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SOMOS AGUA, MURO Y FUEGO: SOMOS MEDICINA DE FAMILIA Y COMUNITARIA

MESA DEBATE

La necesaria reforma de la Atención Primaria: propuestas desde la heterodoxia

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#14SEMFyC

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ANALYSIS

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Sacrificing patient care for prevention: distortion of the role of general practice

Expansion of preventive clinical recommendations in primary care has had the unintended consequence of destabilising this foundation of the healthcare system, argue Minna Johansson and colleagues

Stephen A Martin, [1] Minna Johansson, [2,3] Iona Heath, [4] Richard Lehman, [5] Christina Korownyk[6]

For thousands of years, clinicians cared exclusively for people who were sick. Only over the past five decades has primary care's focus been increasingly redirected towards risk, not symptoms.[1] The change to medical prevention was ushered in during the late 1960s, when diuretic treatment of diastolic blood pressures of 115-129 mm Hg was found to prevent cardiovascular events with a number needed to treat (NNT) of 6 people a year.[2-4]

This beneficial intervention was targeted at a high risk population. However, today primary care is increasingly asked to prevent disease in lower risk populations that, at times, compose the majority of the population. Lower baseline risk leads to higher numbers of patients nee
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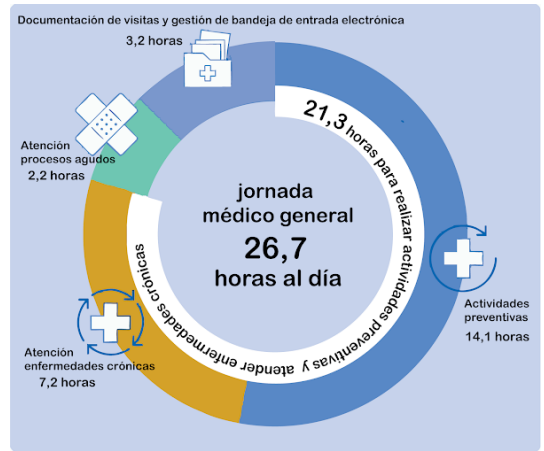
a profession dedicated t

This expansion of medical territory—without a commensurate benefit or an impossible expansion of time—is a major contributor to the primary care crisis in many high income countries. To save primary care from collapse, the enthusiasm for minimally beneficial clinical preventive services in asymptomatic, low risk populations must be curbed and responsibility for primary disease prevention returned or reassigned to public health.

Reconciling competing demands with patient needs

Each new prevention activity or expanded target population exacts an unacknowledged opportunity



Adaptación al español de @roanel.bsky.social para @sanoysalvo.bsky.social
Infografía tomada del artículo Martin, S.A. , et al. Sacrificing patient care for prevention: distortion of the role of general practice. BMJ 2025;388:e080811

ANALYSIS

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Guidelines should consider clinicians' time needed to treat

Minna Johansson, Gordon Guyatt, and Victor Montori argue that assessing the implementation time of guidelines would help make best use of clinical resources

Minna Johansson, [1] Gordon Guyatt, [2] Victor Montori[3]

Clinical practice guidelines aim to contribute to efficient and high quality care.[1] Efforts are already made to overcome barriers to implementation such as lack of credibility because of financial or intellectual conflicts of interests, and clinicians' inability to change habits or keep up to date with new recommendations. However, what is rarely acknowledged is that implementing guidelines may require appreciable clinician time and therefore have considerable opportunity costs in the clinical encounter. Including an assessment of time needed to implement might alter the recommendations of guideline committees and help clinicians to prioritise.

quality metrics or pay-for-performance schemes. However, since clinician time is finite and scarce, the chosen interventions and patient groups will inevitably be prioritised at the expense of other interventions and other patient groups.[6,7] Thus, time spent implementing a particular guideline may carry a substantial opportunity cost, and the element of clinical care that is lost might be of more benefit than what is gained.

