Medicines Information to Support Concordance

This pre-congress two-day symposium was part of the FIP Pharmacy Information Section and was facilitated by Professor Marja Airaksinen from the University of Helsinki in Finland, and Professor DK Theo Raynor from the University of Leeds, UK.

The symposium aimed to describe the concordance model, listing the key principles on which partnership in medicine taking is based; outline how pharmacists can use patient counselling and written medicine information to support concordance; and how future developments in patient counselling through the provision of medicine information can enhance concordance between patients and health professionals, in particular pharmacists.

The symposium consisted of a series of brief didactic sessions interspersed with small group workshop activities and presentations, video vignettes and a role play.

Dr Joanne Shaw, Director of the Task Force on Medicines Partnership (a UK Department of Health funded initiative to promote the quality use of medicines by patients) commenced the symposium by presenting the origins and implications of concordance. Dr Shaw explained and emphasised the differences between concordance, and compliance and adherence. It is important to note, that although compliance and adherence essentially refer to the same patient medication taking behaviour, concordance is not synonymous with either term, and should not be used interchangeably as a more politically correct term. Concordance, as a process, refers to the frank exchange of information, as well as negotiation and cooperation between the patient and the health professional. It can not be imposed on the patient or on the interaction between the patient and health professional.

Dr Shaw focused on non-compliance to therapy as the primary rationale for establishing a concordant relationship. A concordant relationship can have many benefits for both the patient and health professional, with the most significant benefit being that of compliance to therapy, leading to quality use of medicines. Dr Shaw described the traditional compliance model as consisting of firstly, a doctor deciding the diagnosis and treatment of an illness, following this with some explanations and instructions, in particular about the therapy. The onus was on the patient to comprehend the information provided. A successful compliance model with compliance as the outcome is dependent on the correct diagnosis, provision of correct treatment and information, and patient's understanding of the information provided as well as the actions to be taken. However, the literature has indicated that a successful compliance model is not frequently observed.

In a concordant model, the doctor and patient negotiate the diagnosis and treatment. The doctor elicits information from the patient, explains the diagnosis, illness and therapy, and accommodates the treatment to suit the patient's life style, ensuring that a limited behavioural change is required by the patient in order to follow the treatment regimen. The patient is actively involved in this negotiation and treatment accommodation. The outcome of a concordant model is a successful negotiated agreement which can lead to adherence to therapy.

Group activity exploring the benefits and problems associated with implementing concordance in practice, revealed the following benefits: patient and health professional

satisfaction, compliance, better health outcomes, less medication waste, reduced health costs, and patient safety. The problems reported as associated with implementing a concordance approach to patient-health professional consultations included: limited evidence on the benefits associated with concordance, increased cost and time, the established paternalistic medical culture, few if any concordance outcome measures, and patients' expectations of a different approach to consultations with health practitioners. A further problem highlighted by the symposium participants was the limited global awareness and understanding of the concept of concordance or partnership in medicine taking by patients and health professionals.

Dr Shaw finished her presentation by a description of the three "pillars of concordance", essentially, the major changes required to establish concordance in current health practice. These pillars constituted patients having adequate knowledge to participate as partners in medicine taking, consultations with prescribers involving patients as equal partners, and patients being supported in taking their medicines.

Professor Theo Raynor, Head of the Pharmacy Practice and Medicines Management Group at the University of Leeds, reviewed the link between concordance and patient information, including both verbal and written information. Professor Raynor compared and contrasted the top five categories of information that patients have stated that they are interested in and those that doctors believe that patients are interested in receiving. The important information categories for patients, in decreasing rank order, were side effects, indication or action, lifestyle changes, dosing and drug interactions. However, doctors believed that the important information categories (also in decreasing rank order) were drug interactions, dosing, lifestyle changes, missed or overdosing information, and risks of not taking the medication. The presentation highlighted patients' needs, the different perspectives of patients and health professionals, and the broad range of preferences for medicine information by patients.

In discussing patients needs for verbal information, Professor Raynor focused on the product-centered nature of verbal counselling delivered by pharmacists as well as the limited information given to patients because pharmacists believed that patients do not want medicine information. Although verbal counselling is not a legal requirement in most countries, pharmacists have a professional duty of care to provide information to their patients to ensure quality use of medicines. Professor Raynor concluded by stating that there is a limited level of verbal information received by patients, supporting the need to provide useable written medicine information to patients, with attention directed to the differing needs of patients, in particular those with special needs, such as the blind and patients with low literacy.

