

Exploring medication use to seek concordance with 'non-adherent' patients: a qualitative study

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SUMMARY

Background: 'Concordance' has been proposed as a new approach towards sub-optimal medication use; however, it is not clear how this may be achieved in practice.

Aim: To develop a strategy for understanding sub-optimal medication use and seek concordance during primary care consultations.

Design: A developmental qualitative study using a modified action research design.

Setting: Three Scottish general practices.

Method: Patients using treatment sub-optimally and having poor clinical control were offered extended consultations to explore their situation. Their authority to make treatment decisions was made explicit throughout. Clinicians refined a consultation model during ten 'Balint-style' meetings that ran in parallel with the analysis. The analysis included all material from the consultations, meetings, and discussion with patients after the intervention.

Results: Three practitioners recorded 59 consultations with 24 adult patients. A six-stage process was developed, first to understand and then to discuss existing medication use. Understanding of medication use was best established using a structured exploration of patients' beliefs about their illness and medication. Four problematic issues were identified: understanding, acceptance, level of personal control, and motivation. Pragmatic interventions were developed that were tailored to the issues identified. Of the 22 subjects usefully engaged in the process, 14 had improved clinical control or medication use three months after intervention ceased.

Conclusions: A sensitive, structured exploration of patients' beliefs can elucidate useful insights that explain medication use and expose barriers to change. Identifying and discussing these barriers improved management for some. A model to assist such concordant prescribing is presented.

Keywords: concordance; patient non-adherence; medication use.

Introduction

AROUND one-third of people in the United Kingdom receive long-term medication, although many do not use treatment as prescribed. This has been blamed for considerable morbidity and mortality.^{1,2}

Medication use is complex and the relatively simplistic models, such as the Health Belief Model, Self-Efficacy Theory, and the Theory of Reasoned Action, have failed to provide adequate explanation.² Two relatively new models of patients' decision making — Leventhal's Self-Regulatory Model and Dowell's Therapeutic Decision Model³⁻⁶ — are novel in that they portray a central role for patients' assessment of treatment. Leventhal also suggests that emotional as well as cognitive processes are involved. However, the application of these explanatory models has not been reported in the clinical setting where consultation behaviour must also be accommodated. There is little literature to suggest how this should be done at present.⁷⁻⁹

Sociological studies indicate that patients' beliefs about medicines arise from many sources and can influence use substantially, but that they are rarely discussed during consultations.¹⁰⁻¹⁴ It also appears that interventions involving enhanced patient communication (not information) offer promise for improving outcomes, so it seems sensible to develop skills specifically to explore the beliefs underlying an individual's medication use within the consultation.¹⁵⁻¹⁷

Acknowledging the complexity of this issue, a qualitative technique was employed to develop a strategy for exploring beliefs within general practice consultations to better understand sub-optimal treatment use. Within a strictly patient-centred approach, this understanding was used to foster greater concordance with patients, to enable them to select and pursue their treatment goals.¹⁸

The aim of the study was to develop a strategy for exploring non-adherent medication use, an understanding of patients' medication use, and a method for seeking concordance with these patients.

Method

The project used a modified action research approach in which cycles of qualitative data collection and analysis were employed to develop a consultation strategy for exploring patients' beliefs and medication use,¹⁹ each cycle of consultations and analysis being used to test and refine the approach used.

Three general practitioners (GPs) familiar with the Therapeutic Decision Model,⁶ Concordance,¹⁸ and the Patient-centred Clinical Method²⁰ purposefully sought 30 non-adherent adult patients who had problems managing a

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HOW THIS FITS IN*What do we know?*

Considerable benefit appears to be lost owing to sub-optimal medication use; however, it is clear that patients have the right to choose not to take treatment. Concordance has been suggested as an approach for reconciling clinical and patient agendas that accommodates this autonomy. It is not known how this can best be achieved in practice or if doing so will improve patient care.

What does this paper add?

This paper proposes a consultation process, based on detailed study of attempts to achieve concordance with non-adherent patients in primary care.

broad range of chronic illnesses. We identified patients using discussion with partners and reviews of prescription request records in three computerised semi-rural Scottish practices. All subjects had documented prescription request records $\pm 50\%$ of that prescribed and poor clinical control. Patients were informed about the study by letter and invited to participate during a subsequent telephone call from the GP (who was only rarely their usual GP). It was made explicit at the outset that patients' values had precedence over their doctor's and the importance of their views and authority in negotiating decisions was emphasised. They were offered 'additional medical time to discuss their care in more detail' but we did not mention treatment use at this point. Up to four extended consultations were offered which were unusual by virtue of their length, research nature (audio-taped), and the consent process. Patient opinion, clinical progress, and drug use were reviewed at least three months after the intervention.