One strategy to address this problem would be for guideline panels to estimate the time needed to implement an intervention when determining the direction and strength of recommendations. A recent

Prioritizing Patients With the Greatest Care Needs: Time for Family Physicians to Lead

Amanda Niklasson, MD; Victor M. Montori, MD, MSc; and Minna Johansson, MD, PhD

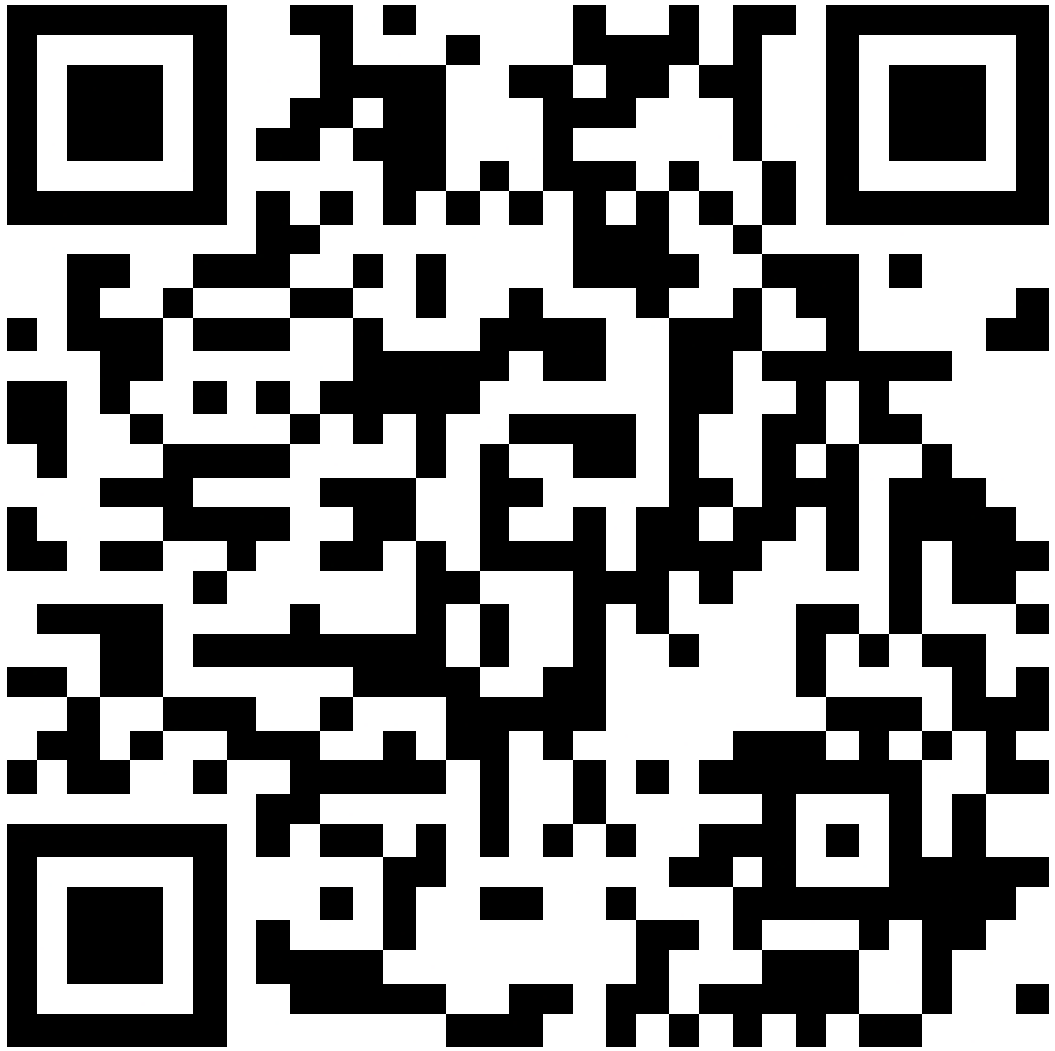
According to one estimate, family physicians would need to work 27 hours every day to follow the clinical practice guidelines that apply to their patients, and more than one-half of those hours would be spent on prevention in asymptomatic individuals.[1] We face a tsunami of recommendations but can follow only a small fraction of them.[2] Prioritization (eg, patients with severe symptoms over those with mild or no symptoms, interventions with greater benefits over those with small or uncertain benefits, prevention for high-risk populations over low-risk populations) is difficult and haphazard in primary care.[3]

