

Patients' ideas about medicines: a qualitative study in a general practice population

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SUMMARY

Background. Little attention has been paid to patients' ideas about medicines and such ideas might well have relevance for understanding non-adherence to medication.

Aim. This qualitative study set out to describe the ideas about medicines and the self-reported adherence to medication of a general practice population.

Method. Semistructured interviews were conducted with 30 adult patients (attenders and non-attenders) from two general practices.

Results. The main themes emerging from the analysis were: perceived properties of medicines; orientation towards medicines, that is, patients' general preference for taking or not taking medication; and actual usage of medicines. The data revealed that on the one hand much medicine taking was taken for granted and on the other hand that patients had many fears and powerful negative images of medicines.

Conclusion. Any assessment of the appropriateness of a proposed treatment for an individual patient should include an exploration of his or her preferences, orientation towards medicines and social context.

Keywords: patient use of medication; patient health beliefs; patient compliance; patient non-compliance.

Introduction

ALTHOUGH there is an extensive literature on patients' adherence to medication, much less attention has been paid to their ideas about medication. Such ideas might well have relevance for understanding non-adherence to medication. A small number of sociological and anthropological studies have described lay beliefs about medication which are incompatible with the biomedical model.¹⁻⁷ Most of these were concerned with long-term medication for chronic illness and do not necessarily have relevance for more general populations. The research reported in this paper describes the ideas about medicines and self-reported adherence to medication of a general practice population. It is based on two premises: first, that patients have views about medication which may not conform with medical orthodoxy, and secondly, that it is possible to distinguish between favourable and unfavourable views.

Method

The study sample comprised patients from two five-doctor practices in socially contrasting areas — a socially deprived area in

south London and an affluent suburban area in south west London.

The sample consisted of attenders and non-attenders. Recent attenders were identified from the practice appointment sheets in such a way as to ensure variation in doctor seen, day of the week, time of day, and patient's order in the appointment schedule. Exclusions were as follows: anyone under the age of 21 years; those whose notes were missing; those judged to be too ill for interviewing; and members of the same household. Non-attenders were defined as patients who had not attended the practices for at least two years and were identified by the practice managers. It was not intended that the sample be statistically representative, because the purpose of the analysis was to describe the range of responses given.⁸

Letters were sent to all patients identified asking them if they would be prepared to help with some research on patients' ideas about medicines and treatment. It was explained that the discussion would be totally confidential and that they were under no obligation to agree to be interviewed. The letters of introduction were signed by the practice managers or the patient's own doctor. The author then arranged to interview those patients who agreed to take part.

Interviews were conducted in patients' homes in 1991 and were audiotape recorded with patients' permission. Three interviews were carried out in the south London practice premises and three interviews (including one of the practice interviews) were not taped. A semistructured interview schedule was used (Appendix 1), but respondents were encouraged to talk freely. If respondents brought up relevant points spontaneously, the order of the questions was varied to maintain the flow of the interview. The first two themes reported in the results emerged spontaneously and were not derived from specific questions, because although respondents' orientation towards medicines was a key issue direct questioning did not appear to be the best way of obtaining this information.

The tape recorded interviews were transcribed in full and the analysis was based on the typed transcripts. In the case of the untaped interviews, the analysis was based on notes made immediately after the interview. The method of analysis used was charting, which is a technique for selecting and reorganizing the transcript material according to themes.⁹ The themes were identified from several thorough readings of all the transcripts.

Results

A total of 30 patients were interviewed: 11 women and 19 men of all ages from early 20s to late 70s. The majority were white, there being only one middle eastern respondent and two black respondents. Twenty one interviewees were attenders and nine were non-attenders. Twenty one came from the south London practice and nine from the south west London practice.

Three main themes were identified which related to respondents' ideas about medicines and self-reported adherence: properties of medicines; orientation towards medicines; and actual usage.

Properties of medicines

This section is concerned with the properties attributed to medicines and the terms in which they were described. Leaving aside

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obvious characteristics of medicines such as cost and effectiveness, the more generalized properties of medicines can be divided into positive and negative properties. Very positive feelings were elicited in some cases.

'That magic word antibiotic.' (Patient 9)

Those with more cautious attitudes in the present may nonetheless have been more positive in the past.

'In the old days it was penicillin for everything. Penicillin was the golden spoonful that answered everything.' (Patient 14)

Drugs were perceived as being one of the benefits of modern medicine. Some medication was perceived as having a high degree of acceptability by virtue of having been around for a long time.

'Something like penicillin it's sort of reached the status of, like an aspirin, it's something that people accept... it's been around for a long time... it's proven if you like.' (Patient 24)

Negative attributions were also made of medicines. They were perceived as being damaging in various ways. The most extreme statement of this position was that all medicines are carcinogenic.