Three forms of analysis were used. The primary analysis was performed on verbatim consultation transcripts using the approach advocated by Strauss and Corbin for coding and enhancing theoretical sensitivity.²¹ ATLAS/ti software was used to help organise data.²²

Ten three-hour 'Balint-style'/analysis meetings were held, during which emerging categories and theoretical concepts were discussed using transcripts or sections of tape for reference.²³ (Recorded meetings with three clinicians, an analyst and a facilitator.) These meetings performed joint functions; by deepening the analysis and informing the developing consultation strategy they induced further experimentation and reflection. Prompt cards were developed to guide the emerging format of these consultations (Box 1). Meetings were facilitated by an experienced group therapist who also played an explicit role as patient advocate to compensate for the medical nature of the group.

A case summary was subsequently developed for each patient outlining the perceived issue causing sub-optimal use, the strategies employed to resolve this, and the outcome. The final analysis considered the most promising strategies and case summaries in combination.²⁴ From this, a consultation process model was derived and compared with all original data to seek disconfirming examples.

Lastly, the principal analyst met with six patients and interviewed 15 more by telephone to establish their views of the process and help validate the analysis.

Results

The first 45 patients identified were approached. Twenty-four agreed to participate illustrating a range of conditions, including hypertension, asthma, hypercholesterolaemia, diabetes, and epilepsy. To explore the limits of the approach

Quote 1

Doctor: 'So can I ask you to run through with me how you actually manage to take ...'

Patient: 'I take them all in the morning.'

Doctor: 'Right. You just take them all ...'

Patient: 'Eight o'clock every morning.'

Doctor: 'Take them all together.'

Patient: 'The wife has them all laid out for me.'

Doctor: 'Right. Okay.'

Patient: 'So I just take them when I come downstairs.'

Doctor: 'Right okay. Do you ever forget them?'

Patient: 'Not usually 'cos the wife ...'

[Case 10: interview 1, hypertensive.]

Doctor: 'Any idea ... what was going wrong before? Why wasn't it working out right before?'

Patient: 'Well remember I stopped my pills when I was feeling great and I stopped them for a while and I think that was the bug bear. And then you put me back on them.'

[Case 10: interview 4, hypertensive.]

Quote 2

'Well I've had relations who have had diabetes and they had their legs amputated, they lost their sight so the fear is there that these sort of things happen.'

[Case 19: interview 1, diabetes.]

Quote 3

Doctor: 'So do you feel that you could tell when your blood pressure is up?'

Patient: 'Yes I can tell within myself like you know.'

Doctor: 'Based on what? Your ...'

Patient: 'My face goes red you know.'

Doctor: 'Okay.'

Patient: 'And the wife will say to me "You're blue about here", you know that's it. Blood pressure.'

[Case 10: interview 1, hypertensive.]

Quote 4

'Well I'm not convinced the tablets I'm taking are the right ones I should be taking because it hasn't cured it ... It may have helped slightly but I'm not sure.'

[Case 16: interview 1 hypertension]

'But like I say I've never given this a lot of thought ken. It's never ... it's no something you can see or feel or anything ken so therefore I don't have a lot of thoughts about it.'

[Case 16: interview 1, hypertension]

Quote 5

'I had an ear operation ... when was that? ... About four years ago. I think it was 'cos my ears were closing inside and they opened them at the back is it? And drilled a hole through and that's when they discovered I was diabetic. 'Cos I didn't know I was diabetic. I was only ten minutes from my operation when he comes through and says "I'm sorry your operation's cancelled 'cos you're diabetic".'

[Case 11: interview 1, diabetes.]

Continued overleaf

Quote 6

Doctor: 'What would you do if you have a bad spell. I don't know what would provoke one but if you got a cold or something and that often triggers people off, or whatever reason you have a bad spell, how would you manage at the moment? What do you do?'
 Patient: 'I increase the four, all four.'

Doctor: 'So how often would you take them at most?'

