EDITORIAL – Non-compliance? The Pursuit for Concordance

Non-compliance is a problem that has plagued medicine since its advent. Non-compliance occurs when a patient does not follow the advice of his or her physician. Do we really want compliant patients who blindly obey whatever we command of them, or do we want patients who better understand their conditions and both comprehend and agree with our advice? Patients who we might call “concordant.” It is estimated that lack of concordance costs the health care industry over a billion dollars in hospital expenditure, loss of productivity at work and medico-legal issues. Concordance itself is a wide ranging scope of possibilities. It ranges from a routine GP visit to a patient on strict warfarin therapeutic monitoring. Since both these patients have seen the doctor, they may be called concordant. However, the consequences of non-concordance will have different severities in each case. Similarly, non-concordance ranges from a patient who does not take one aspirin a day to a patient who fails to continue with triple therapy for HIV treatment.

What factors are involved in non-concordance? Perhaps there is a lack of effort on the part of the physician to explain the situation to the patient causing the patient to ignore the doctor’s advice. If a patient is unable to grasp the full extent of the disease he/she is less likely to be motivated and may simply be overwhelmed with all the information. Perhaps physicians, due to time constraints, have a tendency to speed through technicalities of treatment, relying on the patient to pick up some of the slack by educating themselves. Depending on factors such as level of education and resources, this may occur; However, one must keep in mind that it may not.

Where does one draw the line as far as doing too much? Physicians are in a position of ultimate responsibility and their words have a resounding impact on patient decisions. However, freedom of choice allows the patient to choose therapy he sees fit and to omit what he feels as unnecessary despite understanding the dire consequences. One cannot legally make a patient adhere to a certain treatment even if the consequences of not doing so could be fatal. For instance, a woman who abuses alcohol during her pregnancy despite doctor’s advice. It would seem to be ethical to take action against this individual, but legally there is little that a doctor can do to save the life of the unborn child. A “good” doctor should know his or her limits and utilise resources by working within these limits.

Many strategies that deal with patient education, support and empowerment have been proposed to overcome non-concordance. More often physicians are going to great lengths to make sure that patients know how to take their medications correctly. A common strategy is to educate patients on monitoring blood sugar levels in the case of diabetics, on nutrition, and giving contact numbers for existing support groups. These measures help put the patient at ease about therapy and enables them to get much needed emotional support. A more drastic strategy includes patients visiting wound-care facilities for diabetics, visiting victims of DUI’s (driving under the influence of alcohol or drugs) in intensive and coronary care units so that these patients can see the dire consequences of their non-concordance. Other physicians have given ultimatums to their patients stating that if they don’t follow their advice for successful treatment then therapy would be terminated and there would be little point to come back. This strategy aims to either scare the patient into concordance, make him comprehend the gravity of the situation (impending death), or drive him to another doctor who may have better luck.

The impact of doctor-patient interactions as they relate to non-concordance is of paramount importance to the health-care industry. As medical students, it is highly prudent to evolve strategies on how to bridge any gaps that impact on this interaction. We are in prime position to create a paradigm shift in the future of healthcare practice. The internet, TV and radio all offer modalities of communication which allow us to

encourage patients to selectively use as current, informative resources for better health. It is logical to argue that a more informed patient will prove to be a more concordant, happier and healthier patient.

I feel that the greatest reward for doing is the opportunity to do more.
—Jonas Salk, Microbiologist

Raj Puri
Editor-in-Chief

I am honoured to be the first Editor-in-Chief of TSMJ and to have worked with such a dynamic group of people. I would like to express my sincere gratitude to the entire panel of TSMJ board members, and to the Editorial Board whose work heightened the quality of the Journal. Their diligent contributions have lifted the Journal to a level that will help it continue as a vital element of Trinity's illustrious literary and scientific tradition. Finally, thanks to Prof. O'Brien, Prof. Feighery, Martin MacGuill, and Rajesh Balagani for their critical appraisal that has enhanced my skills as an editor, and to Fatima Ali for her creative contribution.

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