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SEMINAR REPORT

Clinical prevention: patients' fear and the doctor's guilt

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Introduction

Contrary to its apparently straightforward concept, the word "prevention" has become a sort of "mantra" whose meaning is difficult to establish, at least in relation to health services (1). In its application in the wide field of health, prevention has a different significance depending on whether it is related to populations or to patients (2,3).

Clinical prevention is the activity which anticipates and tries to avoid and reduce harm, generally offered to patients at the doctor's office by health professionals (4). With the introduction of the risk factor concept, the clinical prevention field has substantially broadened, practically without limits, as is clearly demonstrated, for example, by the numerous cardiovascular risk factors currently described (5). A risk factor era has emerged as the result of the growing predominance of clinical activity and public health programmes intended to minimize the risks for certain diseases, especially cardiovascular disease and cancer (6). Furthermore, the appearance of the concept of "pre-illness" increases the scope of prevention, as the goal becomes to anticipate and treat situations which could result in established disease. A good example of this is pre-diabetes (7).

Prevention has some unquestionable successes. However, the extension of its influence has brought about proposals for activities which are not very efficient in clinical prevention. It is not clear why doctors and patients have accepted such clinical prevention, considering the huge impact it has on their jobs and daily life. There are two main issues involved: feelings of fear (among patients) and feelings of guilt (among doctors).

Patient fear

Patients go to the doctor with a number of expectations and fears. For example, a patient may be worried about a surprising number of differential diagnoses when he or she goes to the doctor for a "simple" acute cough (8). Patients fear for their lives, they worry about suffering from diseases and/or becoming seriously disabled (9).

Fear makes patients feel vulnerable, as they put themselves in the hands of doctors, expecting a solution to everything. It also gives rise to unfounded expectations of avoiding disease and death due to *zero risk*, and systematic control of all risk factors (10).

Excessively high expectations among patients bring with them the desire for perfect health, which paradoxically creates the feeling of having poor health (11). Furthermore, patients consent to medical interventions when the benefit is doubtful or marginal. With regards to screening, the inclusion of routine breast ultrasound may be used as an example. This test decreases the positive predictive value of the recommendation of breast surgery from 23% to 11% (12). In the desire to be in perfect health, in order to meet all expectations and eliminate all fears, prevention could do more harm than good (13).

In order to avoid the harm of excessive prevention activity, the doctor should consider the fears and expectations of the patient, within the consultation, and provide appropriate answers.

Doctor's guilt

Disease was once related to sin, whereas nowadays it tends to be associated with a "possible error in clinical

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prevention". Because of this, there still exists some feeling of blame, currently transformed into the doctor's feelings of guilt regarding the patient, for example, with a myocardial infarction. The doctor immediately goes through the patient's clinical record and detects the *missed opportunities* for prevention.

Doctors feel guilty in the face of disease and suffering. It is not sufficient to be a healer; it seems that modern times demand that you should also be a scientist and apply the guidelines and norms which ensure good results. The guidelines, norms, and protocols stop being an aid to decision making and become instructions which must be followed.

Clinical practice becomes prescriptive and ignores the way patients think about and experience their own lives and illnesses. It is said that "there are no illnesses, just ill people", but it is difficult to resist the pressures of normative "standards of care", even knowing that the sick person himself must remain in charge of his own personal evolution.

We cannot ignore the obvious—the indisputable law of epidemiology—that "all that lives, dies" (14). We should be honest with patients and let them know that there are cases of clinical prevention which simply change the cause of death, and do not even delay the process or allow one to die with dignity. For example, in the case of cardiovascular prevention in the elderly, life is not extended but the cause of death may be different (dementia and cancer) (15).

Doctors should act responsibly but should not be made to feel guilty for arbitrary and contingent events. This increases unhappiness in the doctor as a professional, but it is impossible to respond to the excessively high expectations of prevention without limits (10,16). Currently, medical training is still based on the illness and its diagnosis, which contributes to the frustration caused by the contrast between training and daily clinical practice (16,17).

Conclusion

Clinical prevention should not be allowed to evolve into a categorical imperative in which the end justifies the means, which fuels patients' fears and doctor's guilt, and which endorses clinical intervention with a certain sense of righteousness in the search for good (18). Clinical prevention is an important activity which nearly always has a place in the doctor–patient consultation (19). However, clinical prevention has its limits (20). Above all, the activities of clinical prevention should not be introduced/maintained as a result of feelings of fear (in the patient) or guilt (in the doctor).

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Competing interests

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