

Good Questions

Issue Nine: Special Issue on Concordance

September 2007

Compliance, adherence or concordance: what difference does a word make?

In recent conversations with clients and colleagues, we have been surprised by how frequently and unreservedly the term 'compliance' is still used. The debate about whether 'compliance' should be replaced by or can be used interchangeably with 'adherence' and 'concordance' is not a new one - yet patients are often expected to simply comply with prescribed medication.

'Compliance' suggests a rather paternalistic view of health behaviour, with the implication that the patient should do what the doctor tells him/her to do. Importantly, 'non-compliance' implies a conscious decision by the patient to go against the doctor's instructions; labelling a patient as 'non-compliant' is as good as calling him/her a lost cause! Yet, there can be many reasons why a patient does not take medication as recommended (see figure 1).

Figure 1: Barriers to optimal medicine use

<i>Professional</i>	- Inappropriate prescribing Mistakes in dispensing
<i>Practical</i>	- Forgetfulness Inability to open containers
<i>Information</i>	- Misunderstanding condition, treatment or instructions
<i>Lifestyle</i>	- Unpleasant side effects Inconvenience / inflexibility No perceived benefits
<i>Beliefs</i>	- Medicine is unnatural Medicine is addictive / toxic Lack of efficacy



In contrast, the term 'adherence' implies that the patient has control and choice in their treatment and 'non-adherence' can be considered more usefully as:

- 'Intentional' - attributed, for example, to perceived lack of efficacy or intolerance of side effects. Other reasons include inconvenience or inflexibility of dosing and timing of medication.
- 'Non-intentional' - caused by many factors, eg poor communication of treatment instructions, confusion about timing of medication.

None of these reasons necessarily suggest a deliberate act of sabotage. If non-adherence (intentional or otherwise) is understood from the patient's perspective, it becomes clear that there are many reasons why a patient may not stick to a pre-defined treatment regimen or may stop altogether. If more is known about how patients perceive the effect of their medication, how satisfied they are with treatment, then more can be done to find a solution that is most suited to the patient.

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Let your reactions count!

This is the ninth issue of 'Good Questions' and we hope you have enjoyed our regular addition to your email inbox every month.

We would like to know what we can do to make future issues of greater interest and relevance to you, our discerning reader. So, we are conducting a brief survey to find out - it will take no more than 3 minutes of your time. **For every completed survey received, we will donate £1 to our chosen charity, REACT.**

React
GIVING DEPTH TO SHORT LIVES

REACT is a UK-based charity, providing Rapid Effective Assistance for Children with potentially Terminal illnesses. REACT is a dynamic charity responding quickly to improve the quality of life of children with life-threatening illness.

So, please let us know what you think of our e-bulletin and let your reactions count! Look out for our survey arriving in your inbox soon.

Concordance is a shift in how we think about medicine-taking, challenging us to consider the patient's priorities

... continued from page 1

So, a shift from compliance to adherence facilitates an understanding of the patient's perspective and consideration of the various factors that might result in sub-optimal medication-taking. But is this enough? 'Concordance' is a *process* of prescribing and medication-taking, based on a partnership between the health professional and the patient. It is founded on three assumptions.

Concordance requires that the patient has acquired *sufficient knowledge* about his/her condition and its treatment to be able and willing to participate as a partner. Importantly, patients should be as involved as they choose to be in the decision-making. We must remember that not all patients will choose to do this and some will continue to want their clinicians to make decisions on their behalf.

For the second assumption, clinicians need to be willing to *involve the patient* as a partner, to invite the patients' views on their condition and its treatment, and to discuss any concerns the patient might have. Patients are invited to talk about their understanding of the medication, the dose / timing instructions and their ability to follow the treatment as recommended (see '*In the Journals*', page 3).

The third and final assumption surrounding concordance is that the *patient is supported* in his/her medication-taking. Progress needs to be reviewed regularly and openly, so that the patient feels able to share any practical difficulties he/she has been experiencing. Ultimately, the clinician needs to be prepared to reconsider treatment options that may be better suited to the individual, even if that means potential loss of efficacy. Moving from 'compliance' to 'concordance' requires a cultural change, or a paradigm shift. This all sounds fine but why do we need concordance?

