

PATIENT-CENTERED CARE

# Patient-Centered Prescribing

seeking concordance  
in practice

Jon Dowell, Brian Williams and David Snadden

# **Patient-Centered Prescribing**

## **Seeking concordance in practice**

**Jon Dowell** BMed Sci, BM, BS, MRCGP, MD  
*Senior Clinical Lecturer in General Practice*  
*University of Dundee*

**Brian Williams** BSc, PhD  
*Senior Lecturer in Behavioural Science*  
*University of Dundee*

**David Snadden** MBChB, MCISc, MD, FRCGP, FRCP (Edin)  
*Vice Provost Medicine*  
*University of Northern British Columbia*  
*Associate Dean, Northern Medical Program*  
*University of British Columbia*



**CRC Press**

Taylor & Francis Group  
Boca Raton London New York

---

CRC Press is an imprint of the  
Taylor & Francis Group, an **informa** business

First published 2007 by Radcliffe Publishing

Published 2016 by CRC Press  
Taylor & Francis Group  
6000 Broken Sound Parkway NW, Suite 300  
Boca Raton, FL 33487-2742

© 2007 Jon Dowell, Brian Williams and David Snadden  
CRC Press is an imprint of Taylor & Francis Group, an Informa business

No claim to original U.S. Government works

ISBN-13: 978-1-85775-835-1 (pbk)

Jon Dowell, Brian Williams and David Snadden have asserted their right under the Copyright, Designs and Patents Act 1998 to be identified as the authors of this work.

This book contains information obtained from authentic and highly regarded sources. While all reasonable efforts have been made to publish reliable data and information, neither the author[s] nor the publisher can accept any legal responsibility or liability for any errors or omissions that may be made. The publishers wish to make clear that any views or opinions expressed in this book by individual editors, authors or contributors are personal to them and do not necessarily reflect the views/opinions of the publishers. The information or guidance contained in this book is intended for use by medical, scientific or health-care professionals and is provided strictly as a supplement to the medical or other professional's own judgement, their knowledge of the patient's medical history, relevant manufacturer's instructions and the appropriate best practice guidelines. Because of the rapid advances in medical science, any information or advice on dosages, procedures or diagnoses should be independently verified. The reader is strongly urged to consult the relevant national drug formulary and the drug companies' and device or material manufacturers' printed instructions, and their websites, before administering or utilizing any of the drugs, devices or materials mentioned in this book. This book does not indicate whether a particular treatment is appropriate or suitable for a particular individual. Ultimately it is the sole responsibility of the medical professional to make his or her own professional judgements, so as to advise and treat patients appropriately. The authors and publishers have also attempted to trace the copyright holders of all material reproduced in this publication and apologize to copyright holders if permission to publish in this form has not been obtained. If any copyright material has not been acknowledged please write and let us know so we may rectify in any future reprint.

Except as permitted under U.S. Copyright Law, no part of this book may be reprinted, reproduced, transmitted, or utilized in any form by any electronic, mechanical, or other means, now known or hereafter invented, including photocopying, microfilming, and recording, or in any information storage or retrieval system, without written permission from the publishers.

**Trademark Notice:** Product or corporate names may be trademarks or registered trademarks, and are used only for identification and explanation without intent to infringe.

Visit the Taylor & Francis Web site at  
<http://www.taylorandfrancis.com>

and the CRC Press Web site at  
<http://www.crcpress.com>

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library.

Typeset by Advance Typesetting Ltd, Oxford

# Contents

Series editors' introduction	iv
About the authors	vi
Acknowledgements	viii
1 Introduction <i>Jon Dowell</i>	1
<b>Section 1: Understanding the issues</b>	7
2 Taking medicines <i>David Snadden</i>	9
Part 1: The burden of the problem	9
Part 2: The medical perspective	18
3 Understanding medicine taking in context <i>Nicky Britten</i>	29
4 Understanding medicine taking: models and explanations <i>Brian Williams</i>	44
<b>Section 2: The patient-centered prescribing process</b>	63
5 Decision making and the patient's voice: the therapeutic decision model <i>Brian Williams and Jon Dowell</i>	65
6 Finding common ground <i>Jon Dowell</i>	80
7 Finding common ground in 'special' situations <i>Jon Dowell</i>	93
Part 1: The therapeutic alliance model	94
Part 2: Vignettes of negotiation	110
8 Unresolved issues in patient-centered prescribing <i>Jon Dowell</i>	121
Part 1: Individual issues	122
Part 2: Professional issues	130
Part 3: Societal issues	133
9 Summary <i>Jon Dowell</i>	137
References	142
Index	155

