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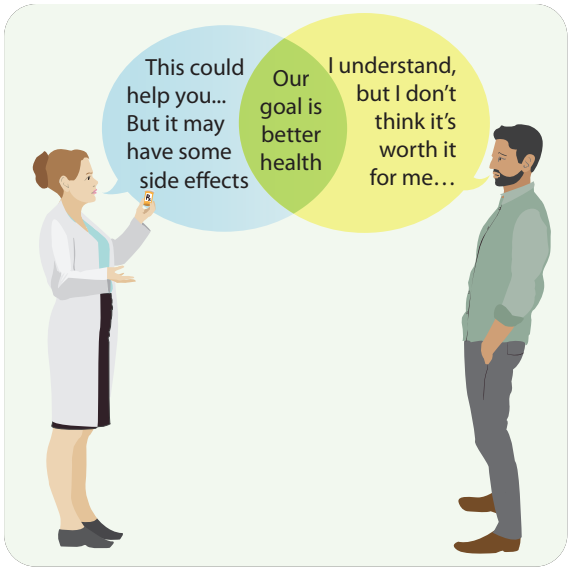
THERAPEUTICS INITIATIVE
Independent Healthcare Evidence

# Rethinking Medication Adherence




**Vignette:**

*An 83 year old faces conflict between her own preference for a simpler medication regime and a specialist who emphasizes that she will "need" to take her 8 drugs (14 doses/day) "for the rest of her life." She takes an NSAID regularly because it helps with pain, but not the bisphosphonate "pill for my bones". She finds it hard to swallow and doubts that the small chance of preventing a fracture described by her family doctor/NP is worth the bother. Her family doctor/NP supports shared decision making. Wanting to avoid causing harm to her patient, she feels trapped between specialist advice and guidelines and her patient's preferences. Can documenting a shared decision-making dialogue help resolve their dilemma?*

Health professionals can find it challenging when patients do not follow well-intended advice. What was formerly called 'non-compliance' is now referred to as 'non-adherence.' This acknowledges the individual right to make one's own health decisions as well as external factors such as price that determine access to medications.

There is a spectrum along which the importance of adherence to prescribed therapy varies. Sometimes it may be essential for safety or to achieve benefits important to a patient. Examples include vaccines, anticoagulation, contraception, seizure prevention, drug treatments of communicable diseases or treatment of microorganisms that select rapidly for drug resistance (e.g. TB, HIV). More often, we have no available evidence from randomized controlled trials (RCTs) as to how important perfect adherence may be for preventive therapies or symptom control.

Patients often find it difficult to access medications. A 2021 systematic review found that cost-related non-adherence to prescribed medications affects between 3.6% and 15% of Canadians.[1] Challenges that clinicians can help overcome include: costs, no regular primary care provider to organize refills, medication stigma (e.g. antipsychotics, methadone) and time away from work or caregiving for follow-up.

## Is medication adherence the right goal for all patients?

Discourse about adherence often assumes that patient "non-adherence" implies failure to achieve the benefits of pharmacotherapy. This approach ignores patient preferences and logistical barriers to adherence.[2,3,4,5]

Health benefits of improved adherence may appear self-evident, but understanding the available evidence is more challenging. For example, a 2006 meta-analysis suggested that increasing adherence to drugs prescribed for multiple chronic medical conditions reduces risk of premature death from all causes.[6] However, this post-hoc analysis did not include RCTs specifically designed to test benefits/harms of increasing adherence, and may reflect a "healthy adherer" effect (the tendency of healthier people to follow medical instructions).

Three Cochrane systematic reviews assessed studies testing mixed interventions and reminder packaging specifically designed to increase medication adherence or medication-taking ability. Despite enhanced medication-taking ability or adherence, they found insufficient evidence of improved clinical outcomes important to patients.[7,8,9]

Pushing for improved adherence at any cost does not address **informed, intentional non-adherence** – a patient's deliberate choice not to take medication. People who feel that a treatment benefit is not worth the burden or inconvenience may prefer not to follow the prescriber's advice.[10] This is more likely when people already take many drugs for multiple medical conditions.[11]

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Prescriber recommendations **often differ from a patient's own preferences**.[12] One should not **assume** that a patient is willing to take medication regardless of the intended outcome, probability or magnitude of benefit, cost, duration of treatment, or risk of harm.[10] For example, the 83 year-old in the vignette concludes that her chance to prevent a fracture does not warrant the nuisance of taking an additional daily pill.