Performance measures, tied to guidelines that are impossible to follow, exacerbate the prioritization problem. Examples of such measures include the proportion of people screened for alcohol consumption or physical inactivity, or the proportion of patients with diabetes achieving target A1C, blood pressure, interventions with limited or uncertain benefits for asymptomatic, low-risk populations at the expense of interventions with greater benefit for patients with greater needs. For example, one study estimated that five to seven patients with symptoms would need to be treated to improve outcomes for one. For prevention on the other hand, estimates ranged from 40 to 1,000 patients, and even higher for lifestyle interventions.[6]

The UK National Institute for Health and Care Excellence recommends 379 lifestyle interventions, of which almost 100 apply to more than 25% of the population.[7] Only 3% of these are supported by high- or moderate-certainty evidence that the intervention helps people change behavior. More physicians (of all specialties) and five times more nurses than available in the United Kingdom would be needed to follow just the recommendations on lifestyle interventions.[8]

Dar prioridad a los pacientes con mayores necesidades asistenciales: es hora de que los médicos de familia tomen la iniciativa

https://acortar.link/14video



Atención primaria
Base del sistema
¡Es el sistema!
Atención integral
Polivalencia
Competencia. Resolución

Pediatría...
ÑAM!

Embarazo...
ÑAM!

Paliativos...
ÑAM!

Atención
telefónica...
ÑAM!

Atención
domiciliaria...
ÑAM!

Paciente
crónico
complejo...
ÑAM!

Gestión bajas
laborales...
ÑAM!

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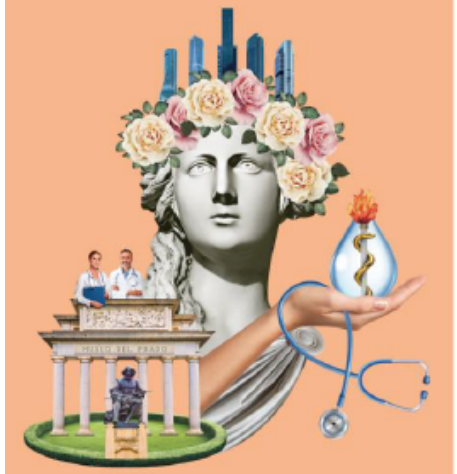

Propuestas para la AP desde la Heterodoxia

Mar Sacristán Germes
CS Paseo Imperial (Madrid)

Socia SEMFYC y EGPRN
Sin conflicto de intereses… o sí…

When the Going Gets Tough, the Tough Get Going

https://www.youtube.com/watch?v=llxUKbV0UEM

Cuando las cosas se ponen difíciles, es cuando los los duros se ponen en marcha

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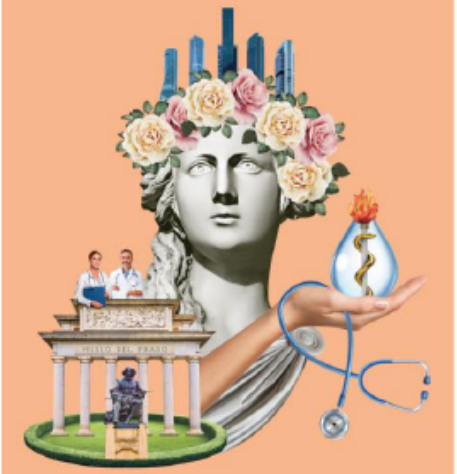

¿Cueces o enriqueces? Rompiendo moldes en la Atención Primaria.

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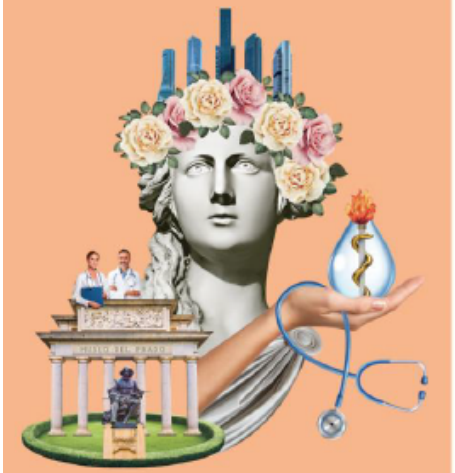

La Autogestión, la reforma evaluada

Dr. Jaume Sellarès Sallas
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