CONCORDANCE — IS IT A SYNONYM FOR COMPLIANCE OR A PARADIGM SHIFT?

Christine Bond says that the concept of concordance is not fully understood by health care professionals and that it has yet to be accepted as a paradigm shift in health care provision

Health care professionals should talk to patients as equals

Non-compliance with the taking of prescribed, and often dispensed, medicines leads to waste of a valuable resource and ineffective treatment. Undisclosed non-compliance can also confound future management of a patient's condition. In 1995, a working party was convened to explore the reasons behind non-compliance with medicine taking. I was privileged to be a member of that working party, charismatically and efficiently chaired by Professor Marshall Marinker. Together we all made the journey from a medically dominated, paternalistic view of non-compliance to one which realised the patency of the patient's perspective — and thus concordance was born.

ACHIEVEMENTS

What has been achieved since the publication of the working party's report "From compliance to concordance: achieving shared goals in medicine taking"?[1] There has certainly been an increased awareness of the patient's perspective by health care professionals and lip service, at least, is now paid to this in the consultation. The exact extent of health care professionals' real understanding and application of the principles of concordance to their interactions with patients remains unquantified, as do the effects on patient outcomes. Isolated research reports do indicate, however, that this sort of approach should bear fruit.[2,3] However for the most part, I cynically observe that my colleagues happily substitute the word "concordance" for "compliance", believing this to be politically correct while not appreciating the difference.

There has also been an increased interest in the psychological and sociological theories that can be applied to medicines taking (eg, the health behavioural model, illness representation, attribution theory and the theory of planned behaviour). Much of this theoretical work dates from 20 years ago or more. It is sad that it has taken so long to link with colleagues in other related and relevant disciplines to enhance our own professional-patient behaviour and understanding.

The biggest achievement is Government funding for the Medicines Partnership initiative, which has the remit to put medicines concordance — or do we mean partnership? — into practice. This initiative has been instrumental in successfully raising the profile of the importance of informed decision-making through a range of approaches.

Concordance has evolved at the same time as other similar initiatives that increasingly recognise the roles and rights of the patient or client in a professional interaction. Medicine is no different in this from other professions, such as education, and we are seeing a sociological and cultural paradigm shift across our whole community. Within the health care environment, other related mantras include patient autonomy, holistic care, patient centredness, shared decision-making, patient partnerships and patient empowerment. These are taken forward in such policies as NHS modernisation, and the expert patient and patient information initiatives.

A topical example of the latter is "Ask About Medicines Week". This campaign is designed to increase patients' access to information about their medicines, in the belief that information will improve compliance — or do we mean concordance?

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PARADIGM OR SYNONYM?

In its original conception, concordance represented a paradigm shift in the way patients are treated by health care professionals. Compliance with treatment is in many ways the key outcome of the old paternalistic paradigm yet, as already implied, the word "concordance" is still substituted too readily for "compliance". We have seen compliance, adherence and concurrence with treatment and now we have concordance. But leaving aside conceptual understanding, there is a semantic problem if we say patients are concordant with their treat-

ment, when we mean compliant. Although a patient is more likely to comply with a treatment decision with which they were involved and fully agree, ie, are in concordance with, and which takes into account all their beliefs and expectations, it is by no means inevitable that they will.

It is timely therefore to rethink the concept of concordance, and consider its implications and future.

CONCORDANCE *AD ABSURDUM*?

Concordance is the name given to the "agreement between the patient and the health care professional, reached after negotiation, that respects the beliefs and wishes of the patient in determining whether, when and how their medicine is taken . . . and the primacy of the patient's decision [is recognised]." The perceived benefits of this open and equal negotiated process are that patients will be empowered to share all their concerns and expectations about their symptoms and their management, including fears of side effects. They will receive a treatment which acknowledges these and, ultimately at follow-up consultations, they will also be able to report any decision not to take their medicines and to discuss the reasons for this.

Inevitably the concept of concordance may lead to agreed decisions which are not what the health care professional would want or advise on his or her own. This is because the goal of the health care professional is to treat symptoms or cure disease, and for the patient these are but components of a spectrum of other life circumstances. So people continue to smoke despite obvious respiratory problems, and others do not take antihypertensive or lipid lowering treatments because they do not see any immediate benefit to compensate for potentially suffering the side effects of treatment. This is nicely encapsulated in the theory of planned behaviour, one aspect of which predicts behaviour as a balance of the likely outcome ("if I take these tablets I will improve my health") and the value placed on that outcome ("being healthy is important"). As health care professionals, we assume being healthy is important for patients but this may not be the case, and certainly not at the expense of other factors, such as the pleasure derived from smoking.

Having accepted this, it is inevitable that there will be times when an agreed decision may give the health care professional concerns, because they know the patient is not doing the best for their health, whether short term or long term. The medico-legal implications of this have been much debated but, to the best of my knowledge, never tested. There is an intuitive feeling that at the end of the day decisions have to be the patient's. However it is a role for health care professionals to ensure that in coming to that decision the patient is fully aware of the relative risks and benefits of this decision. An assessment of this understanding is the responsibility of the professional. Documentation of these discussions, and perhaps even signed agreements, may be something for the near future in an increasingly complaint-ridden and litigation-bound health care system. It is also something that clinical governance frameworks should incorporate.

But although a decision not to take a medicine — the "best treatment" — may, despite professional misgivings, be ultimately condoned and supported, there may also be a patient who insists on being prescribed a treatment for which there is no or little evidence of benefit, or is contraindicated. Can we as professionals agree to the use of scarce resources in this way? Should the needs of the population or patient take priority? Should there be primacy for the patient's views under these circumstances?

Taken to even further extremes, what about the well-publicised issue of body dysmorphia,[4] where patients desire limb amputation because the limb does not feel part of them. In extreme cases some patients have effected their own versions of amputation. Concordance still has to come to terms with these situations and perhaps be rearticulated to remain credible as a health care paradigm.

IMPLICATIONS FOR PROFESSIONALS

Professionals are now expected to practise "in a concordant way", yet the true benefit of concordance is still unclear. To date there are no units of concordance so it cannot be quantified or causally associated with any measurable outcome. Thus research evidence of improved patient outcomes, even improved patient compliance, associated with concordance are still awaited. Evidence of cost-effectiveness is even further in the future. However, in the interim some of the associated mantras referred to earlier have led to improvements in adherence and satisfaction.[2,3] Therefore it is right that we should, under whatever umbrella, encourage professionals to talk to patients as equals, in a non-judgemental way, eliciting their concerns and ensuring they are making informed decisions. For prescribers, which for pharmacists includes those making over-the-counter recommendations and prescribing on the NHS, all of the above apply in order to maximise the benefit of the client contact. For those dispensing the prescriptions of others, there is an equally important role to discuss progress with treatment, to motivate and inform. Eliciting ongoing concerns is key, and the increasingly integrated role for pharmacists within the NHS will support this role and maximise our contribution to effective health care.

It must be recognised that this sort of interaction will come more naturally to some patients and to some professionals than others.

Although professionals can be trained to practise in this way, not all patients will want this approach, and another key role for the professional is to assess the level of partnership the patient wants with respect to decision making.

THE FUTURE

Concordance as a paradigm shift has not yet arrived. But it has been instrumental in focusing interest on the prescribing decision, recognising the different patient perspectives and ultimately in generating resource to support this important patient-centred agenda. As with pebbles smoothed by the sea, its shape will continue to change as it moulds itself to fit within the bigger ocean of health care.°

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