# Series editors' introduction

The strength of medicine in curing many infectious diseases and some of the chronic diseases has also led to a key weakness. Some believe that medicine has abdicated its caring role and that, in doing so, it has not only alienated the public to some extent, but also failed to uphold its promise to 'do no harm.' One hears many stories of patients who have been technically cured but still feel ill, or who feel ill but for whom no satisfactory diagnosis is possible. In focusing so much attention on the nature of the disease, medicine has neglected the person who suffers the disease. Redressing this twentieth-century phenomenon required a new definition of medicine's role for the twenty-first century. A new clinical method, which was developed during the 1980s and 1990s, has attempted to correct the flaw and to regain the balance between curing and caring. It is called the *patient-centered clinical method* and has been described and illustrated in *Patient-Centered Medicine: Transforming the Clinical Method*, by Stewart *et al.* (2003). In the latter book, conceptual, educational and research issues were elucidated in detail. The patient-centered conceptual framework from that book is used as the structure for each book in the Series introduced here. It consists of six interactive components to be considered in every patient–practitioner interaction.

The first component is to assess the two modes of ill health, namely disease and illness. In addition to assessing the disease process, the clinician explores the patient's illness experience. Specifically, the practitioner considers how the patient feels about being ill, what the patient's ideas are about the illness, what impact the illness is having on the patient's functioning, and what they expect from the clinician.

The second component is an integration of the concepts of disease and illness with an understanding of the whole person. This includes an awareness of the patient's position in the life cycle and the proximal and distal contexts in which they live.

The third component of the method is the mutual task of finding common ground between the patient and the practitioner. This consists of three key areas, namely mutually defining the problem, mutually defining the goals of management/treatment, and mutually exploring the roles to be assumed by the patient and the practitioner.

The fourth component involves using each visit as an opportunity for prevention and health promotion. The fifth component takes into consideration that each encounter with the patient should be used to develop the helping relationship. The trust and respect that evolve in the relationship will have an impact on other components of the method. The sixth component requires that, throughout the process, the practitioner is realistic in terms of time, availability of resources and the role of collaborative teamwork in patient care.

However, there is a gap between the description of the clinical method and its application in practice. The series of books introduced here attempts to bridge that gap. Written by international leaders in their field, the series provides clinical explications of the patient-centered clinical method. Each volume deals with a common and challenging problem faced by practitioners and serves to reinforce and illustrate the patient-centered clinical method.

The book series is international, to date representing Norway, Canada, New Zealand, the USA, England and Scotland. This is a testament to the universality of the values and

concepts inherent in the patient-centered clinical method. We feel that an international definition of patient-centered practice is being established and is represented in this book series.

The vigor of any clinical method is proven in the extent to which it is applicable in the clinical setting. It is anticipated that this series will inform further development of the clinical method and move thinking forward in this important aspect of medicine.

**Moira Stewart PhD**

**Judith Belle Brown PhD**

**Thomas R Freeman MD, CCFP**

**March 2007**

## **Reference**

Stewart M, Brown JB, Weston WW *et al.* (2003) *Patient-Centered Medicine: transforming the clinical method* (2e). Radcliffe Medical Press, Oxford.

# About the authors

**Jon Dowell BMed Sci, BM, BS, MRCGP, MD** is a graduate of the University of Nottingham. He trained in family medicine in Tayside, Scotland, and subsequently joined the academic unit in Dundee. Practicing as a part-time family doctor in Forfar, a small rural town in northern Tayside, he is also a Senior Lecturer in General Practice in the Community Health Sciences Division of Dundee Medical School. Although his prime responsibilities and interests are in education, his early academic career focused on researching the prescribing process and medication use in the primary care setting. It is this primarily qualitative research that has provided the foundation for this book. This work has been published, presented internationally and contributed to the Royal Pharmaceutical Society of Great Britain's 'Compliance to Concordance' initiative ([www.concordance.org](http://www.concordance.org)). His combined interest in education and the consultation has led to extended postgraduate courses for family doctors, specialists and practice-based clinical pharmacists.

