

# WHY DO OLDER PEOPLE NOT ALWAYS TAKE THEIR MEDICINES?

*Juanita Westbury recently completed an MSc at Keele University exploring concordance issues in older people. In this article she asks if older people are ready for concordance*

Mrs Welsh looked worried as she waited at the counter, patient information leaflet in hand. One of my regulars, Mrs Welsh was 82 years old and recently widowed. I knew from her repeat prescription that she suffered from mild heart failure and hypertension.

She had returned to the pharmacy to ask me about blood potassium levels. The leaflet in her new fluid tablet box stated that they should not be taken with ramipril, one of her blood pressure tablets. She was not sure that she needed a new fluid tablet in any case, because she did not feel the swelling at her ankles was too bad. She told me she had decided not to take the new tablet.

Not only had Mrs Welsh picked up an interaction that a general practitioner and a pharmacist had missed, but she had also made a conscious decision, for a valid reason, not to take her prescribed medication. So was Mrs Welsh unique? I was under the impression that most older people faithfully follow their doctor's orders: "What the doctor says, goes." I also thought that the main reason why older people miss their medicines is that they forget them, or they become muddled owing to the sheer number many have to take.

Is non-compliance in the older age group a problem? We know that as much as 50 per cent of older people may not be taking their medicines as prescribed.<sup>1</sup> This non-compliance can result in inadequate management of disease, hospital admission and even premature death. Not taking medicines can also lead to large wastage of expensive medicines. It is important to find why older patients do not take their medicines to ensure optimal health gain and efficient use of health resources.

Two research groups, Lowe and Raynor<sup>2</sup> and Cooper *et al.*,<sup>3</sup> compared older patients' accounts of their medication regimens with medical records, and found that a third of older patients had consciously decided not to take their medicines. Over 70 per cent of the recorded non-compliance was intentional. Both studies also showed that the reasons older patients reduced their drug intake were related to concerns and beliefs about potency, overuse and long term effects. The specific reasons given by older patients not taking their medicines were:

- Adjustment of medication according to symptoms
- Adjustment of medication to suit daily routine
- A belief that the drugs were not working
- A belief that the drugs were not needed
- Experience of side effects
- Too many tablets
- Misunderstandings

It is common to picture many older people as confused or disabled. Thus it becomes easy to attribute most instances of non-compliance in older people to forgetfulness and confusion. However, when the medication adherence of 121 rheumatoid arthritis patients was electronically monitored, older people made the fewest adherence errors. Younger patients with busy lifestyles and middle-aged adults made the most.<sup>4</sup>

An Open University report on the management of medication in older adults found that although three-quarters of older people take medicines, over half of these reported that their health was "good to very good".<sup>5</sup> The World Health Organization advises that "it is a minority of older people who become disabled to the point that they need care and assistance with the activities of daily living".<sup>6</sup> The classical picture of older patients as confused is outdated and inaccurate. This perception of older people as muddled and infirm may mean that we are unable to appreciate the extent to which older patients consciously modify their drug therapy.

It appears that older people are as likely as younger people to alter their drug therapy on purpose because of beliefs and concerns they hold about medicines. The concordance concept recognises that patients can and do make considered judgements about their drug therapy. If health professionals involve the patient to a much greater extent when decisions about drug treatment are made, the patient's preferences and beliefs about treatment can be sought and appropriate therapy tailored for them. A concordant approach could result in a negotiated agreement about drug treatment. It could incorporate the patient's delegation of decision-making activities to the doctor. Alternatively, a concordant consultation could result in the patient deciding not to take a medicine or medicines, but that decision should be understood and respected by the health professional.

The National Service Framework for Older People supports the concordance concept when it states that the NHS should enable older people to make choices about their own care. The NSF further stresses

that older people need to be more involved in decisions about treatment and to receive more information than they currently do about the benefits and risks of treatment.<sup>7</sup>

If decisions about drug treatment were more concordant and involved older patients to a greater extent, it is thought that patients would be more likely to take the therapy. Drug wastage would also be reduced. If a patient had made an informed choice not to take a medicine, the medicine would simply not be prescribed. This allows discussion and acceptance of treatments, which might be more acceptable to the patient, and consequently deliver greater benefit, even if they were not the preferred option from the clinical perspective. Finally, the adoption of a concordant approach also encourages patients to be involved to a greater extent in their own treatments in line with the NSF for Older People.

