

Diabetes and compliance to treatment



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\n[[Table of Contents](#)]\n

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1. [Introduction](#) \n \t
2. [Summary of Patient's condition](#) \n \t
3. [Psychosocial analysis of diabetes management](#) \n \t
4. [Theories of compliance](#) \n

\n[/toc]\n \n

Introduction

In spite many years of study into compliance, the questions about why patients do or do not take medicines and what should be done to change this behaviour still remains (Ross et al, 2004). Managing patients with diabetes medically, should be a dynamic collaboration between the patient and the clinician (Kaye et al, 2009). In order for an optimal outcome to be achieved, a number of systemic factors, such as knowledge of disease condition of patient by the clinician, accurate communication between patient and clinician, and the understanding of information passed on to the patient by the clinician (Kaye et al, 2009) should occur. Prescription of medicines is a common intervention in healthcare, and the appropriate use of prescribed medicines is fundamental to the self-management of nearly all chronic illnesses (Horne et al, 2005).

Medical non compliance can be a complex problem, especially for patients with chronic illnesses. Some studies of non compliance have indicated that about ten to ninety percent of patients do not fully follow their clinician orders, most researchers agree that at least half of all patients do not take

their prescribed drugs correctly (Breslow and Cengage, 2002). The rate of noncompliance is as high as fifty percent in patients with chronic conditions (Ross et al, 2004). Many factors might influence a patient's judgment over compliance; these may include fear of complications of diabetes, lack of knowledge with regards to disease condition, improvement in health, worsening health, disapproval of medicines and distress over side effects (Ross et al, 2004). For some patients the fact that they have no symptoms with diabetes and feels well may encourage them not to comply with treatment.

Non compliance to medical intervention is a major public health problem which increases the financial burden on modern health care system (Vermeire et al, 2001). However the rate of compliance for preventive health behaviors has been identified to be lower than those behaviors requiring long-term management of chronic conditions (Breslow and Cengage, 2002). The concept of adherence instead of compliance has been introduced to revolutionise the way in which doctors and patients interact over medications and treatments. This highlights the importance of patients and clinicians working together to achieve a healthy outcome (Ross et al, 2004).

This paper focuses on a case of a patient admitted to the ward with a diagnosis of high blood glucose (hyperglycaemia) due to noncompliance. The concept of compliance and adherence has been discussed and some theories such as the health belief models perspective of compliance have also been explored. Causes of noncompliance and the role of the clinician in achieving optimal compliance have also been discussed.

Summary of Patient's condition

An 80 year old patient was admitted to the ward with a diagnosis of high blood glucose (hyperglycaemia) and uncontrolled diabetes due to non compliance to treatment regimen. She had been brought to the ward after she visited the surgical out patient department, for assessment for a total knee replacement operation. During the assessment it was found out that her blood glucose was extremely high, so much so that the procedure could not be carried out unless her blood glucose level has been restored to normal. Patient was accompanied to the ward by her daughter who confirmed that her mother had not been compliant with her medication. According to her daughter, her mother has changed three general practitioners (GP) because they had all diagnosed her of having diabetes. Patient claimed it was all in the doctors heads and she was fine. She claimed she was eating well and has been rather fit all her life and there was no way she could suffer diabetes as it was not in her family.

Her current GP also diagnosed her with diabetes , and prescribed insulin injections for her which according to daughter, patient complied only for a week and stopped because she did not like them and found doing finger pricks to check her blood sugar before administering the insulin very painful. Since then she was referred to the diabetic nurse who tried her on tablets, but still patient refused to take them.

Two weeks prior to admission, patient had been eating takeaways and dinning out every night. According to patient, it was the anniversary of her husband's death and she has been eating out in memory of her husband. The daughter said, her mother only agreed to come on admission because

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she was told at the assessment unit that the only time her knee replaced will be done, was if her blood glucose was controlled. Which patient is keen in getting done because she lives alone and likes to be independent, though daughter lives a few yards away. She finds the pain in her knee limiting and unable to move about easily, do gardening or go shopping.

Psychosocial analysis of diabetes management

Nurses and most practitioners are used to viewing diabetes clinically, however with a newly diagnosed diabetic; concerns may not be with diet or insulin therapy, but sometimes something more fundamental (New nursing skills, 1985). A patient, who has been advised by any health professional regarding blood glucose levels, sees it as been required to change some aspects of their lives and behavior (Shillitoe, 1988). Changes required to manage diabetes such as, checking blood sugars at specified times to obtain feedback on blood glucose levels, eating specified amount of food to obtain optimal body weight, Taking medication in the correct dosage at a particular time to control blood glucose and Taking exercise to improve and maintain good physical condition (Shillitoe, 1988), can all be seen as a threat to the lifestyle patient is accustomed to. It is hoped that these changes will yield a restoration of normal blood glucose level. However unless a patient does these, outcomes can not be achieved. It is essential that patients not only grasp the information and instructions given to them by their clinician, but should also comply with these instructions (Kaye et al, 2009). Compliance to treatment is thought to be the process that can lead to an outcome in medical care, therefore non compliance with a therapeutic regimen can

negatively impact the clinical outcome of the disease condition (Virmeire et al, 2001).