**Brian Williams BSc, PhD** is a graduate of the University of Surrey. His first degree was in economics and sociology, with an emphasis on medicine and healthcare. He was employed for seven years as a researcher within the National Health Service in North Wales, conducting research into patients' experiences of both their illness and service provision. In 1998 he took up the position of Health Services Research Coordinator for Tayside, before being promoted to the position of Senior Lecturer in Behavioural Science within the Department of Epidemiology and Public Health. He has an international reputation in the field of patient satisfaction and patients' evaluations of services, but in more recent years has concentrated on the experience of illness and how these beliefs and experiences relate to behaviors such as adherence. His recent research has examined adherence in the context of schizophrenia, depression, exercise, cystic fibrosis, childhood asthma and the potential benefits of fixed drug combinations (FDCs). He is now the Associate Director of the Social Dimensions of Health Institute ([www.sdhi.ac.uk](http://www.sdhi.ac.uk)), and is part of an alliance of researchers developing a programme of work around 'self-care' ([www.ascr.ac.uk](http://www.ascr.ac.uk)). He is also responsible for behavioral science and health promotion teaching within the Dundee Medical School curriculum.

**David Snadden MBChB, MCISc, MD, FRCGP, FRCP (Edin)** is a graduate of the University of Dundee. He trained in family medicine in Inverness, Scotland, and practiced as a rural family physician for 10 years in the north of Scotland before taking a Masters Degree in Family Medicine at the University of Western Ontario, Canada. He returned to Scotland to academic practice at the University of Dundee, where he was Senior Lecturer in General Practice and Director of Postgraduate General Practice Education at Tayside Centre for General Practice before becoming acting postgraduate dean. His primary interests are in medical education and family medicine, and his main research activities, including his doctoral thesis, have used qualitative methods to investigate reflective learning mechanisms. He has also researched patient experiences with chronic illness and collaborated with Jon Dowell in the research projects that provided much of the material for this book. He is currently Professor in the Northern Medical Program at the University of Northern British Columbia (UNBC), and affiliate Professor

in the Department of Family Practice at the University of British Columbia (UBC) in Canada. He is also Associate Vice President of Medicine at UNBC and Associate Dean of the Northern Medical Program UBC, where his responsibilities are to establish the Northern Medical Program as part of UBC's distribution of medical undergraduate education throughout British Columbia.

## Chapter contributor

**Nicky Britten MSc, PhD, FRCGP (Hon)** is a graduate of the University of Oxford, where she studied mathematics. She then obtained a Master's degree in management science and later a PhD in sociology, both at the University of London. She spent 10 years working on two of the British birth cohort studies before joining the Department of General Practice at what used to be the United Medical and Dental Schools of Guy's and St Thomas' hospitals as a lecturer. She ran their MSc in general practice for many years before joining the newly opened Peninsula Medical School as a professor in 2003. Her research interests include medicines use, patient professional communication, complementary and alternative medicine, and the synthesis of qualitative research. She was a member of the Royal Pharmaceutical Society of Great Britain's working party which produced the document *From Compliance to Concordance: Achieving Shared Goals in Medicine Taking*. At the Peninsula Medical School she is leading a new MSc in integrated healthcare, which offers a framework for studying the potential for the integration of conventional and complementary approaches to healthcare.



# Acknowledgements

We thank the Community Health Sciences Division (formerly Tayside Centre for General Practice) at the University of Dundee for providing a supportive environment in which to conduct this research and write this book. In particular we express our thanks to Professor John Bain and Professor Frank Sullivan for their consistent encouragement.

We are of course indebted to the research participants, both patients and physicians, who so generously shared their stories and experiences with us and without whom academic progress in this domain would be impossible.

