Compliance, adherence, concordance – what's in a NAME?

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In the UK, about £100M each year, enough to build a sizeable hospital, is wasted on medication prescribed, dispensed but returned to pharmacies. And this figure, though large, does not include any unused medication disposed of in other ways. Reducing this waste makes sense but how can we achieve it? As anyone who has tried to complete a course of antibiotics knows, it isn't easy to take medication consistently, particularly if you aren't feeling ill anymore and especially if adverse effects are troublesome. The factors influencing consumer behaviour include the balance between perceived benefit and risk, age (the older the more compliant), and the complexity of the prescribing regime. Some diseases, asthma for example, seem to be associated with particularly high rates of non-compliance.

We do however, need to consider another potential problem, namely how well we can identify and work with patient beliefs and cover the agendas of our patients as well as our own. All these issues are well described in a review of the subject produced by the Medicines Partnership (Carter *et al.* 2003). The Cochrane review group set up to study the problem concluded rather pessimistically that 'current methods of improving medication adherence for chronic health problems are mostly complex, labour intensive and not predictably effective' (Haynes *et al.* 2002).

When this editorial was commissioned, I was asked by the Editor – with his tongue slightly in his cheek – for an article on 'how doctors can get patients to do what we want'. And that of

course is just what the terms 'compliance' and its slightly more politically correct equivalent, 'adherence' imply. The doctor advises a particular therapy or course of action; the patient acts on the recommendation, complies in fact or, if you prefer, adheres to the management plan laid down by the doctor. For some people this is precisely what they expect when they visit their doctor, and for them it seems to work well. The likelihood of this model of behaviour being acceptable certainly varies between countries – it is more acceptable in the UK than Germany and the US, for example.

Doctors probably vary too in their ability to influence compliance, although perhaps less than we think. An interactive session at a recent meeting of the Association of British Neurologists showed that neurologists were reasonably accurate in estimating overall non-compliance rates in epilepsy treatment (30–50%), but at least some of them thought that they themselves achieved better compliance rates. They were almost certainly wrong in that assumption.

For those individual patients who want to take a more active part in decision making, simply having a course of action laid down is likely to be counter-productive. An outright refusal to comply is infrequent but verbal and particularly non-verbal cues will usually indicate that a different approach by the doctor is required. This is where the newer term 'concordance' comes in. For the purposes of their literature search, the Cochrane review group (Haynes 2002) equated the three terms but whereas compliance and adherence are similar, refer to an individual (the patient) and imply a degree of passivity and obedience, a *person* cannot display concordance; rather this term refers to the process of discussion between doctor and patient, and demands active participation by both in reaching an agreement about a management plan (Weiss & Britten 2003).

What then to do when there is no agreement, when the doctor is clear that a particular course of action, pursued by a determined patient, is inadvisable? In practice, this will be a rare event but whilst we should make our opinions clear, in writing if necessary, we must accept the fact that people will not necessarily do what we think is correct. Better by far to have the issue out in the open, for otherwise the next time you meet, your patient will have the uncomfortable choice of telling you that they haven't followed your advice, difficult even for the confident, or alter-

"That's odd Wayne - you never miss your medication but it's not detected in your blood..."

natively lying to you, and thus sowing the seeds of an on-going deception.

Concordance therefore is a formal recognition of the fact that at the end of the day the individual patient will do what he or she wants. Our task is to adapt our consultation according to the needs of the individual patient. At one extreme this may be a discussion of available information for the confident and well-informed and, at the other, a didactic 'prescribing' approach for those who do genuinely want simple advice. An increasing proportion occupy the middle ground of wanting and benefiting from a partnership with their doctor. It all takes a bit longer than simply advising or prescribing (health service managers please note) but the small extra costs here may help reduce some of those wasted prescriptions. And anyway, clinics are much more satisfying when the aim is a concordant management plan rather than a compliant patient.

REFERENCES

- Carter S, Taylor D & Levenson R (2003) A question of choice – compliance in medicine taking. Medicines Partnership, London. <http://www.medicines-partnership.org>.
- Haynes RB, McDonald H, Garg AX & Montagne P (2002) Interventions for helping patients to follow prescriptions for medication. *The Cochrane Library* – last update February 2002. [Summary Article in JAMA, 2002, 2868–79.]
- Weiss M & Britten N (2003) What is concordance? *Pharmaceutical Journal*, 271, 493.