To help a newly diagnosed patient cope with diabetes, practitioners have to develop not only their clinical knowledge but also a practical understanding of how the disease condition affects the social life of the patient (New nursing skills, 1985). In diabetes care, patients may tend to resist therapeutic regimens because, they want to control their daily eating and living, they are not sufficiently educated on diabetes management, or have different perceptions about their diabetes management based on the cultural beliefs (Lutfey and Wishner, 1999).

It is therefore not acceptable for the clinicians to diagnose the patient with hyperglycaemia due to non compliance without looking at other factors that are likely to come into play. This diagnosis only makes the patient solely responsible for the state of her diabetes. It appears to mean that the patient would have had her glucose levels controlled had she accepted the diagnosis and followed the treatments prescribed by the GP. But compliance behaviour can not be explained by means of understanding one or more underlying variables (Rietveld and Koomen, 2002). Compliance to medical advice is seen as the extent to which an individual's behavior corresponds with the clinician's advice; this includes taking medication regularly, attending follow-up appointments, and observing a healthy lifestyle (Breslow and Cengage, 2002). Although this may have positive health benefits, many patients fail to comply with medical advice for reasons best known to them (Breslow and Cengage, 2002).

The term compliance has been strongly criticized as it is thought to portray a negative image of the relationship between patient and the clinician, whereby the clinician issues orders and the patient just follows the orders (Horne, 2006). Noncompliance is therefore interpreted as deliberate, self-sabotaging behavior or inability to follow instructions (Horne, 2006).

Compliance is not only restricted to medicines or healthcare settings. In the outside world, clients do not always follow professional advice. Even though they do not have the expertise claimed by their advisers, they always balance advice with their beliefs and information from different sources before they decide (Shillitoe, 1988). Therefore a patient is at perfect liberty to reject advice from a healthcare professional. Glasgow et al (1985) have long advocated for the replacement of the term compliance with what they call levels of self care behaviours. This they say avoids the derogatory implication of compliance as doing or not doing as one is told and the portrayal of adherence failures as the sole responsibility of the patient. Moreover making patients entirely responsible is misleading and reflects a lack of understanding of how other factors which affects patient capacity to comply with treatment (Salud, 2003).

Adherence is introduced in an attempt to identify a patient's choice and to eliminate the concept of blame (Horne, 2006). It acknowledges the need for patients and doctors to work together, and appreciates that some opposing views can potentially occur between patients and health care professionals (Horne, 2006).

Lutfey and Wishner (1999) assert that using the word compliance suggests patient's yields to clinician instructions. This implies conforming to medically

defined goals without question. However adherence, alternatively, takes into account the complex nature of medical care by portraying patients as superior, intelligent, and autonomous individuals who takes active roles in defining goals for their own care (Lutfey and Wishner, 1999). Horne et al (2005) also explain adherence as the degree to which the patient's behaviour corresponds with agreed recommendations from the prescriber. This has been approved by many as an option to compliance, because it emphasises patient's freedom to adhere to a clinicians recommendations. However, failure to do so does not give a reason to blame the patient. Adherence extends the definition of compliance by emphasising the need for agreement between the patient and the clinician (Horne et al 2005).

Nonadherence on the other hand can be a hidden problem, mostly not revealed by patients and unrecognised by professionals (Horne et al, 2005). It can stop patients from benefiting from the best treatments available which can particularly be a problem with the management of chronic medical conditions, such as diabetes (Horne et al 2005). The patient can agree with the clinician and choose their treatment, but it does not guarantee that patient will adhere to treatment. Besides the knowledge of the patient regarding the disease condition may be limited, and the appropriateness of patient choice will have to be brought into question. It has to be said though, that in the case of the above patient both terms can not predict her behaviour towards the treatment regimen. Replacing compliance with adherence does not change what the patient thinks of her susceptibility to diabetes. In the end if the patient had to change GP's and still will not accept her diagnosis then the term will not make any difference.

It is estimated that diabetic patients have fifty percent chance of having surgical procedures during their life time (Ellenberg and Rifkins, 1990). The complications of diabetes are important as they may not only cause preoperative morbidity but are also the reason for most of surgeries undertaken (Ellenberg and Rifkins, 1990). Surgery and anaesthesia have profound metabolic effect by exacerbating insulin deficiency in diabetes (Ellenberg and Rifkins, 1990). The poorly controlled diabetic will be in a state which will amplify the effects of the surgery leading to increase risk of infection and delayed healing (Ellenberg and Rifkins, 1990). Based on these risks a knee replacement surgery at the time of assessment could not be carried out with such levels of glucose in the patient's blood. All these risks makes nonadherence bewildering to the clinician, however it often represents a legitimate response from patients due to their own perceptions and experiences including concerns about side effects of medicines (Horne et al 2005). Patients therefore try to balance perceived concerns and priorities, which subsequently impacts their adherence to treatment. And in the case of the patient she found the needle pricks from the injections and testing her blood glucose very painful. Also she had her own beliefs, attitudes and expectations that influenced her motivation to persist with the treatment regimen. However she was keen to have her knee replacement surgery because she was keen on getting her independence back.