We would like to thank the series editors for their contributions and challenges, and especially Jana Bajcar for her detailed and helpful suggestions and Andrea Burt for her coordination and attention to detail. Thanks are also due to Professor Pamela R Ferguson, Department of Law, University of Dundee, for advice regarding legal precedent in the UK.

The funding bodies that have supported both the individuals and the studies which have contributed to this work are acknowledged, but we should point out that the ideas and suggestions presented in this book are those of the authors and series editors alone, and no other endorsement is intended or should be inferred.

As everyone who has been through the process of writing a book knows, heartfelt thanks are surely due to those nearest and dearest who have to share the experience, and provide the time and support required by it.

# Introduction

*Jon Dowell*

The original Greek term for drug – ‘Pharmakon’ – has three meanings; remedy, poison, and magical charm.

(Montagne, 1988)

This book is about medication use and the prescribing process in the western context. Increasingly, patients want to participate in decisions about their care, and we consider how the ‘patient-centered’ approach can help this process. In particular, we focus on the difficulties that suboptimal medication use can create and how this issue (often labelled as *non-compliance* or *non-adherence*) can be approached within consultations using techniques based on this philosophy. This problem has vexed clinicians for generations, but the increasing trend towards partnership between patients and clinicians is shifting thinking and offering new approaches. In the UK, the term *concordance* has been coined to exemplify this shift but, to us, this simply represents the maturation of the principles and practice of truly patient-centered care into the therapeutic element of the consultation. Increasingly, it is not seen as sufficient for clinicians to explore patients’ perspectives in terms of feelings, ideas, function and expectations and then to direct them as to how to respond – for instance, what medication to take. Sharing decisions about treatment has always been present in the patient-centered clinical method, but the emergence of a literature on how this might be achieved reflects the increasing emphasis placed upon it (Brown *et al.*, 1989). We argue here that there is enormous potential value in understanding this process and building the skills to implement it for two reasons. First, there is ample evidence that medicines are used suboptimally throughout the world, and any means of improving this is worth exploring. Secondly, *non-compliance* commonly undermines the clinical relationship, sometimes including deliberate deceit and making rational advice or decisions impossible. Avoiding or overcoming this trap must be a worthwhile objective.

Just as gathering the biomedical details of a clinical history is based upon an understanding of the potential pathologies involved, it is also valuable to appreciate how patients’ beliefs, values and other influences can influence their eventual use of a treatment. In the same way that ideas or fears about a symptom can assist or prevent patients accepting a diagnosis, ideas or fears about medicines will affect their willingness to accept them. Appreciating the range and origins of different beliefs about medicines will enable clinicians to identify symptoms of problems and explore these further, just as they would for physical problems. This book is designed to provide an understanding of the types of problems that underlie ineffective medication use and some tools for opening up this topic with patients. This is not always easy, especially when deceit is involved, and this area is covered in some depth in Chapter 7.

Conceptually it might be helpful at this point to introduce the notion of a spectrum of prescribing. Clearly there are times when patient involvement is not possible, helpful or appropriate to seek, emergency care being the prime example. However, even here patient autonomy is acknowledged through advance directives precluding blood transfusion for Jehovah’s Witnesses, for instance. At the other end of the spectrum are choices where the clinical evidence does not allow clear guidance or there may be genuine clinical ‘equipoise’ (Elwyn *et al.*, 2000). An example of this might be the short-term use of hormone replacement for menopausal symptoms. Within this spectrum there is scope for increasingly empowering patients by involving them in decisions as they wish (Howie *et al.*, 1997). There is also scope for the preferred style of the patient and the clinician to match or clash. Depending on the nature of the decision and the preferences of the individuals concerned, it might be more or less easy and, indeed, comfortable to achieve agreement. However, outside the hospital setting, patients obviously control their medication use and have the final say, so it beholds clinicians to gain their support. The question is how and what to do if they can’t.