Patient: 'Erm ... quite often actually. Really quite a lot.'

Doctor: 'Every hour?'

Patient: 'Oh yeah, anyway.'

Doctor: 'And you'd increase the amount of all four every hour?'

Patient: 'Maybe three or four puffs of each every hour.'

Doctor: 'And how quickly does that have effect?'

Patient: 'More or less immediately I feel a lot better for it.'

[Case 7: interview 1, well-controlled asthma on four separate inhalers.]

Quote 7

Patient's emphasis implies the condition is an issue for them.

'... since I had the illness like you know. Never bothered about tablets. It doesn't worry me at all'

[Case 10: interview 1, hypertension.]

Quote 8

Patient's emphasis implies the condition is now seen as part of life.

'My diabetes doesn't affect me all that much. It did at the start when I knew about it, but not now I've learnt to live with it now.'

[Case 11: interview 1, diabetes.]

Quote 9

'There's one in my handbag, one in my pocket and there's one in the medicine drawer.'

[Case 6: interview 1, asthma.]

Quote 10

This asthmatic patient 'fought' against treatment and clinicians. This was reflected by a desire for sub-optimal oral treatment, to avoid the stigma of using inhalers in public.

'But I probably because of my asthma do more work than somebody else because you're trying to prove that you ... It doesn't hold you back.'

'It makes you understand why people will lie sometimes about their health, I certainly would never put it on a form.'

'I used to carry these inhalers about with me you know and it didn't matter whether you had your suit on or not. So they were rattling. These blinking inhalers and it's a bit embarrassing. I mean even though I've had asthma all my life it's still a bit embarrassing taking inhalers. That's why I wanted to go on to something that people don't see [treatment in tablet form].'

[Case 2: interview 2, asthma.]

Quote 11

'Basically I don't want to be dependent on these tablets. 'Cos I've taken them. I'm thirty-four. I'd be twenty-one, twenty-two when I got married and I've been taking tablets well basically for thirteen years I've been taking these tablets.'

[Case 4: interview 1, epilepsy.]

Quote 12

Doctor: 'That people don't follow exactly what a doctor says but they consider other things that they've heard.'

Patient: 'Aha ... And their experience.'

Doctor: 'And their experience. And what sort of experience would alter your taking a new medication do you think?'

Patient: 'Well sometimes when I take the medicine you've upped it to fifty mgs or whatever. Now when I take them ... I took it for six days ... fifty and then I thought well I'm a bit tired so the next day I halved it. That's experience.'

Doctor: 'Sure. You've experienced what the drugs do to you?'

Patient: 'Aha.'

[Case 17: interview 1, hypertension.]

After a long discussion about the risk from untreated hypertension, a change of treatment was decided and control over blood pressure monitoring handed to the patient:

Doctor: 'I'll prescribe you some ... would you like to try that you know, for a month and come and see me at the end of that and if you want to take blood pressure readings at home before you come and see me that would probably be ...'

Patient: 'A better ... yes.'

Doctor: 'The better way of doing it because you'd be convinced that that was a fair reflection on what your blood pressure was doing.'

Patient: 'Yes, When I did it at home it seemed to soon settle down.'

[Case 17: interview 2, hypertension.]

Quote 13

'It's probably made me do something [exercise and lose weight] about it rather than just you know. I'd probably just have carried on the way I was before, taking a pill every second day and hoping for the best.'

[Case 18: interview 3, hypertension.]

Quote 14

Patient: 'Fine. Changed my attitude towards my inhalers you'll be pleased to hear.'

Doctor: 'Well, go on, tell me all.'

Patient: 'I'm now not so apprehensive to use my Becotide anymore.'

Doctor: 'Right. Yes, you were quite stand-offish about the Becotide.'

Patient: 'I was. I was.'

[Case 6: interview 3, asthma.]

Involvement within the research project allowed this patient with longstanding poorly-controlled asthma to gain more control over her medication use and evaluate inhaled steroids correctly.

Patient: 'If that wasn't working I would have no qualms about coming in and saying to the doctor "look I'm on Becotide 50, I've upped it to four times a day, I'm still needing my Ventolin. Please give me Becotide 100 so we can see if it works".'

[Case 6: interview 3, asthma.]

Quote 15

'But it all depends if I've cheated. Sometimes I do cheat you know. I'll have a couple of biscuits when I know I shouldn't at night but I take my tablets and that's supposed to counteract that isn't it?'