Theories of compliance

There is no single theory that adequately explains compliance; however the health belief model and social support are deemed the most influential (Rietveld and Koomen, 2002). The health belief model explains the different

perceptions and beliefs about health and illness and how it impacts on behaviours such as compliance (Kelleher, 1988). The Model sees behaviour change with regards to health based on a balance between barriers and benefits of action (Munro et al, 2007). It hence predicts compliance to be dependent on factors such as the level of patient's interest on health issues in general, their vulnerability to the related disease and its complications, Perceived seriousness of the disease, cost and benefits of adhering to therapeutic regimen (Kelleher, 1988). The Model is therefore a framework for motivating a positive action in people, which hinges on the desire to avoid a negative health consequence as the key motivating element (Recapp, 2009). Therefore a patient who manages their diet, monitors their blood sugar and takes medication to avoid complication of diabetes fits the model perfectly. This is because they are motivated by the negative health outcome of diabetes. This model however applies partly to the patient in the sense that she has agreed to comply with treatment to regain her independence by having her knee operation done. She is only motivated by the fear of loosing her independence which is a negative consequence, however she does not feel susceptible or perceive her diabetes to be serious based on her beliefs.

Although a patient beliefs about their condition do not always explain compliance, the health belief model suggest non compliance may be intentional as patients tend to weigh up cost and benefit of complying with treatment with reference to their beliefs and other valued aspects of health (Kelleher, 1988). Intentional nonadherence can result from the beliefs, expectations and attitudes that influence an individual's motivation to start and persevere with the therapeutic interventions (Horne et al, 2005). The

above patient does not even believe she suffers from diabetes because of her family history.

Factors such as marital status, social class, social isolation, and education have been linked to noncompliant behavior (Lutfey and Wishner, 1999). It has also been suggested individual emotional response to illness can also encourage maladaptive behaviors such as denial leading to non compliance (Ross et al, 2004). In the case of diabetes noncompliance is also related to patients' ability to understand treatment regimens and the general willingness to know about diabetes (Lutfey and Wishner, 1999).

support from family members is usually recommended to aid compliance, however patients who feels their symptoms enhances affection and assistance from others can choose not to comply to induce affection (Rietveld and Koomen, 2002). Even so support from family may often make compliance unpredictable as these supports tend to fluctuate (Shillitoe, 1988). Support is generic, some may imply that support means been socially integrated happily married or having strong family bonds, but can the presence of a badly controlled blood glucose strengthen and secure social ties or have a deleterious effect on relationships? Whichever way support maybe defined, giving practical help such as reminders of medications, assisting with meal planning are all important in keeping to diabetes regime (Shillitoe, 1988).

CLINICIANS ROLE IN ACHIEVING OPTIMAL PATIENT COMPLIANCE

Adherence to treatment is unpredictable, a patients previous adherence behaviour maybe the only good indicator for future adherence; however this

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can even change (Breslow and Cengage, 2002). The health care professional can enhance adherence by tailoring treatment regimen to suit the needs of the patient and identifying behavioural cues, as well as encouraging family support (Breslow and Cengage, 2002). Due to the multifactorial nature of adherence, strategies to encourage adherence should focus on factors such as knowledge, beliefs, subjective norms, environmental and interpersonal relationship between the clinician and the patient and family (Breslow and Cengage, 2002). Good communication between the clinician and the patient is also important to the subsequent behaviour of the patient (Shillitoe, 1988). Communication skills need to be taught and the clinician ought to learn, to ensure effective communication the clinician has to engage in friendly talks with the patient, paying attention to patient feelings and worries and not just concentrate on medications, diet and symptoms management (Shillitoe, 1988).

Education of patient enhances the general understanding of the patient on the importance of the disease condition and medical management (Breslow and Cengage, 2002). However since information and increased knowledge does not guarantee adherence it is necessary for the Health care provider to employ a combination of verbal and written instruction to ensure adherence (Breslow and Cengage, 2002) especially individuals with low literacy skills often benefit from educational messages which a tailored directly towards treatment, purpose of medication, frequency and dosages (Breslow and Cengage, 2002).

CONCLUSION

As explained above medical non compliance is a complex problem and can not be explained by considering one or two factors. The term adherence is more suitable however it can not even aid in predicting the behaviour of some patients. The clinician will have to use a multifactorial approach in helping the patient to achieve an optimal outcome.