A prescribing spectrum

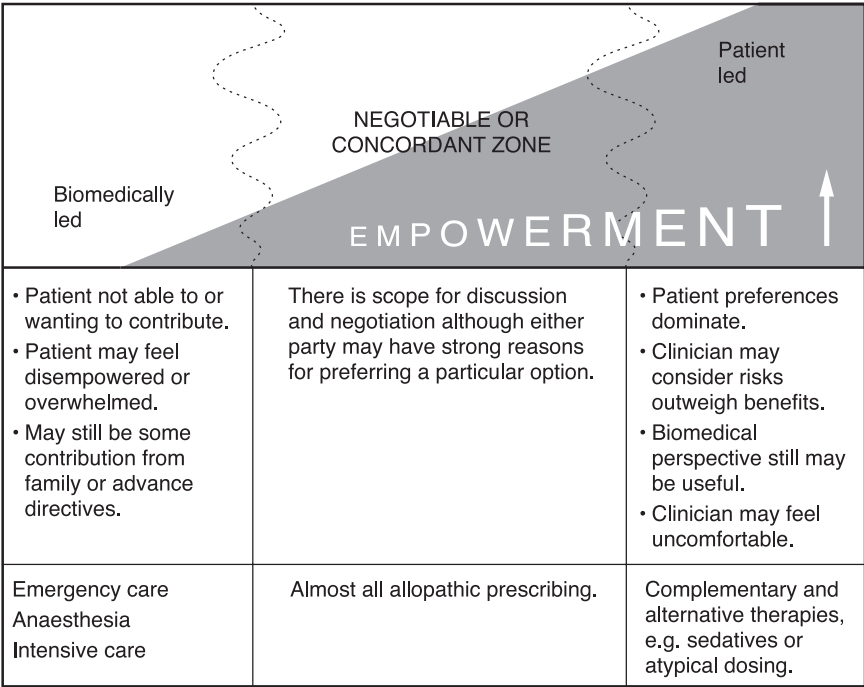


Figure 1.1 A prescribing spectrum.

Prescribing in a patient-centered way is therefore an approach designed to foster mutual understanding and collaboration. It does not imply that all patients should receive whatever they want. Clinicians have responsibilities to wider society as well as professional and institutional rules within which they must operate. How these factors can be managed when they conflict with patient-centered care is described in Chapter 7.

As most prescribing occurs in the primary healthcare setting, we make no apologies for the fact that much of our evidence and supporting case studies originates from family practice. To date this principally reflects interactions between doctors and patients, but nurses and pharmacists in both hospital and family practice are playing an increasing role in the prescribing process. Consequently, this book is aimed at all professionals involved in the process of helping patients to consider and use pharmaceutical products. We use the generic term 'clinician' throughout to include anyone playing this role in a pharmacy, family practice or hospital setting, and in Chapter 6 we discuss how different professionals can help patients to participate in the process even if they themselves do not prescribe.

The book is structured in two sections. The first section (Chapters 2, 3 and 4) considers what the literature tells us about medication use from the perspectives of the clinician, the patient and behavioral sciences, respectively. This more academic perspective is illustrated with numerous patients' stories and quotes, especially in Chapter 4, and is designed to provide the understanding required to interpret what patients are likely to say. The second section (Chapter 5 onwards) is a more practically orientated 'how to' guide, and for hasty clinicians who wish to skip the background material we would recommend Chapter 5 as the start of the more applied techniques for exploring individual patients' medication use and intervening in a patient-centered manner.

Chapter 2 commences by discussing the volume of medicines prescribed and some of the problems that appear to result from patients' responses, before exploring these issues from the medical perspective. We then move on to consider how medicines fit into patients' lives more broadly, how their views affect their decisions about medicines, and what this implies for the prescribing process. In Chapter 4, using research material from our own projects and from the available literature, we shall explore how various psychosocial models might help to explain medicine-taking behaviors and the implication of this for practice.

The second section of the book is aimed specifically at those with responsibility for prescribing. We present a potentially more manageable single model of the relevant factors developed through research based on both patients' experiences of receiving medicines and doctors' experiences of prescribing in a number of settings. By presenting patients' stories we hope to help clinicians to see how they can access patients' thinking about both illness and treatment. This is extended in Chapter 6 by considering how to develop more patient-centered approaches to the process of prescribing, under what we might term 'normal' conditions of clinical practice. It also considers how other professionals can assist or disrupt this process. Chapter 7 introduces techniques that have been devised from patient-centered principles to use when *non-compliance* is thought to be likely. Again, examples are given to illustrate the process. Chapter 8 presents some of the unresolved issues and highlights the difficult issues that can arise – for instance, when patient choice clashes with evidence-based approaches. The final chapter contains a synopsis of patient-centered prescribing, discusses some areas that merit further research and presents ideas about how you may seek to develop these skills if you wish to.

