



Danielle Mazza

Patient 'buy-in' and prevention

'Do I really need to take the warfarin doctor I feel so well? I hate taking it. It thins my blood too much and I feel cold all the time...'

Implementing preventive care and achieving adherence to preventive care plans is a difficult task for general practitioners. If we consider the preventive elements of the problems described in the focus articles in this month's issue of *Australian Family Physician*, or for cardiovascular disease prevention for example, the preventive activity we are asking our patients to undertake can be a 'real ask' and for many, too unpalatable.

Wearing compression stockings on long haul flights is not necessarily the most comfortable thing in the world, and for the elderly and others who are not supple, the stockings can be a real challenge to put on and take off. Warfarinisation also poses enormous problems for patients with the need for frequent monitoring, bruising and the risk of haemorrhage.

Today, much of our preventive care involves the use of medicines (eg. statins and warfarin). While there may be strong evidence for the effectiveness of such measures, studies show that compliance and long term adherence is problematic.¹ Patients may be reluctant to take preventive medications due to cost, side effects, myths about long term outcomes, or just because they feel well and can't understand what the fuss is about.² In addition to these factors, people with poor health literacy, who are often the very ones carrying an increased burden of chronic disease, are less responsive to health education messages and disease prevention.³

Achieving compliance and adherence with prevention requires interventions which involve both educational and behavioural

components. Factors to consider include the way an individual perceives their personal risk, the perceived benefits and disadvantages of the preventive action, their belief in their own ability to change their behaviour and sustain that change (their self efficacy), and the level of communication they are able to achieve with their doctor.⁴

Communication of risk is an integral component of preventive care, but is a task often handled poorly. Words such as 'high', 'low', and 'minimal risk' have different meanings for different patients. Individuals bring their own values, education, needs and preferences to the consultation, all of which will affect their perception of risk. These perceptions may be skewed by media reports, their own previous health experiences or those of friends and family resulting in certain outcomes being more feared more than others (eg. stroke versus cancer). In addition, health professionals may use terms that are indecipherable to patients such as 'odds ratios' and 'relative risks'. Describing risk in percentages or frequencies, using graphical representation and short timeframes, helps to overcome these issues.⁵

Motivational interviewing is also a useful technique in encouraging preventive behaviours.⁶ With a focus on persuasion, the overall goal is to increase the patient's intrinsic motivation so that change arises from within rather than being imposed from without. Motivational interviewing involves assessing patients' motivations for behaviour change and building motivation for healthy behaviours by expressing empathy, developing discrepancy, rolling with resistance and supporting self efficacy.⁷

Another complementary approach is using decision aids to help individuals come to grips with the problems they face in an understandable fashion. Systematic reviews have found this approach to increase people's

involvement in decision making about their care and lead to informed values based decisions.⁸ The trouble with general practice is that we are dealing with patients who often have comorbidities and it is hard to find decision aids that move beyond individual issues and address the multitude of preventive action that is required by the individuals who sit in front of us in the consulting room.

Patients seek treatment approaches that are manageable and in their view effective, and their preferences can differ considerably from those of professionals. Awareness of this has resulted in consumer involvement in the design and implementation of guidelines being increasingly recognised as an essential component of evidence based practice.⁹ Consumer perspectives give a reality check to recommendations which, while derived from the evidence, may be unimplementable, and their input helps ensure that evidence can be translated into practice.

Current reform agendas emphasise the need to engage patients as active partners to be more effective in implementing successful preventive care. If primary care is to excel in this endeavour, patient voices need to be heard and there needs to be patient 'buy-in'. Without listening to these concerns we are at risk of rolling out expensive initiatives that prove fruitless because of lack of participation by the very people they are designed to assist.

Author

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