Compliance

THE number of prescriptions issued by general practitioners is still rising and Mapes and Williams (p. 406) today show that this trend far exceeds the rate of rise for the population. The topic of prescribing remains in the forefront of the profession's mind and is the subject of several articles in this issue of the *Journal.*

A closely related and equally important aspect of prescribing is the extent to which patients follow the advice they are given. The somewhat unattractive word 'compliance' indicates a growing point of interest.

The pressures are on. Medication is becoming much more expensive and adverse reactions are now more widely recognized. The danger of undue dependence is being further studied. All the evidence points to general practice developing a much more critical self-awareness about prescribing policies and their consequences.

Compliance can be considered under two broad headings: mechanical factors and relationship factors.

Mechanical factors

Compliance is naturally improved if the medication is provided in a form which is simple and convenient for patients to take. Thus the fewer doses per day, and preferably only a once-a-day dose, helps the patient. The fewer the number of different preparations and the fewer the number of doctors prescribing for each patient all improve compliance, as Graham and Suppree (p. 399) note today; compliance falls as more 'work' is required by the patient.

Some patients dislike capsules, especially large ones, and therefore the presentation of the drug is important, including the colour.

Although only a few patients fail to take their prescriptions to the pharmacist, a much greater number fail to follow advice properly, as Wandless and colleagues (p. 391) confirm today. Furthermore, they offer an interesting technique for predicting problems with compliance.

Relationships and communication

The second principle of compliance is the quality of the communication within the doctor/patient relationship. Although it is obviously common sense, evidence is accumulating to show that if patients have had an opportunity to discuss their treatment, and to air any personal preferences about their medication, they are more likely to take it. The more the patient is involved in decisions about treatment and can accept personal responsibility for management, the less he is merely the passive recipient of a plethora of potions.

Ley and colleagues (1976) in a classic study showed that arranging information in a logical structure and communicating it clearly to patients improved compliance.

Communication about medication can be regarded as yet another aspect of the doctor/patient relationship in general practice, and Charney and colleagues (1967) showed that the taking of penicillin by children was improved when the prescription was issued by the personal doctor rather than a partner.

The prescription symbolically represents the doctor himself and may well be treated the same way. Patients who do not take the tablets often have ambivalent feelings towards the doctor.

Many doctors are trained in hospitals where the nursing staff can be relied upon to ensure that medication is taken. The same is not true in general practice where all adult patients and many children have the chance to decide for themselves if they will comply. Whether they do so or not is becoming of increasing importance as costs rise and the medication becomes more complicated.

Improving compliance is now a vital task for all doctors to tackle, especially general practitioners, who have collective responsibility for the majority of prescribing costs in the National Health Service.

It is no longer enough to ensure that the patient gets the right prescription: the doctor today must think ahead and consider if the patient understands the treatment, agrees with it, and is likely to take it.

Mechanical methods are useful and important, but at the end of the day the key to compliance is likely to be better communication between doctors and patients.

References

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