[Case 10: interview 1, diabetes.]

we deliberately included all patients suggested. Consequently, two subjects were not constructively engaged in the process, both had significant mental health problems, one also had Munchausen's syndrome. Fifty-nine research consultations were recorded, lasting between 15 to 40 minutes. As clinicians became more experienced they progressed through the process more quickly and the num-

ber and duration of contacts tended to reduce (Table 1).

A consultation model was developed based on the analysis (Figure 1). It is presented diagrammatically as a cyclical model, although more than one consultation may be required. It is accompanied by quotes and case stories that show how patients progressed through the process.

Case 4

This woman was an epileptic with acknowledged poor adherence. She resented her disease and medication and felt that, after a period of time, the treatment made her feel unwell, although she knew it suppressed her seizures. She had developed a strategy of not taking her medicine for about three months at a time and felt that she knew her condition well enough to know when to resume her medicines to prevent further seizures. She would then restart her medicines and continue them for six to nine months. She had been seizure-free for two years, felt she had control over her condition and did not want further intervention or drug changes. The doctor understood her better and accepted her decision as she understood the potential consequences of her fits.

Here she (a) describes how she 'hates' having fits, (b) starts disclosing her non-adherence and (c) is offered responsibility by her doctor to facilitate open discussion.

Patient: *'The last one I had it was in the evening which was ... I didn't like it because I wet myself. I'd never wet myself before. I was sick and it was a long time since I've been sick. I just hated it. I was absolutely "oh, not doing this again". Panic. I just hated it.'*

Doctor: *'How about these ones?'*

Patient: *'I do sometimes don't take them. Sometimes I do get fed up taking ... tablets. Does that sound ... that sounds daft?'*

Doctor: *'No it doesn't sound daft. No, no.'*

Patient: *'I feel guilty for not taking them. It sounds daft but you do. You feel guilty for not taking them and you hope to God ... well that's fine, I feel fine and then you feel that guilty and ... oh must get back. Must get back into ...'*

Doctor: *'Would you feel less guilty if someone like me said "okay I can understand that you don't want to take the pills and that there are times you might want a break from them and that that would be okay.'*

Patient: *'Mmm.'*

Doctor: *'Provided that you know yourself when you want to go back on them. But you have to accept that the risks of you having a fit when you're off them are higher. So the kind of compromise for you then is to ...'*

Case 17

This woman's attitude towards anti-hypertensive treatment is explored, indicating what we termed the 'discomfort zone', where crucial emotions were aired and progress was often made.

Doctor: *'So what are we going to do?'*

Patient: *'I'm doing fine as we are, aren't we. I've had no dire effects or ... can I say I think the treatment of hypertension and blood pressure is fashionable just now. It's easy for doctors.'*

Doctor: *'It's easy for doctors?'*

Patient: *'Easy for doctors ... "take a pill and come back".'*

Doctor: *'Right. Tell me about that.'*

Patient: *'Well that is how I feel. It's easy for patient to come. You don't do anything, nothing unpleasant happens, just take the pill and come back again. Everybody's happy.'*

Doctor: *'But you're not happy.'*

Patient: *'I'm not happy taking pills if I don't need them.'*

Doctor: *'Right. You sound a bit annoyed about it.'*

Patient: *'No I'm not annoyed. But I think you've to have it in perspective. I could come every month and say "oh, I'm feeling a bit low", and you would be more worried and I would be more worried because I have to come. It requires ... what can I say ... me to think now "am I ill enough to go and see Doctor X or can I just think what I'm about". And I also consider that I eat too much. I*

don't think I'm terribly overweight but I think if I ate less my whole system wouldn't have to work as hard.'

This woman had tried other medicines for her hypertension but eventually elected to primarily use diet and exercise to maintain her health and accept the risks from her condition. She accepted the need for monitoring and the relationship with her practitioner was improved.

