one is better able to observe, from family history, the ultimate consequences of any health problem. The simplest and most basic way to achieve effective care is by continuing care [1,30].

On the other hand, the individual disease is an expression of the sick or problematic context. The patient is a spokesman from sick structure contextual (family conflict, social conflict...). So, symptoms can be expressions of biological alterations, the group context, or symbols or ways of coping with a situation. One of the factors which influence the type of symptoms is the family life cycle. This perspective considers the social and physical situations, and the resulting behaviour, as well as biological and psychosocial processes that act through all stages of life, affecting not only the risk of disease, but framing the symptomatic expression the affected people [31]. For example, when an acute coronary syndrome occurs, the different stages of family life cycle may favour the formation of natural groups of patients showing differences in the presentation of symptoms [32].

In family medicine we can see "turnings point" or transitions of patients in their contexts. These "turnings point" are mainly related to the life cycle of individual and family, but family doctor should consider also: 1) Sudden loss of stability (new factors emerging in the contextual or personal level with acute or penetrating form); 2) Recurrence of problematic factors (dysfunctional repetitive behaviors and repetition of severe traumatic experiences); 3) The bifurcation that is produced during a path (a basic sequence or repeated in successive generations over time); 4) The progressive oscillation which consequently favors stability loss (a number of factors that eventually accumulate in number and come to cause new types of them) [33].

During a transition, people experience stress and anxiety. However, overcoming the consequences of transition imply an increase in knowledge, obtaining new skills, and the reformulation of identity. The focus on addressing the turning points in family medicine has conceptual characteristics, nuances, approaches, problems and own tools. Family doctors could explore in an active way this fundamental concept of the turning points, using a holistic frame. Thus, the practical approach with patients could be a way not only see "problems" in the patients, but also their "transitions" and "turning points". That is, the family doctor can allow changes in where patients move from one stage to another, while him help keeping all possibilities to achieve positive results. From this perspective, addressing the apparent problems and obstacles of life does not necessarily mean risks or chaos, but opportunities to gain depth in vision, and identify strengths unknown. Once the family doctor adopts this position, he can help his patient to rearrange and recreate their world better [33].

Conclusion

Family medicine presents a unique opportunity to do preventive tasks – "Opportunistic prevention" and these have important, different, and specific connotations and implications at this level of care, which have not been sufficiently systematized conceptually. The essence of family medicine is to assist individuals in families and communities, and this implies, a good Continuity of Care, Anticipatory Care and "Case Finding". As theory and evidence accrue, the challenge is to combine the strengths of primary medical care and health improvement, in integrated, sustainable systems of anticipatory care, case finding, and continuity of care, addressing the heterogeneity of individual needs and solutions, while achieving high levels of coverage, continuity, co-ordination and outcome.

References

1. Stott NCH (1983) Primary health care. Bridging the gap between theory and practice. Springer-Verlag, New York.
2. Hart JT (1988) A new kind of doctor. The general practitioner's part in the health of the community. Merlin Press, London.
3. Davies P (2000) Is it time for a new definition of general practice? General practitioners' main interest is people. BMJ 32: 173
4. Povar GJ (1996) Primary care: Questions raised by a definition. J Fam Pract 42: 124-128.
5. Turabian JL (1995) Cuadernos de medicina de familia y comunitaria. Una introducción a los principios de medicina de familia. Family and community medicine notebooks. An introduction to the principles of family medicine. Díaz de Santos, Madrid.
6. Hesse M (1966) Models and analogies in science. University of Notre Dame Press, Notre Dame.
7. Watt G, O'Donnell C, Sridharan S (2011) Building on Julian Tudor Hart's example of anticipatory care. Prim Health Care Res Dev 12: 3-10.
8. Thomas P (2006) General medical practitioners need to be aware of the theories on which our work depends. Ann Fam Med 4: 450-454.
9. Olesen (2003) A framework for clinical general practice and for research and teaching in the discipline. Fam Pract 20: 318-323.
10. Sayer S, Lee TH (2014) Time after Time-health policy implications of a three-generation case study. N Engl J Med 371: 1273-1276.
11. Sacks O (1998) The man who mistook his wife for a hat. Touchstone, New York.
12. Turabian JL, Perez-Franco B (2016) The family doctors: Images and metaphors of the family doctor to learn family medicine. Nova Publishers, New York.
13. Turabian JL, Franco BP (2017) Responses to clinical questions: Specialist-based medicine vs. reasonable Clinic in family medicine. Integr J Glob Health 1: 1.
14. Turabian JL (2017) Fables of family medicine. A collection of fables that teach the principles of family medicine. SEditorial Académica Española, Aarbrücken, Deutschland/Germany.
15. Turabian JL (2017) Stories Notebook about the fundamental concepts in family medicine: An introduction. J Gen Pract 5: 283.
16. Crebolder HFJM, van der Horst FG (1996) Anticipatory care and the role of Dutch general practice in health promotion - A critical reflection. Pat Educ Couns 28: 51-55.
17. (1984) Anticipatory care. Fam Pract 1: 133-134.
18. Scottish Governement (2010) Anticipatory care planning: Frequently asked questions.
19. Hart JT (1970) Semicontinuous screening of a whole community for hypertension. Lancet 2: 223-226.
20. Hart JT (1974) Milroy lecture: The marriage of primary care and epidemiology: Continuous anticipatory care of whole populations in a state medical service. J R Coll Phys Lond 8: 299-314.
21. Hart JT (1975) Management of high blood pressure in general practice. Butterworth gold medal essay. J R Coll Gen Pract 25: 160-192.
22. Hart JT, Thomas C, Gibbons B, Edwards C, Hart M, et al. (1991) Twenty five years of case finding and audit in a socially deprived community. BMJ 302: 1509-1513.
23. Whooley MA, Avins AL, Miranda J, Browner WS (1997) Case-finding instruments for depression. Two questions are as good as many. J Gen Intern Med 12: 439-445.
24. Turabian JL (2017) A narrative review of natural history of diseases and

continuity of care in family medicine. arch community. Med Public Health 3: 041-047.

25. White ES, Gray DP, Langley P, Evans PH (2016) Fifty years of longitudinal continuity in general practice: A retrospective observational study. Fam Pract 33: 148-153.
26. Beaulieu MD (2013) Teaching the essence of family medicine. Can Fam Physician 59: 1017.
27. Stokes T, Tarrant C, Mainous Iii Ag, Schers H, Freeman G, et al. (2005) continuity of care: is the personal doctor still important? A survey of general practitioners and family physicians in England and Wales, the United States and the Netherlands. Ann Fam Med 3: 353-359.
28. Hill AP, Freeman GK (2011) Continuity of care. Promoting continuity of care in general practice. RCGP policy paper. J R Coll Gen Pract.
29. Morrell D (1991) The art of general practice. Oxford: Oxford University Press.
30. Turabián JL, Báez-Montiel B, Gutiérrez-Islas E (2016) Type of presentation of coronary artery disease according the family life cycle. SMJ Community Med 2: 1019.
31. Turabian JL, Perez Franco B (2012) The symptoms in family medicine are not symptoms of disease, they are symptoms of life. Aten Primaria 44: 232-236.
32. Turabián JL, Báez-Montiel B and Gutiérrez-Islas E (2016) Type of presentation of coronary artery disease according the family life cycle. SMJ Community Med 2: 1019.
33. Turabián JL, Franco BP (2016) Turning points and transitions in the health of the patients: A perspective from family medicine. J Fam Med Community Health 3: 1087.

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