By the end of this book we hope that you, the reader, will have a good understanding of the current issues with regard to the prescribing process and medicine-taking behaviors. You should also be in a position to experiment with new approaches to prescribing medicines, based on a richer understanding of patients' thoughts, feelings and behaviors. You might do this in the hope of at least diffusing potentially difficult

clinical relationships and sometimes significantly improving suboptimal patient care. And here, immediately, we strike upon one of the key issues for this whole concept. Is the goal always to improve what clinicians see as suboptimal care? Surely this is true when it accords with the patient's priorities, but what if it might not do so? Even assuming that we have overcome the difficulties of sharing information and can be confident that a decision is truly *informed*, when do a patient's values override clinical practice or protocols? Throughout this text, as we weave a course between patient autonomy and clinicians' responsibility, this line becomes as blurred as it is in practice. But, as authors, our stance is clear – it is the clinician's role to advise to the best of their abilities but not to dictate what patients should do unless they are explicitly invited to do so.

## Definitions

The language surrounding medication use is often a sensitive matter, and it can obscure the issues if not handled consistently. It might therefore be helpful to clarify the way we have sought to address this problem and to indicate how we have chosen to use selected words. Although many readers will be very conscious of a preference for the term *adherence* over recent years, we have elected to use *compliance* throughout the text precisely because it highlights the paternalistic nature of the underlying assumptions that this concept reflects. This is not because we support the term, but rather because we want to highlight the incongruence of the concept unambiguously. Adhering to advice, even voluntarily, does not seem to be sufficiently distinct from complying with an instruction. Neither requires the patient to participate in or share the decisions that are made.

In order to provide a more considered approach, we clarify here how we are using these terms.

### Compliance/adherence

This is the extent to which medication use follows the prescriber's instruction. This may be ideal, over or under that recommended, or vary in other ways such as timing, frequency of dosage or route of administration.

### Compliant/adherent

This term describes a pattern of medication use that matches the prescriber's instruction. The extent to which use and instruction correspond may vary, but the acceptable level is determined by the clinician.

### Concordance/patient-centered prescribing

Here there is agreement between the patient and the prescriber that a treatment is an effective way of achieving the patient's goals. It is characterized by an exchange of views designed to mutually inform each other, and a process of establishing a sufficiently shared decision. Agreement may be easy, may require negotiation or may possibly be agreement to differ, in which case the beliefs and wishes of the patient take priority. Discordance is not a judgemental term, as it does not favour either view. Hence non-concordance is a misnomer and is not in any way a synonym for *non-compliance*.

**Discrepant medication use**

This term is suggested to describe patterns of medication use that do not match those intended by the patient – for instance, due to low motivation or perhaps memory problems.

**Medication use/actual use**

This refers to the actual way in which a prescribed medicine is used, in terms of frequency, timing, route and dosage employed, irrespective of instructions or intentions.

**Non-compliance/non-adherence**

This occurs when any parameter of medication use varies from that advised or instructed. Research studies often use a cut-off value of 20% or more variance to define this (Morris and Schulz, 1992). This is independent of clinical outcome and may be categorized by the following:

- parameter – dose, frequency, timing, route
- extent – amount above or below recommended dose
- impact – dangerous vs. trivial
- intent – intentional vs. accidental
- disclosure – open vs. concealed.

**Non-encashment**

This occurs when a prescription is issued but not collected from a pharmacist. In such circumstances the medication cannot have been taken and may offer one way of estimating medication use.

**Therapeutic coverage**

This refers to the range of medication use which might be expected, from the pharmacokinetic viewpoint, to produce the desired effect with minimal risk (Meredith and Elliott, 1994).



# Taylor & Francis

Taylor & Francis Group

<http://taylorandfrancis.com>

# Understanding the issues





# Taylor & Francis

Taylor & Francis Group

<http://taylorandfrancis.com>