## DO OLDER PATIENTS WANT TO PARTICIPATE IN THERAPY DECISIONS?

It is often assumed that older patients will be less comfortable than younger patients participating in decisions about their drug therapy. One researcher, McKinstry, a GP, offered 410 of his patients the choice between a "shared decision making" consultation and the traditional "directed" consultation using contrasting video vignettes. McKinstry concluded that older patients preferred the "directed model".<sup>8</sup> However, his study attracted a good deal of debate, because some of his vignettes were not considered to be in keeping with the concordance concept in that the preferences and beliefs of patients were not sought. Patients were also not counselled about the benefits of becoming involved in therapy decisions. They were simply shown two consultation approaches and asked to choose their preferred approach.

Conversely, other studies have found that many older patients want to be actively involved in decisions about their treatment. For instance, Protheroe *et al.* asked 260 patients aged from 70 to 85 years with atrial fibrillation about their preferences regarding warfarin treatment.<sup>9</sup> Over 85 per cent of patients wanted to be involved in clinical decision-making. One of the strengths of this research was that older patients were educated about the risks and benefits of treatments and informed of the likelihood of side effects as part of the decision-making process. Perhaps with this higher level of knowledge they felt more comfortable participating.

## DRUG INFORMATION

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In order to be able to participate in decisions about drug treatment, patients need to know about the proposed therapy and they also need to know the various treatment options available to them. It is doubtful whether older people are provided with this level of drug information. A group of Danish researchers, Barat *et al*, collected information on drug use in over 300 75-year-olds. They found that 40 per cent of patients did not know the purpose of their treatment and only 5 per cent had knowledge of side effects.<sup>10</sup> Another study, in which more than 1,000 GP consultations were analysed, showed that a discussion of alternative treatments occurred in less than a fifth of appointments.<sup>11</sup>

Older people may be less likely to ask questions and seek information about their medicines than younger people. A study of older patients with heart failure concluded that these patients did not ask questions because they assumed their doctors knew what was best for them.<sup>12</sup> Older patients were raised in an era where doctors adopted a paternalistic approach. They presume that it is expected that the doctors make the therapeutic decisions. If older patients were encouraged by health professionals to ask more questions about medicines they would gain more drug information and be better equipped to participate when decisions about their therapy are made.

#### DO PROFESSIONALS INVOLVE OLDER PEOPLE IN TREATMENT DECISIONS?

There are few studies that actively focus on health care professional consultations with older patients. This is surprising given the focus in the NSF for Older People on promoting older people's involvement in therapeutic decisions. There are, however, studies that consider decision-making in GP consultations, which also include interactions between GPs and older patients.<sup>13,14</sup>

In a truly concordant consultation, the doctor or pharmacist is obliged to inform the patient and share his or her preference for treatment. The patient should then be actively encouraged to communicate his or her beliefs, concerns and preferences to the health professional. However, several observational studies of consultations in general practice identified that doctors and patients did not share information or participate in mutual discussions about medicines.<sup>13,14</sup> Doctors typically gave instructions for use but most patients did not offer opinions or preferences. This led to unwanted prescriptions and non-adherence to treatment. Doctors seemed to be unaware of the relevance of patient's ideas about medicines.<sup>13</sup>

As the last health professional to have contact with the patient before a medicine is issued, pharmacists are in a good position to encourage patients to ask questions about medicines and discuss any concerns or preferences they hold about drug therapy. However, in Raynor *et al*'s research regarding interactions of community pharmacists with patients, most consultations were characterised by instructions. Rarely were patients' specific concerns about treatment elicited or addressed.<sup>15</sup>

Unless GPs and pharmacists are prepared to initiate open discussions about patients' values and preferences, these important determinants for successful concordant consultations are unlikely to be known.

So, what happened to Mrs Welsh? Her GP was contacted and decided not to prescribe the co-amilofruse tablets. Mrs Welsh's potassium levels were already slightly elevated. He said he would write a new prescription for furosemide tablets instead, which Mrs Welsh could collect from the surgery.

To my knowledge, Mrs Welsh did not collect the new prescription. She did not believe she needed fluid tablets. The inap-

propriate diuretic she was first prescribed shook her confidence. If either the GP or the pharmacist had adopted a concordant approach, would this situation have arisen? Had the GP informed Mrs Welsh about her medicines and explored her concerns and preferences for treatment, a prescription probably would not have been issued. Alternatively, if the pharmacist had counselled Mrs Welsh about her medicines, the drug interaction may have been detected sooner and her doubts about taking a diuretic would have come to light and brought to the attention of her GP.

A concordant approach has a lot to offer all age groups. Health professionals need to be more open to involving older patients in decisions about their drug treatment. That means providing more information about medicines and available treatment options. Ultimately though, for concordance to exist, GPs and pharmacists need to develop respect for the beliefs and wishes of their older patients and appreciate that this age group is capable of making considered judgements about their drug therapy.

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