## Engaging in constructive dialogue

SHARE is one approach to exploring patient goals and possible reasons for non-adherence, promoted by the US Agency for Healthcare Research and Quality.[13] (Table 1)

Before assessing medication adherence, this model recommends addressing all aspects of a shared decision-making approach. Was all the most relevant information shared between the clinician and patient? Does the patient understand short and long-term effects of the disease and treatment? With hypertension, for example, does the patient understand that a prescription drug's purpose is not only to reduce blood pressure, but to avoid or delay long-term complications like heart disease or stroke? Based on best available evidence, is the proposed treatment likely to support the goals that a patient considers important? If so, is the expected magnitude of benefit meaningful, or marginal?

Periodic comprehensive medication reviews and prescription refills are opportunities for prescribers and pharmacists to engage patients in a respectful dialogue about their own values and preferences. If a non-adherent patient wishes to adhere more closely to recommended therapy, clinicans can offer helpful tools, including support for funding when needed.[14,15] **But when patients choose informed non-adherence, it is democratic, ethical and practical to respect their freedom of choice.**

**Table 1: SHARE Approach[13]**

| | |
|---|---|
| **S** | **S**eek your patient's participation |
| **H** | **H**elp your patient explore & compare treatment options |
| **A** | **A**ssess your patient's values and preferences |
| **R** | **R**each a decision with your patient |
| **E** | **E**valuate your patient's decision |

## Document what you learn

Implementing a shared decision-making approach to drug therapy works best when clinicians clearly document their discussions and reasoning. As patients encounter other clinicians in their healthcare journeys, accessible and lucid records help everyone involved to make wise and mutually respectful decisions. Clinicians can leave an "intellectual footprint" by documenting specific patient preferences, by writing **STOP orders** to deprescribe medications, or by recording that the patient understands potential benefits and harms of a therapy and has chosen informed non-adherence.[16] Incorporating the purpose of treatment into prescriptions ("indication-based prescribing") adds clarity for patients and for others involved in their care. [17]

**Table 2: Documenting an 'intellectual footprint' on a prescription or hospital order**

| Issue | Example of documentation |
|---|---|
| Indication-based prescribing | *Ramipril 10 mg/d to improve heart pumping. Supply 90 for 3 months. Renew 3 times.* |
| Deprescribing | *STOP glyburide (frequent hypoglycemia).* |
| Patient preference for informed non-adherence | *STOP hydralazine. We agreed to focus on drugs with best evidence for prevention of CV events & de-emphasize BP measurements.* |
| Change in therapeutic goals and strategy | *STOP drugs 1,2,3,4,5. Reduce 6 to once/d. He now desires comfort care approach to diabetes, coronary artery disease, and CKD.* |

Patient preferences often change over time. Some may deem that medications used for decades are no longer appropriate to their current life goals. Communicating such changes clearly may prevent re-prescribing by subsequent clinicians, or other broken links in a chain of care. Good communication about pharmacotherapy is analogous to and just as important as ascertaining and documenting resuscitation preferences and "level of care" goals.

## Conclusions

- Non-adherence offers clinicians an opportunity to learn about patient goals and what makes treatment worthwhile for an individual.
- A shared decision-making framework or structured questioning can facilitate meaningful dialogue and help clinicians understand patient preferences.
- Informed non-adherence is an acceptable choice compatible with personal autonomy.
- Documenting patient preferences can improve communication between clinicians and reduce confusion during transitions in care.

*For the complete list of references go to:* **https://ti.ubc.ca/letter132**



The draft of this Therapeutics Letter was submitted for review to over 100 experts and primary care physicians in order to correct any inaccuracies and to ensure that the information is concise and relevant to clinicians.