

The appropriateness of prescribed medication: Who decides patients, GPs or evidence-based medicine ?

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Overview of the presentation

- ◆ Appropriateness
- ◆ Programme of work
- ◆ Focus on the qualitative phase
- ◆ Findings
 - Patient experiences of hypertension
 - Antecedents for evaluation
 - Incongruity between patients & GPs
- ◆ Implications
- ◆ What next?



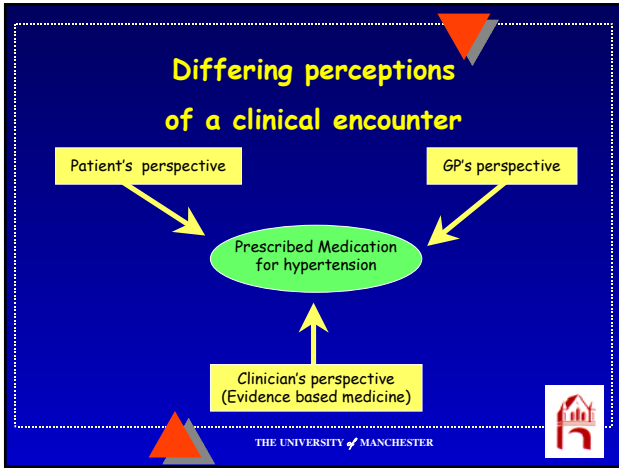
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Appropriateness

- ◆ **Clinical perspective**
 - Medication Appropriateness Index (MAI)
 - Appropriateness of Prescribed Medication Index
 - Clinical dimensions only
 - Indicators related to individual patient's clinical profile
 - Individual patient's view remains elusive
- ◆ **Evaluation of appropriateness**
 - Varies with who makes it, for whom and when made.



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- Appropriateness**
- ◆ Existing studies
 - focus group - achieves only an aggregate view
 - assumptions patients use same criteria as HCP
 - ◆ Social science perspective
 - health & illness dynamic
 - woven into person's life
 - ◆ Reasons why important
 - patient's decisions regarding their own care
 - medicines management/pharmaceutical care
 - concept of concordance
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- Programme of work**
- ◆ Qualitative phase
 - In-depth interviews
 - ▼ Patients diagnosed with hypertension (n=32)
 - ▼ Nominated GP (n=10)
 - Review of patient's medical notes
 - Narrative analysis & constant comparison method
 - Analysis down & across each group
 - ◆ Q-methodology phase (n=80 ongoing)
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Why hypertension?

- ◆ Has well defined & established prescribing guidelines.
- ◆ Clinically defined as asymptomatic.
- ◆ Hypertensive medication has known side effects
- ◆ Demonstrated to have low compliance.



In-depth interviews

- ◆ Schedule generated during pilot study
- ◆ 'How did you come to find you had high blood pressure?'
- ◆ Researcher background deliberately hidden




Findings

- ◆ Patients experiences of hypertension
- ◆ Antecedents for appropriateness evaluation
- ◆ Incongruity between patient's & GP's perceptions of treatment




Patients experiences of hypertension

- ◆ Associations
 - ▼ experiential learning
 - ▼ ways of explaining
- ◆ Experiences varies with time
- ◆ Fears and concerns
 - ▼ varies with the age of patient
 - ▼ "normal" then "not normal"

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Antecedents for evaluation

- ◆ When asked directly
 - 'if its lowering blood pressure'
 - 'I do not know what would it be like if didn't take it'
 - 'only decide in conjunction with GP'
- ◆ Related to their relationship with GP
 - time available
 - explained aspects of care
- ◆ Influenced by past experiences
 - them and significant others

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Antecedents for evaluation

- ◆ The influence of side effects
 - Mild & occasional skin irritation - okay
 - Calming effect of beta-blockers -okay
 - Frequent urination
 - ▼ Problem for Russell (working)
 - ▼ Not for Albert (retired)
 - Impotency
 - ▼ problem for some e.g. John (72 years of age)
 - ▼ not for others
 - ▼ not generally know by patients

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Incongruity

- ◆ **General practitioners**
 - patient's intellectual ability
 - conceptualise risk by using charts
 - intellectualise from population based studies
- ◆ **Hypertensive patients**
 - individualised information
 - consequences of not being treated
 - talk about their concerns
 - more involvement as duration of treatment increased

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Implications

- ◆ **Patient partnerships**
 - experiences used to evaluate medication
 - not necessarily risk/benefit paradigm
 - patient requires more individualised information
 - varies with age of patient & duration of treatment
- ◆ **Concept of concordance**
 - patients' requirements vary across time
 - initially leave to HCP - with more involvement later
 - need to be more open regarding potential side effects

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What next

- ◆ **With this research**
 - ▼ Q-methodology phase
 - ▼ Investigate implications for practice
- ◆ **Further research**
 - Children with asthma or diabetes
 - ▼ similar above but more complex
 - ▼ involving parent/teachers/friends
- ◆ **Collectively - 'Sense of agency'**
 - ▼ difference between cultures
 - ▼ individual - family orientations

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