'I have a belief whether I am right or wrong that all medicines to an extent are carcinogenic. It's like everything else if you take enough of it and overdose over a long period of time you are always prone to perhaps... advancing the nature of things like cancer.' (Patient 7)

Other statements were made to the effect that medicines were not good for the body and that they were harmful. They were described as unnatural, both in the sense that they were not naturally grown and in the sense that they are not natural to the body.

'I just don't like artificial things... [natural remedies] are not chemically made, like flowers are naturally grown things. I prefer to take those than factory made chemicals.' (Patient 2)

'Medication as an alien force.' (Patient 7)

Various mechanisms were described by which medicines manifested this damage. They were described as lowering the body's resistance to infection and disease. Drugs might reduce the body's ability to combat infection naturally by preventing the body's own immune system from working or they might actually damage the body's immune system.

'My belief is that antibiotics do stop... your own antibodies, the immune system performing... I think antibiotics do actually harm the body in some way.' (Patient 5)

Another aspect was that medicines were seen as dealing with the symptom and not the cause, leading to partial treatment. Medicines were perceived as offering uniform treatment for all problems, in other words not being tailored to the needs of the individual.

Drugs were also seen as dangerous, addictive, and as a temptation for oneself or others if left lying around, particularly if there were children in the house. Lastly, in some cases it was felt that the treatment could be worse than the disease as in the case of chemotherapy and cancer.

Orientation towards medicines

This section is concerned with respondents' orientations towards medicines, that is, their general preferences for taking or not taking them. Once again it is possible to distinguish positive and negative orientations. Starting with the former, explicit or implicit acceptance of medication was evident in several accounts, but this was not commented on at any length. For some people the taking of medication appeared to be an activity that was taken for granted and did not need to be explained.

'At 16 I had implicit trust in medication, and I was in hospital and everybody else was taking it, I didn't have any thoughts about it.' (Patient 25)

Turning to negative orientations, a strong theme emerged about people preferring not to take medication if this was possible. Some people said that they would not take medication if they could avoid it or if it was not really necessary.

'I think why take something if you don't necessarily need it... I'm not frightened of taking them at all but if I don't need them I won't use them.' (Patient 13)

Some people were more specific, saying that they particularly avoided strong drugs. Timing was another factor, with some not wanting to take medication at the first symptom of pain and others regarding medication as a last resort. A variety of negative statements were made ranging from one man who said he had 'never been fond of medicine', through suspicion and distrust, to a man with diabetes who said he hated medicines. Past experience of side effects could create aversion. For some, the orientation towards medicines seemed a large part of their lives.

'The fight that I have to live without medicine.' (Patient 7)

Fears were expressed about long term use of medication, addiction and the possibility of being stuck with drugs for the rest of one's life. Antipathy towards medication was also translated into a preference for less rather than more medication or for 'low level' medication. Evidence of shame associated with some drug taking was apparent.

'So I am creeping about trying to find a chemist where they won't recognize me.' (Patient 6)

A theme emerged about why taking medication was not necessarily the best course of action. According to this view, medication should not be necessary if people could sort their problems out themselves. Sometimes this view implied a degree of stoicism.

'I said I didn't want to go onto HRT... I'm not suffering as badly as I've seen others... I haven't dismissed it completely it's just... I might get through without it.' (Patient 9)

To summarize this section, the data showed that it was possible to distinguish positive and negative orientations. Some people were consistently positive or negative while others had mixed views depending on the situation.

Appropriate and actual use of medicines

This section analyses the accounts people gave of medication they had actually taken or were currently taking, and links this self-reported adherence to the orientations described in the previous section.

Respondents were asked whether they took their medication as prescribed or whether they evolved their own way of taking it. Those people who said that they normally did take medication according to instructions tended to be those with positive orientations. There were various contexts in which these answers were placed. Some people referred to following instructions or taking medication at the right time. Sometimes a value judgement was made and the effort to take a medication at the right time would only be made if it was very important. Others put their adherence in terms of doing what the doctor told them. Some of those with negative orientations said that if they went for help they would certainly take what was prescribed.

'If the doctor gives me 60 tablets I take 60 tablets... if you don't take those tablets you waste her time, the money, and you may not feel better at the end of it.' (Patient 16)

Stronger statements were made to the effect that whatever the doctor prescribed respondents took, or that they took their medication because they had faith in the doctor.

Those with negative orientations or mixed views tended to say that they did not always take their medication as prescribed. Sometimes this was simply because they forgot, especially if the medication had to be taken at regular intervals throughout the day. Sometimes non-adherence related to the symptoms, so that if the symptoms were not very troublesome the person might not bother to take the medication. Others adopted an 'as and when' policy, taking medication when needed or leaving off if no symptoms were experienced.

'If I find I'm not getting it [hay fever] very much then... I will personally stop taking them, whether I'm supposed to be doing that or not, maybe I'm supposed to continually take them to keep them working, I suppose I probably am, but I try to take them as and when needed.' (Patient 13)

Several people had stopped taking medication because they experienced side effects.

