Improving drug concordance in patients with chronic conditions

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A significant proportion of patients with chronic illnesses fail to take their medication as prescribed (Barber et al, 2004). Failure to adhere to medication regimens is a widespread problem that has serious implications for patients and the health service. However, to improve concordance, health care professionals need to understand patients’ reasons for not taking their medication as prescribed. While in many cases these reasons are relatively straightforward, others are complex and difficult to identify. In addition, the concept of informed choice means that, provided they have been given all the relevant information about the treatment options, patients have the right to refuse the treatment recommended to them.

A study reported in Nursing Times last week (Chatterjee, 2004) found that a significant proportion of chronically ill patients fail to take their medication as prescribed (Barber et al, 2004). This has major implications for both them and the health service.

For patients, non-concordance can result in increased morbidity and mortality – it has been suggested that improving concordance with medication may have a greater effect on health than advances in treatment (Haynes et al, 2001).

For the NHS, the money spent on wasted drugs and additional care and treatment could be better spent elsewhere. This article discusses possible reasons for non-concordance, and how nurses can help to reduce it.

**What is non-concordance?**

Patients may be partially non-concordant, for example missing doses or taking the wrong amount of medication, or completely non-concordant, where they have stopped taking their medication altogether. To reduce non-concordance, health care professionals need to understand why patients fail to adhere to drug regimens. It may be unintentional, for example where they forget to take their medication or misunderstand the instructions they have been given, or intentional.

Barber et al (2004) studied patients who had been prescribed new medication for one of a range of chronic conditions that have been identified as priorities for the NHS (Box 1). They found that 43 out of 171 patients (25 per cent) were non-concordant four weeks after being prescribed their medication. Of these, 17 (40 per cent) had stopped taking their medication altogether. Just under half (45 per cent) of the non-concordant patients were intentionally so and, of these, 89 per cent had completely stopped taking their medication.

The study excluded patients who were unable to understand spoken English, so it is unclear whether the rate of non-concordance in this patient group is different from that in the general population.

**Reasons for non-concordance**

Little empirical research has been conducted into the reasons for non-concordance, although a number of possibilities have been suggested (Barber et al, 2004). In recent years, a growing recognition of levels of non-concordance among patients with chronic disease has coincided with changes in the relationship between patients and health care professionals (Murphy and Tallis, 2003).

Old models of passive patients complying with ‘doctors’ orders’ no longer apply, as patients are now given increased choice over when, where, and how they are treated. For patients with chronic conditions, these changes have given them the chance to become more actively involved in managing their conditions and making decisions about their care.

This transfer of power from health care professionals to patients means that, increasingly, patients will not take the medication they are prescribed unless they share the prescriber’s belief that its benefits outweigh its negative effects. However, patients’ perceptions of benefits and negative effects may differ from those of health care providers. If nurses and doctors are to discuss medication in a way that enables patients to make informed choices, they need to gain an understanding of individual patients’ priorities. For example:

- Patients may see the process of taking long-term medication as harmful – even if it alleviates symptoms and improves overall health without noticeable side-effects;
- They may have difficulty fitting the medication into their daily routine or experience difficulty actually taking it (for example, if tablets are very large);

**BOX 1. CONDITIONS INCLUDED IN THE CONCORDANCE STUDY**

- Stroke
- Coronary heart disease
- Asthma
- Diabetes
- Rheumatoid arthritis
They may find its side-effects intolerable (Barber et al, 2004; Murphy and Tallis, 2003).

Lack of information is another significant cause of non-concordance. This may be due to inadequate information when the treatment is prescribed, or patients having difficulty remembering or understanding what they have been told. In Barber et al’s study, patients expressed a substantial and sustained need for further information concerning either their medication or their condition. At four weeks, 52 per cent of patients who were still taking their medication correctly, expressed a need for more information about it, and 30 per cent wanted to be told more about their condition.

In many cases it is easy to establish patients’ reasons for failing to take their medication. However, some have complex reasons for non-concordance that are less obvious, such as cultural beliefs. For example, Murphy and Tallis (2003) discuss a case study involving a young Asian woman with severe asthma. Her condition was failing to respond to medication even though she was given alternative medications and increased doses. After some months without any improvement in her asthma control, a professional with whom the woman had developed a trusting relationship asked for her views on the medication and how it fitted in with her lifestyle. It emerged that her inhalers were a clear sign to her community that she was asthmatic and therefore not ‘normal’. Her parents had told her this would compromise her chances of marriage to the most eligible suitor. As a result, she had been failing to use her inhalers.

Once the woman’s reasons for non-concordance became clear, her regime could be adapted to meet her needs. A compromise plan was agreed that did not involve an inhaler short-acting beta₂-agonist. Although this was not optimal in terms of controlling her asthma, it was acceptable to the patient, and her overall control of the disease and satisfaction with the treatment improved significantly.

Nurses’ role in improving concordance
In many cases, specialist nurses are responsible for the ongoing care of patients with chronic conditions once they have been diagnosed and their medication has been prescribed. They, and other nurses, can play a key role in improving concordance among patients with chronic conditions by making this a priority and taking practical steps to address issues that affect concordance (Box 2).

When medication is causing problems for patients, regimens can often be adjusted to fit in with their lifestyles or reduce side-effects. Clinical protocols and care pathways increasingly enable nurse specialists to alter medication within defined parameters without referring the patient back to a doctor. Ongoing involvement with patients enables nurses in nurse-led clinics to develop trusting relationships in which patients are more likely to feel able to express negative feelings about their medication. If they see patients shortly after diagnosis and prescription, specialist nurses can ensure that they understand their condition and the reasons for their medication. They can also take the time to check patients’ goals and priorities, both at the time of diagnosis and on an ongoing basis, as these may change over time.

Non-specialist nurses in all settings can also play a role in improving concordance by discussing medication with patients with chronic conditions. If patients are non-concordant, nurses can address this by discussing the reasons with the patient, finding information for the patient or referring them back to their doctor as appropriate.

Primary care nurses are particularly well placed to address concordance issues as the nature of their work means they see certain patients regularly, while many of them run clinics in GP surgeries to help patients to manage chronic conditions themselves.

Conclusion
Failure to adhere to medication regimens is a widespread problem that has serious implications for patients and the health service. However, to address concordance, health care professionals need to understand patients’ reasons for not taking their medication as prescribed. While in many cases these reasons are relatively straightforward, in others they may be complex and difficult to identify.

A patient-focused approach can eliminate or ameliorate some medication-based problems that lead to non-concordance, and identify where patients have information needs.

It can also identify less obvious reasons for non-concordance, which may require more compromise, imagination, and lateral thinking to address effectively.

While improving concordance may be the goal, however, patients should be allowed to make informed choices about their care and treatment.

Health professionals must accept that provided patients have been given all the relevant information about their condition and the treatment options in a form they can understand, and they are mentally competent, they have the right to refuse the recommended treatment. If they do not wish to take their prescribed medication, and their refusal does not affect the health of others, the best that health care professionals can do is to ensure that patients understand they can change their decision at any time.

REFERENCES