Doctor: *'We talked about the risks of having a stroke and having problems with your heart and kidney are higher than normal if you have a raised blood pressure. But if you'd rather have these risks ... you've talked before of how you didn't feel it was going to happen to you.'*

Patient: *'Well I don't.'*

Patient: *'I have no symptoms at all. I twigged this blood pressure complaint myself so what else ... how else ... I don't have headaches. What else would I know about.'*

Doctor: *'They often don't give you symptoms. It's just a question that over time your blood pressure can cause problems with your eyes and with your kidneys.'*

Patient: *'But I would know?'*

Doctor: *'You would know ... well you might know but it's worth having things like blood checked from time to time and to have your urine checked from time to time and your blood pressure.'*

Patient: *'Which I have done this summer.'*

Doctor: *'So I think it's maybe worth checking that every six months or every year just to keep an eye on it. To check that those complications aren't arising.'*

Patient: *'Yes, yes.'*

Doctor: *'Does that seem a reasonable compromise? 'Cos I think we've been through lots of different combinations of treatment.'*

Patient: *'Now would you say that I am medium, poor or good with the blood pressure? My blood pressure medium, is it in the poor range requiring more treatment or it's good, I can trot along like this?'*

Doctor: *'I would prefer if you had more treatment.'*

Patient: *'Ah but you're the doctor.'*

Case 10

Open discussion proved difficult to establish with this patient but his medication use and blood pressure control improved dramatically after the first meeting (see quote 1). Cards 4 and 5 were revisited during the third consultation to confirm his attitude to medical advice. This discussion, among others, indicated he preferred a directive style of doctor.

Doctor: *'... but which of these do you feel you might be in?'*

Patient: *'This one.'*

Doctor: *'You feel that you're fairly passive about the way that you ...'*

Patient: *'Yes, aha.'*

Doctor: *'And do you feel happy about doing it that way?'*

Patient: *'Yes, anytime I'm happy as far as my health goes.'*

Doctor: *'Right. You'd prefer to just hand it over and let the doc ...'*

Patient: *'Hand over and let the doctor deal with it. Well we're under your care so.'*

Doctor: *'Sure.'*

Patient: *'It's what I look for.'*

Doctor: *'Is that the way you would sort of address other things in your life. If you were going to get an insurance premium or something would you just take the advice and say "Right, okay. I've found some advice. If that's what you say I'll do it."'*

Patient: *'Yeah.'*

Doctor: *'You're happy with that sort of approach?'*

Patient: *'Mmm, yes.'*

[Patient 10, interview 3: Hypertension.]

Card 1: Acceptance of illness
 'Tell me about when your diagnosis of X was made?'
 — Feelings about diagnosis

Card 2: Understanding
 'What does this diagnosis *mean* to you?'
 — Personal implication

Card 3: Acceptance of medication
 'How do you feel about your treatment?'
 'How do you judge if it is working?'
 'How do you use your treatment?'

Card 4: Attitude to advice
 'In general, where do you fit on this scale?'

Like to follow advice on treatment precisely	Sometimes ignore advice totally
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Card 5: Medication use
 'In general, where do you fit on this scale?'

Take treatment as directed	Sometimes stop treatment against advice
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Card 6: Setting goals
 'What would you like your treatment to do?'
 Identify specific goals

- Patients
- Medical

Management plan

Stamp for case notes

	Patient	Doctor
Treatment Goals		
Drug		
Dose		
Frequency		
Duration		

Box 1. Prompt cards.

Opening discussion: signal a change in consultation style

It was hoped that our explicitly reassuring consent process would enable patients to discuss their treatment use. However, initially we still obtained some defensive accounts of 'compliance' which then obstructed the process (Quote 1). Offering a review, going back to the start, and focusing on disease control (not treatment use) proved more effective. For instance, 'Tell me about when your diagnosis of X was made' worked well, evoking more narrative accounts that revealed associated emotions and thereby indicated barriers to treatment use. The way the process commenced

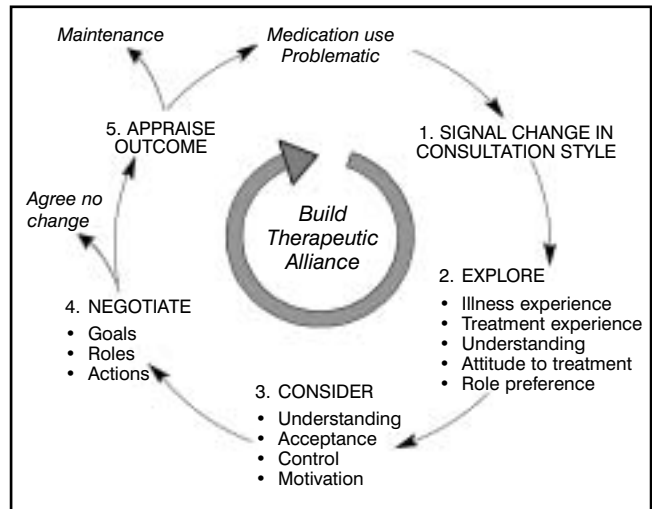


Figure 1. Therapeutic alliance model.

was critical.