At its simplest, the best argument (from the provider's perspective) is that concordance improves medication-taking behaviour. The compliance model has only limited potential for ensuring that the patient takes the prescribed medication as indicated. Statistics about medication-taking are well-known but provide a powerful message: as few as 31% of patients adhere to their treatment as recommended¹.

Can concordance improve this situation? Well, there is limited evidence but a recent study showed that two-way communication between patients and clinicians about medicines led to improved satisfaction with care, knowledge of condition and treatment, adherence to treatment, improved health outcomes and few medication-related problems².

Concordance is a shift in how we think about medicine-taking, challenging us to consider the patient's priorities and preferences, and working towards a solution that will provide optimal outcomes for the patient. Framed from the clinician's perspective, attempts to persuade patients to take medications are rarely successful³. Enhancing the agreement between the clinician and the patient about treatment goals and the specific strategies to be adopted to meet those goals is much more likely to lead to improved patient outcomes than reliance on compliance alone.

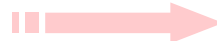
- 1 Donnan PT et al (2002) Adherence to prescribed oral hypoglycaemic medication in a population of patients with Type 2 diabetes: a retrospective cohort study. *Diabet Med* 19(4):279-84.
- 2 Cox K et al (2003) A systematic review of communication between patients and health care professionals about medicine-taking and prescribing. London: GKT Concordance Unit, King's College.
- 3 Wolpert HA, Anderson BJ (2001) Management of diabetes: are doctors framing the benefits from the wrong perspective? *BMJ* 323: 994-996.

Moving from compliance to concordance requires a paradigm shift

Compliance model

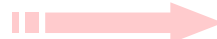
Concordance model

Clinician decides diagnosis and prescribes treatment



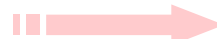
Clinician and patient discuss diagnosis and consider treatment options

Clinician's task is to explain and instruct



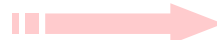
Clinician elicits and accommodates patient's concerns

Patient's task is to understand



Patient considers and accommodates clinician's recommendations

Successful outcome is compliance



Successful outcome is negotiated agreement of a prescription the patient can tolerate



In the Journals

Patient misinterpretations of drug label instructions

- 1** Research suggests that half of adults in primary care outpatient settings misunderstand label instructions.
- 2** The purpose of this study was to investigate the nature and cause of patients' misinterpretations of common dosage instructions on prescription drug container labels.
- 3** 395 US adult patients (mean age 45y) participated in a structured interview (response rate 92%). Patients were asked to interpret the labels of five common prescription medication bottles. Understanding (how would you take the medication? How many would you take?), demonstration and attendance to auxiliary warning label instructions were evaluated. Patients also completed a literacy assessment.
- 4** Overall, 46% patients misunderstood one or more dosage instructions but interpretation varied.
- 5** Many terms commonly used on labels (eg antibiotic, orally, teaspoon (mistaken for tablespoon)) were poorly recognised. Common phrases were confusing eg "take two tablets by mouth twice daily" was often interpreted as "take a pill twice a day". Patients found simpler and more explicit dosing regimens easier to understand.
- 6** 16% patients recalled at least one auxiliary warning instruction. Only 2% sought this information when inspecting prescription bottles.
- 7** Limited literacy significantly impaired the ability to read and demonstrate an understanding of drug label instructions and warnings ($p < 0.001$).
- 8** The study concludes that patients would benefit from more clearly presented prescription drug information; specifically use of explicit language, re-organisation of the label to minimise distracters, and simplification of language use.

Wolf MS et al. (2007). To err is human: Patient misinterpretations of prescription drug label instructions. *Patient Education and Counseling* 67, 293-300.