When asked if they had devised their own method of taking medication some people said they had. This might be to do with making up their own mind about how the medication was working and adjusting the dose accordingly or it might be put in terms of overriding the doctor's instructions. Alternatively the view was put that one could not decide the dosage for oneself as one did not know enough about it, except in the case of aspirin where it was not thought possible to do much damage.

Those who were averse to medicine taking discussed the conditions under which it would be taken. Some medication taking was regarded as conditional on the symptomatology. This might be in response to certain well recognized familiar symptoms which always needed medication such as recurring sinusitis or hay fever. Pain was another trigger for taking medication particularly for those who were otherwise opposed to medication taking in general. The severity of the problem was also linked to the propensity to seek medication for the latter group of people.

'If I had an open wound that had got gangrenous or a large amount of local infection then I think I would have to resort to [antibiotics].' (Patient 5)

In some accounts the balancing of risks and benefits associated with medication taking was made explicit. Benefits such as relief from stress or the ability to carry on working were balanced against the possibility of addiction or having an operation.

The issue of interference with the performance of social roles also entered people's decision making about medicines. Some people only took medication for symptoms that interfered with their performance at work.

'Last Wednesday I took an antihistamine for the first time in many years... I had an important presentation to make.' (Patient 11)

Other social roles were cited such as sports or leisure pursuits.

To summarize the relationship between orientation and self-reported adherence, the results showed that those with negative orientations or mixed views gave examples of non-adherence. For those who said that they were always adherent, this was because the decision to consult was also a decision to take medication. Those with positive views tended to say that they always took the medication as prescribed.

Discussion

The data presented in this paper describe the views of a general practice population about medication for both acute and chronic conditions. The analysis has not been organized according to the type of drug because sufficiently detailed information about drug type was not collected.

In all three sections reported, more detail was given about the negative than the positive aspects. Although it is possible that this reflects bias in the interviewing, most of the questions were factual and the attitudinal questions were carefully asked in a balanced way so as not to lead the respondent in one direction. It is also the case that a number of respondents made very positive remarks about their medication. It seems that a likely explanation is that the beneficial attributes of medication were taken for granted. Those people who were positive about their medication and who were taking it as prescribed (very often for a chronic condition) found this unproblematic and did not comment on it at any length. Those for whom the taking of medication involved an internal struggle or at least a decision making process were perhaps more likely to comment on it.

Since this is a qualitative study, it is not possible to explore statistical relationships between orientation to medicines and self-reported adherence, or between patients' views and their demographic characteristics. These are issues for further research. However, the findings of this research do have clear implications for patient management. It is well established that many people do not take their medication as prescribed,¹⁰ although few studies have explored patients' own ideas about medicines.¹⁻⁷ This study reveals a number of reasons for non-adherent behaviour. Some interviewees preferred not to take medication if they could possibly avoid it, supporting Fallsberg's findings.⁵ Adherence was sometimes a function of the doctor-patient relationship but in other cases was conditional on the severity of symptoms or the patient's assessment of risks and benefits. The data revealed powerful negative images of medicines which may differ from many general practitioners' assumptions. Cartwright and Anderson suggested that doctors may be more aware of the pressure to prescribe than the opposite,¹¹ a finding supported by Virji and Britten.¹²

The implication of the present study for the individual general practitioner is the identification of a number of areas which could be usefully explored before writing a prescription. First, it should not be assumed that medicines are an acceptable form of treatment in every situation. If appropriate, the patient could be asked what kind of treatment they would prefer. Secondly, it is worth establishing the patient's general orientation towards medicines,

that is, whether medicine taking is unproblematic or whether they have fears about it. If there are fears, the doctor should encourage the patient to express them, and then sympathetically discuss the implications for adherence. Finally, the doctor can enquire about the social context to establish if work or leisure commitments are going to affect adherence. An exploration of these issues is likely to help the general practitioner assess the appropriateness of the proposed treatment for the individual concerned.

Appendix 1. Questions asked in the interview.

What do you normally do when you have: a headache; a temperature; flu?
 Are you taking any medicines at the moment?
 What medicines have you had in the past?
 Have you ever taken antibiotics?
 Have you ever had to take a medicine over a long period of time? How do you feel about that?
 What medicines do you buy at the chemists? Which ones? When do you use them?
 What medicines do you have in your cupboard at home?
 When you go to the doctor, do you like to have a prescription or are you looking for something else? Have you had a prescription recently?
 Do you always collect prescriptions as soon as you get them or do you sometimes wait? Do you always take them according to instructions or do you find your own way of taking them?
 Do you think that doctors prescribe too much, too little or about right?
 Does your doctor know what you think about your medicines?
 Have you ever experienced any side effects with medicines?
 Are you given enough information about your medicines or would you like more information?
 What would you think if the doctor asked you about your lifestyle or your personal life?
 Would you ask the doctor to help you if you were feeling depressed or if you had problems at home or at work?
 Have you ever gone to an alternative practitioner?

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