The opening discussion rapidly progressed to a diagnostic phase, which established how patients experienced their condition and sought significant underlying issues. The barriers identified that obstructed treatment use were: understanding, acceptance, control, and motivation. These are each described below.

Understanding of illness and treatment. Personal experience, along with those of acquaintances, formed the foundations of patients' beliefs. These could be true (Quote 2) or misleading (Quote 3). Misunderstanding was a particular problem in asymptomatic conditions, such as hypertension (Quote 4) or following an opportunistic diagnosis when the usual explanations may not occur (Quote 5). These were not simple misunderstandings about the medication regime, but frequently concerned how the treatment worked or was evaluated. Consequently, treatment effects were incorrectly assessed (Quote 6). We found that exploring how patients' drugs worked for them was effective at revealing their beliefs about medicines and often led naturally on to candid accounts of actual use (Card 3). Although a description of use that corresponded with the prescription request record was reassuring, it was not necessary for change to occur (Quote 1).

Illness and treatment acceptance. The level of acceptance was reflected in the way that conditions were described, particularly when discussing their initial diagnosis. The language and tone used when giving the story of their illness could indicate major underlying tensions. One sign of acceptance was that medication and illnesses were described using a personal pronoun, such as 'my', implying ownership, rather than 'it', implying distance (Quotes 7 and 8). Acceptance was indicated by appropriate adjustments to the illness, such as comfortably habitual medication use (Quote 9). Reluctance to accept their situation could be reflected by anger or denial, which hindered other lifestyle changes as well as medication use (Quote 10). Appreciable denial blocked effective treatment use; however, patients frequently appeared to be 'bargaining' or expressing some

Table 1. Patient outcomes and opinions.

Case No	Condition	Primary issue	Intervention in consulting time	Clinical outcome at 3/12 post project	Patient perceived outcome
1	Asthma	Understanding	120 minutes 4 consultations	No hospital admissions (reduced exacerbation rate and severity) Appropriate RMRs	Using medication in a better way because of better explanation and time (T)
2	Asthma	Control	100 minutes 4 consultations	Clinical condition unchanged	More interactive relationship with doctor (FG)
3	Patient with schizophrenia and illicit drug user				
4	Epilepsy	Control	30 minutes 1 consultation	No seizures for 18/12 Flexible anti-epileptic medication documented	Control and flexibility with treatment improved (discussed with GP)
5	Hypertension	Understanding	50 minutes 2 consultations	Clinical condition unchanged	Improved understanding of medication mode and frequency (T)
6	Asthma	Control	80 minutes 3 consultations	Asthma control improved with use of beclomethasone in winter only	Improved confidence, more control (discussed with GP)
7	Asthma	Acceptance	70 minutes 3 consultations	Overuse of medication continues	Remains anxious about symptoms but more appropriate medication use. (T)
8	Asthma	Acceptance	20 minutes 1 consultation	No acute exacerbations of asthma Appropriate RMR	Minimal contact because of family commitments Gained information (T)
9	Hypertension	Understanding	40 minutes 2 consultations	Improved BP control Appropriate RMR	Improved understanding owing to style of consultation (FG)
10	Hypertension	Understanding	80 minutes 4 consultations	Improved BP control	Improved self confidence with medication use Perceived improved care (T)
11	Diabetes Raised cholesterol	Acceptance	60 minutes 3 consultations	Testing of medication instrumental in clinical improvement	Sees doctor as a real person Improved communication (T)
12	Patient grossly manipulative, learning disability, diagnosed with Munchausen's syndrome. Intervention discontinued				
13	Hypertension Diabetes Obesity	Acceptance	70 minutes 3 consultations	Improved BP and HbA _{1c} control Open discussion about diet	Enhanced understanding following discussion and explanation but medication use unchanged (T)
14	Diabetes	Understanding	60 minutes 4 consultations	No change in diabetic control Treatment use now openly discussed	Given information about diabetes More self confidence (T)
15	Hypertension	Acceptance	60 minutes 4 consultations	Poor response to antihypertensive treatment	Still suffering with side-effects No improvement (T)
16	Hypertension	Acceptance	70 minutes 3 consultations	Good BP control Attending hospital outpatients	Given information (FG)
17	Hypertension	Acceptance	60 minutes 2 consultations	No improvement in BP control	Open negotiation Improved understanding (FG)
18	Hypertension	Control	70 minutes 3 consultations	Improved BP control Weight loss	Legitimised homeopathic treatment (T)
19	Hypertension IDDM	Understanding	20 minutes 1 consultation	Did not attend further interviews	Patient wished no further contact
20	NIDDM Hypertension Raised cholesterol	Understanding	50 minutes 3 consultations	Attending diabetic clinic Appropriate RMR	Reassuring, highlighted further treatments and Health improved owing to better understanding (T)
21	NIDDM Hypertension	Control	20 minutes 1 consultation	Improved BP control	Feels has more control (T)
22	RA IHD	Control	30 minutes 2 consultations	Remains symptomatic with RA Reluctant with second-line treatment	Beneficial use of time Improved relationship (T)
23	Hypertension NIDDM	Understanding	40 minutes 1 consultation	Improved BP control	Improved understanding of medication and its use (T)
24	Hypertension	Control	30 minutes 1 consultation	Small improvement in BP control Reluctant to increase medication	Improved communication, greater understanding of medication and appreciates medical perspective (T)

