Patient-related factors of compliance in heart failure: some new insights into an old problem

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This editorial refers to ‘Compliance in heart failure patients: the importance of knowledge and beliefs’† by M.H.L. van der Wal et al., on page 434

Introduction

During the last decades, heart failure treatment has improved rapidly. There are now a number of drugs recommended along with non-pharmacological interventions such as changes in lifestyle and monitoring of symptoms to improve mortality and morbidity in patients with heart failure. Many patients suffering from chronic heart failure need life-long treatment, and if the effects seen in clinical trials have to be replicated, patients must be prescribed treatment according to guidelines. Further, patients must follow the prescribed treatment.

Definition of compliance

The phenomenon of how patients follow treatment was at first known as compliance. Sackett and Haynes defined compliance, almost 25 years ago, as ‘the extent to which a person’s behaviour (in terms of taking medications, following diets or executing other lifestyle changes) coincides with medical or health advice’. Later on, the term compliance was criticized for implying paternalism. Health care professionals dictated terms and the patient had to obey. Alternative terms, such as adherence and concordance, were then proposed to replace compliance. Adherence has more the meaning in which the patient–provider relationship is based on respect and collaboration. WHO has revised and merged old definitions to now define adherence as ‘the extent to which a person’s behaviour—taking medication, following a diet, and/or executing lifestyle changes—corresponds with agreed recommendations from a health care provider’. However, the term compliance is still used widely in medical research, but often with the same underlying definition as adherence. In this editorial, the terms will be used interchangeably.

The issues of non-compliance

Non-compliance increases mortality, morbidity, and the need for hospital care, but it is difficult to estimate the true scope of non-compliance in heart failure. Reviews have shown that medication compliance ranges between very low compliance (10%) and up to numbers above 90%, but the majority seems to be around 70%. It is often stated that it is the responsibility of the patient alone to follow the prescribed treatment, but adherence is a multi-dimensional phenomenon, and five interacting dimensions that affect it have been determined: patient-related factors, condition-related factors, therapy-related factors, health care team/system-related factors, and social/economic factors. Understanding the mechanisms behind adherence or compliance and the factors that influence patients is of great importance. Demographic factors do not influence compliance significantly. The patient–health care provider interaction has been recognized as an important factor. The behaviour and attitudes of health care professionals may have a negative or positive effect on how patients comply with their treatment. Strong social support contributes to increased adherence. In this Journal, van der Wal et al. addressed patient-related factors of compliance in heart failure. They found that compliance with medications was high among elderly Dutch heart-failure patients, but compliance with weighing and exercise was low. Factors related to higher compliance was higher knowledge and absence of depressive symptoms. Beliefs, defined in this study as barriers and benefits of following treatment, were also shown to influence compliance.

Knowledge and beliefs

Compliance is often seen as the most important outcome of patient education. Aims of the education are to motivate the patient to comply with the prescribed treatment and adapt to health-promoting behaviours and to provide the patient with the skills and knowledge needed in order to perform self-care without professional supervision. The underlying philosophy of compliance is that the illness can be controlled if the patient complies with the prescribed treatment. This is true to a certain extent, but the nature
of heart failure is complex and the patient can deteriorate despite being adherent.

In this Journal, van der Wal et al.\(^6\) state that knowledge and beliefs especially influence non-pharmacological treatment. Ekman et al.\(^7\) reported similar findings that beliefs also affect adherence in medical treatment. Belief in the treatment has an impact on how the patients follow treatment advice, their expectations of the treatment, and how they accredit the effects of the treatment. To identify patients’ beliefs about their treatment is therefore important in the counselling and education of patients with heart failure.

Motivation and adaptation
Adapting to a situation of having heart failure is a process with a search for meaning and identity. The process has several steps: first, the crisis event and heart failure diagnosis. After a time, which varies for each individual patient, the next steps of acceptance and adjustment are taken, and then, the last step is reorientation and ‘getting on with life’.\(^6\) In this reorientation, the goal is that patients incorporate the treatment into their daily lives. One critical aspect in this process, as Ekman et al.\(^9\) have pointed out, is that about one-fifth of the patients with heart failure do not consider themselves as chronically ill. When they do not have severe symptoms of heart failure they consider themselves cured, and when they deteriorate they interpret that as a new acute event. This aspect is a risk for non-compliance to treatment.

Patients with heart failure have a higher prevalence of depression\(^3\),\(^6\) and patients with symptoms of depression are more likely to have problems with adhering to treatment, as their ability to be motivated and adapt to their chronic illness is decreased.

Limitations of self-reported compliance
Self-reporting of compliance has, as van der Wal and co-workers\(^6\) themselves point out, limitations. It is well known that patients state that they act as required, but are forgetful, or they follow the prescribed treatment differently from day to day. The latter group takes drug holidays, and this is often one way of self-regulation: to see what happens if they stop taking medication or stop following a diet. It is known that only a minority, about 5–10% of the patients, are completely non-compliant with treatment, 50–60% are always compliant, and the rest of the patients are partly compliant.\(^3\)

There are so many different ways of not completely adhering to treatment: not filling in the prescription, forgetting to take the drug/follow a diet/exercise, forgetting to stop taking a drug, taking medication at the wrong time, taking an extra dose, stopping treatment (drugs, diet, exercise) too early, following the treatment differently from day to day, and so on. In self-reports, some of these aspects can easily be overlooked by the patient.

Adherence to medical treatment in the study by van der Wal et al.\(^6\) was quite high. The reliability of this data can be questioned because of the data-collection by self-report. However, since all the patients had symptomatic heart failure, they might have had higher compliance than those who have other chronic illnesses but with fewer symptoms.

Heart failure management programmes
Heart failure management programmes have been shown to affect adherence and influence self-care behaviour.\(^10\)

Important components of these programmes are patient education, close collaboration with health care professionals, and psychosocial support. It is more likely that factors that might decrease self-care behaviour in patients with heart failure, such as deficits in knowledge and barriers and depression, which have been pointed out by van der Wal et al.\(^6\) as important influencing factors, are addressed in patients that receive this type of follow up.

Taking compliance one step further
In this research area, another term, concordance, has started to be used. Concordance is defined as a state or condition of agreement or harmony. The state of agreement can be achieved by therapeutic alliance reached through negotiation. Concordance is based on partnership in treatment and both parts are equal. It can be hard for many health care professionals to accept that despite their knowledge and long experience of health care and medical treatment, it is the patient who should decide if he or she will follow the suggested treatment. In order to make this partnership in treatment work, the patient must be informed about the different treatment options and the pros and cons attached to each option. The health professional’s positive attitudes toward concordance and partnership in treatment are crucial if this should work.

Conclusion
Compliance is affected by a multitude of factors. The patient’s perspective and the factors that influence the patient are of great importance. The responsibility of health care professionals is to prescribe treatment according to guidelines and to set aside time and effort to help patients to adhere. The paper by van der Wal et al.\(^6\) once again confirms the need for education in this patient group.

Although there is extensive literature on patient compliance, proportionately little attention has been paid to the patients’ own ideas about what influences them to adhere. It is therefore important to also outline patient-related factors in even greater depth from the patient’s insider perspective. Non-compliance can be a rational choice, based on side-effects or drug inefficacy, or beyond that a form of asserting control over the disease.

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References