In the news

Food labels 'hoodwink' shoppers

<http://news.bbc.co.uk/1/hi/health/6958937.stm>

Debate about NICE's cost effectiveness threshold

<http://www.bmj.com/cgi/content/short/335/7616/358?etoc>

New UK study confirms that stigma still surrounds mental illness

http://www.schizophrenia.com/sznews/arc_hives/005451.html

Teen boozing 'stores up problems'

<http://news.bbc.co.uk/1/hi/health/6980133.stm>

AHP Research collaborating with UK specialists in diabetes education

In response to a UK Diabetes Research Network (DRN) call for bids to form research proposal writing groups, Jane Speight was invited to collaborate on a DRN Writing Group for Education. The proposal was successful and will enable the group to meet at regular intervals over the next two years to formulate plans for multidisciplinary research proposals. The group held its first meeting in August.

Good Answers?

Every month in "Good Questions", we give you the opportunity to benefit from your own "Good Answers". Just give some thought to the problems we pose and send your response to us.

Send us your thoughts on our main article "Compliance, adherence and concordance: what difference does a word make?"

If your entry is selected for publication in our e-bulletin, you will win an Amazon voucher. Please send your 'good answers' to: info@ahpresearch.com. The closing date for entries is 12 noon on **Friday 21st September**.

Last month's "Good Answer" was 387.6mm. Congratulations to Lambert Felix of the University of Oxford.

Patients would benefit from more clearly presented prescription drug information



Lunch and Learn



We are piloting a novel idea this autumn: 90-minute in-house sessions, during which you and your team can have a sandwich and at the same time avail of some intensive leading-edge education. We have assembled four favourite questions:

- Developing a PRO strategy: why and how?
- What does the FDA draft guidance mean for me?
- Critical appraisal skills: what do I need to know to understand a paper's true value?
- Why gamble? The perils of selecting the wrong PRO measure for your product's evaluation

There are 6 slots available between now and the end of the year. To compliment these sessions, the topics are also available as full-day in-house workshops.

If this pilot is successful, we will be offering a varied menu of sessions on a quarterly basis. So, if nothing takes your eye this time, you might note a session of more interest to you in the New Year programme. We always welcome suggestions for new training sessions, so feel free to offer ideas.

For more details, contact us by [email](#) or on 01895 273599.

In Brief

[‘HIV denial’ costing lives](#)

‘HIV denialists’ refuse to accept that HIV causes AIDS, rather citing social criteria such as poverty and promiscuity to be the cause. New research in the Public Library of Science suggests that HIV denialists believe the existence of HIV to be a conspiracy, formulated to make money through selling HIV drugs. They also argue that science is based on faith rather than evidence, pointing to flaws in scientific research which links HIV and AIDS. The authors of the research call for scientists to fight back against these claims which may cost lives through encouraging people to stop taking their medication.

[NICE victorious over limiting Alzheimer's Drugs on NHS](#)

The National Institute for Health and Clinical Excellence (NICE) was recently victorious in its first major high court legal dispute. Action was bought against NICE by campaigners and drug makers questioning the recommendation to limit certain treatments for Alzheimer's disease on the NHS. The court's decision to uphold the NICE recommendation means that the core

messages of the guidance will remain unchanged. Consequently, the NHS will not typically support the costs of acetyl cholinesterase inhibitors for newly diagnosed Alzheimer's patients, although it will continue to pay for patients already under treatment. NICE was, however, ordered to amend the diagnostic criteria of the guidance, considered to be in breach of the Disability Discrimination Act and the Race Relations Act.

[WHO warns of global epidemic risk](#)

The World Health Organisation (WHO) annual report suggests that infectious diseases are spreading faster than ever before. New diseases are emerging at a rate of one per year and without increased efforts to combat disease outbreaks and the sharing of virus data between countries to help develop vaccines, there could be devastating impacts on the global economy and international security. The most practical method to achieve health security is through sharing of medical data, skills and technology between rich and poor.

Forthcoming events:

12 - 14 Sept 2007
Division of Health
Psychology Annual
Conference:
Nottingham

10 - 13 Oct 2007
ISOQOL 14th Annual
Congress:
Toronto

20 - 23 Oct 2007
ISPOR 10th Annual
European Congress:
Dublin

1 and 20 Nov 2007
Diabetes UK workshop
'Dealing with
hypoglycaemia':
London and Manchester

13 Dec 2007
UKSBM 3rd Annual
Scientific Meeting:
Warwick

For further details on any of these events, please visit our [events](#) webpage.