The next speaker, Professor Marja Airaksinen, Professor in Social Pharmacy at the University of Helsinki, spoke about how pharmacists can use patient counselling to support concordance. Her presentation focused on several case scenarios demonstrating a paternalistic approach to patient counselling, predominantly a monologue-based transfer of information. The small group work activity during this session centered on how the communication process in the presented cases could be changed to support concordance. A video-vignette of a counselling role play was also shown for the audience to critique in terms of the communication and counselling skills demonstrated to support concordance.

Professor Airaksinen summarised that communication about medicines involved the patient, pharmacist, doctor, nurse and other health professionals, using verbal and written, as well as other sources of medicine information such as the internet, to reach the ultimate outcome of medication safety by the patient. However, to ensure that the communication process supports concordance, an extensive learning process for all key stakeholders, including the pharmacy profession leaders, is required.

The final speaker of the first day, Dr Parisa Aslani, Associate Dean (Undergraduate) and Lecturer in Pharmacy Practice (University of Sydney) spoke about the use of written medicine information by pharmacists to support concordance. She focused on the rationale for the availability of written medicine information, the impact of this information and the advantages and disadvantages of the three common distribution forms of written information (package inserts, loose leaflets and computer generated forms).

Several factors have contributed to the increased availability of written medicine information, including the recognition of patients' rights to know about their medicines, increased demand by consumers for more information and the limited verbal information received by consumers. Although written information can have negative impacts on patients, such as decreased patient satisfaction, experience of side effects and non-compliance, there is a wealth of information on the positive impacts of written information on patients, such as increased knowledge, increased awareness and reporting of side effects, improved use of medications, increased satisfaction, increased questions about therapy, increased compliance, and improved communication with health professionals.

The presentation also focused on the factors that affect the use of written information by consumers. These included the readability and presentation of the document, patients' coping style and health locus of control, patients' perceptions of the severity of their disease, previous problematic experiences with medications, timing of the provision of the information and whether the patient was in a care-giver role.

Armed with an awareness of the positive impact of written information, the advantages and disadvantages of the documents, and the factors that influence the use of written information by patients, the workshop participants were asked to develop an approach or process for the pharmacist to apply when using written medicine information as a counselling tool in supporting concordance. This process would be underpinned by the benefits of written information, address the negative aspects of the document and consider the differences in patient needs in providing written information to support concordance, with the outcome of quality (and safe) use of medicines by patients. Some of the components of the process, highlighted during the small group discussions included, that the pharmacists should firstly increase their own awareness of the content of written medicine information documents, inform patients of the availability of this information and ask patients whether they would like to receive written information. The pharmacists should use the information as a counselling tool, highlighting relevant sections, and reviewing or adding to the information during the patient's subsequent visits to the pharmacy to collect repeat dispensings of the medication.

The second day of the symposium consisted of a presentation by Mr Simon Bell, past president (2003-2004) of the International Pharmaceutical Students' Federation (IPSF) and a current PhD student in Pharmacy Practice at the Faculty of Pharmacy, University of Sydney, on the use of patients with mental illness as educators for health professionals. Mr Bell stated that there is evidence emerging that using consumers or

patients as educators assists mental health treatment and improves prognosis through empowerment of the patients. Results from a recent study on the use of consumer educators have highlighted the positive impact both for the health professional as well as the consumer with mental illness. This approach recognises the patient as an equal partner in the decision making process and healthcare in general, and demonstrates a move towards establishing concordance in consultations between patients and health professionals.

The remainder of the symposium consisted of small group activities with the aim of developing innovations in basic education, continuing education, patient counselling practices, written information and information technology, to support concordance in pharmacy practice. A wide variety of suggestions were made by the participants. These will be summarised by the facilitators Ms Heli Kansanaho, Acting Senior Lecturer and PhD student in Social Pharmacy (University of Helsinki, Finland) and Inka Puumalainen, president of the Finnish Pharmacists' Association and a PhD student in Social Pharmacy at the University of Kuopio, Finland. The summary reports will be available on the following website: www.concordance.org.