RMR = repeat medication request; IDDM = insulin dependent diabetes mellitus; T = telephone contact; NIDDM = non-insulin dependent diabetes mellitus; FG = focus group contact; RA = rheumatoid arthritis; IHD = ischaemic heart disease.

ambivalence.²⁵ Although the focus was on medicine use, accepting the illness appeared to be the main issue (Quote 11). These conversations were often challenging as they dealt with sensitive beliefs that sometimes conflicted with the medical model. However, identifying and exploring these differences seemed to be a fundamental aspect of addressing them and moving the relationship on (Case 17).

Control over illness and treatment. Some patients sought to actively control their own treatment while others seemed content to play a passive role. This appeared distinct from acceptance, being apparently more rational and negotiable during the course of the consultations. This was discussed explicitly using the scales on Cards 4 and 5. Passive patients indicated the far left, 'compliant' ends of these scales, while others tended to indicate a central position, even if still actively adapting advice.

During the consultation process some patients gained confidence, took more control, and assumed greater responsibility (Quotes 12, 13, and 14). For others, however, the desire for control appeared to reduce as the relationship developed and further directive advice was sought (Case 10).

Motivation. Two patients had an adequate understanding of their condition, showed acceptance and chose to be passive about treatment. Such patients should be adherent. (Quote 15) Instead, they were open about their inability to do so and requested specific, directive instructions. These patients, both diabetic, appeared to have particular difficulty maintaining motivation.

Consider relevant issues

This point marked the transition from diagnostic to therapeutic encounter. For some this was barely perceptible, but became difficult on other occasions as the discrepancy between the patient's and the doctor's view became apparent. We termed this the 'discomfort zone'.

We employed pragmatic techniques to help patients' progress, such as tailored patient information, especially about appraising treatment. Denial was highlighted and discussed before a trial of treatment with patient-specific goals was suggested to assess benefit. Recognising the importance of patients' evaluation of therapy, we reinforced many changes using supervised explicit experimentation, where either monitoring or changes in symptoms could demonstrate an effect. This included trial periods without treatment.

Some patients did not wish to use treatment as recommended, which was challenging for us, as we supported their right to decide. To do so we had to be convinced they were fully informed, although there was a danger this could be perceived as pressure to comply (Case 17). When there was such 'discordance,' control was given to patients who sought it after we had discussed the risks and benefits. This did not preclude the clinician from making a recommendation, but we tried to ensure that patients knew the decision lay with them and that we would support their choice (Case 4).

Motivation problems were managed by engendering trust and being directive or, latterly, using Brief Motivational Interviewing.^{25,26}

Agree goals

Before closure, treatment goals, intended use and monitoring had to be agreed. This involved documenting the balance struck during the process above (see card/stamp in Box 1). For some patients it was agreed that there would be no change or treatment would even be discontinued, but that an appraisal of the outcome was planned.

Negotiate role

The final component of the process was a negotiation about future role preference. Some patients wanted responsibility while others explicitly asked us to be directive. The latter concerned us, as it could have reflected an inability to convince patients we were happy to give them control. After reviewing these cases to ensure we had explicitly offered patients control, we considered that seeking a directive style of doctor was another aspect of patient choice (Case 10).

Results

Three months after the active intervention period, the clinician responsible assessed progress according to clinical markers where available, or prescription requests. This indicated that 14 of the 22 patients had evidence of appreciably improved clinical control and/or prescription requests (Table 1).

The analyst discussed the experience of the process with 21 patients. They all reported the process as useful and particularly valued the extra time available for a deeper exploration of their concerns.

Discussion

This paper reports a qualitative study designed to develop a practical approach towards non-adherent treatment use. It provides one step into the complex area of shared decision making implied by concordance.^{18,27,28} Over half of these patients showed signs of managing their conditions better and, as they all had longstanding inappropriate encashment records, any improvements were likely to be the result of the intervention. Although this crude assessment is easily criticised, the aim of the study was to develop, not assess, the techniques and it is encouraging that so many responded. For others, conflict with their doctors was reduced which might itself be a significant benefit. We do not claim to offer a definitive method but would argue that a focused investment of time could be very cost effective if it influences behaviour or improves care in other ways. Although initially our consultations lasted up to 40 minutes, by the end a more feasible initial double consultation of 20 minutes proved workable.

The combination of qualitative study and 'Balint' style clinical meetings has not been reported before, but this proved a fruitful way of generating new techniques. Its strength stemmed from the combination of detailed reflection, the ability to intervene, and then to observe the effect as a group.²⁹ However, further work will be required to refine this approach, demonstrate the extent to which such skills are transferable, and determine the impact of such interventions.

Misunderstandings commonly arise during communica-

tion about drugs.²⁷ Our findings confirm that poor use arises from this but suggest it is especially important for patients and doctors to understand how they are each evaluating the treatment's effects.⁶ The most promising interventions involve combinations of enhanced communication and tailored patient education but it is not clear how these operate.³⁰⁻³² Accepting illness, which requires an adjustment of self-image,³³ necessitates more than information alone³⁴ and may represent the emotional response component of the Self-regulatory Model.³⁻⁵ This study suggests mechanisms by which such interventions could operate through both rational and emotional routes, which fits well with Leventhal's Model. However, we also perceived that an enhanced clinical relationship was a critical aspect of our intervention, hence its central role in Figure 1. Patient-centred consultations increase adherence; our findings suggest that increased trust is one potential mechanism for this, which is not an explicit feature in Leventhal's model.¹⁵

Some patients requested directive instructions, which posed a dilemma. Accepting this could itself be patient centred or may represent a failure to offer patients choice adequately. Studies exploring patients' perceptions of the process are required to investigate this.

We explicitly used planned experimentation to assess the value of treatment. Testing out or discontinuing treatment may be seen as an inappropriate strategy in some circumstances; for example, insulin. However, for those currently using little prescribed treatment, a period of supervised experimentation may be safer than the status quo.³⁵ Evidence-based medicine constricts prescribing, while a concordant approach may licence poor medicine use; ultimately patients' decisions may conflict with established practice leading clinicians to feel vulnerable. We supplied treatment knowingly for sub-optimal use, perhaps implying approval. Consequently, improved record keeping was required. This dilemma has been acknowledged by those supporting guidelines but there is a legal precedent supporting informed patient choice.³⁶⁻³⁸

The limitations of our approach need to be considered. First, we studied a limited variety of conditions and may have failed to identify important issues specific to other drugs or illnesses. Secondly, our sampling strategy recruited just over half of those approached. Those declining may have been more reluctant to enter discussions of this type and require an even more cautious approach in practice. Thirdly, patients initially identified by practitioners tended to have complex problems, such as personality or mental health problems. They often had poor relationships with their doctors and were found to be particularly challenging. Seeking shared decisions with some patients may not be productive.

At present, there is no agreement on how concordance should be assessed, so it is difficult to define success. However, we believe that this type of patient-centred prescribing, focused on patients whose care is sub-optimal, is likely to improve clinical outcomes as well as diffuse the issue of adherence. Consequently this topic merits further exploration.

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