Adherence to Treatment in the Elderly

Olivia Gomes, R.N., M. Bioethics

Abstract
Despite the majority of the elderly patients not being ill or dependent, the Portuguese population's aging raises challenges which can't be ignored. With age, the probability of any physical, mental or social dependency increases. The elderly present more difficulties to adhere to pharmacology treatment regimen, introducing major inefficiencies in the health care system. The professionals need to be familiarized with the client and assure themselves that he is well informed about his clinical situation. The nurse must understand treatment adherence and define intervention programs focused on the client, accepting him as a partner in care to obtain gains in health.

Key Words: elderly, adherence, pharmacology, prevention, patient and family teaching, research, professional research, polypharmacy, accidents.

The demographic aging is a phenomenon observed in many countries of the world, particularly in Europe. Progress in the prevention, diagnosis and treatment of many illnesses caused a large decrease in infant mortality and an increasing number of people reaching advanced ages, especially the group with more than 80 years. Today is also a fact that the elderly contribute heavily to the health care consumption and respective cost. According to Oswald (2001), it is estimated that individuals over 65 years, 15 to 20% of the population, consume 30 to 40% of all health care, representing the recipients of one-third of all the medical and nursing acts including consultations, hospital admissions, complementary examinations, rehabilitation and physiotherapy, medicinal prescription book, among others. The medicines consumption by elderly clients, to which Higgs called polypharmacy, is highlighted as an important problem in the structure of the National Health Care Service to have high incidence of iatrogenic and medicinal interventions.

Corroborating Nilsson (2001), reinforces that the repeated instances of relapse and the extension of the treatment period with long hospitalization leads to an avoidable suffering and to substantial increased costs, making treatment adherence a key factor of the therapeutic success. Adherence is understood here as the level of agreement between the recommendations of the health care professional and the client’s behaviour regarding the proposed treatment regimen (Ramalhinho, 1994). However, for Gallagher, Viscoli and Horwitz (1993), the elderly often has a poor rate of adherence by not following properly the therapeutic measures. The non-adherence is probably the main cause of therapeutic failure, introducing inefficiencies in the health system by the increase of morbidity and mortality.

In 1980 Buckalew and Sallis cited by DiMatteo and DiNicola (1982), estimated that, of the 750 million new prescriptions each year in the USA, there were 250 million cases of non-adherence, which led to an annual loss of hundreds of thousands of dollars. Haynes
(1979, identified 250 factors responsible for non-adherence, in which were included family factors, lack of resources and even the colour and size of the medication. These initial studies pointed to the lack of perception of the health care professionals in assessing their clients’ level of adherence and began pointing out other consequences of non-adherence to medical recommendations: the mortality rate; the large number of medical consultations; the absenteeism; the increase of social security costs and family problems.

For Bond and Hussar (1991), the non-adherence to treatment is a problem shared by almost all illnesses (on average, 40% of clients do not adhere properly to treatment) and given the diversity and complexity of behaviours we can find, it becomes even more difficult to determine precisely the non-adherence level to the therapeutic regimen. In spite of Nilsson (2001) considering that it is in treatment adherence of long duration that the adherence problem is felt, which is most often below 50% and because the current adherence does not predict the future adherence. According to Delgado and Lima (these authors validated for Portugal in 2001 a measure of adherence) it is still unknown in Portugal the existence of global data on the problem of adherence, although there do not seem to be reasons to believe that the problem of non-adherence to treatment in this country has a less severe impact than elsewhere, as many factors, particularly on the elder, are facilitators of non-adherence, as the need to comply with the treatment programmes; the chronicity of the illness; therapeutic complexity; the accompanying in consultations; the acquisition and take of the prescribed medication; the meet of diet or the practice of physical activity; treatments that interfere with the old habits and also social isolation.

Should also be mentioned, according to Guerreiro (2003), that many aged people live alone, representing 51% of people living alone in Portugal as a result of the depopulation that occurred in the countryside and the generalised process of population aging installed practically throughout all national territory. The same is true for older adults, suggesting the continuity of the processes that lead to residential isolation in the older generations and demanding a more careful intervention on how to look at the elder and to his family, socio-economic and cultural background. On the other hand, the effectiveness of early interventions aimed at changing the non-adherence behaviours was not visible, because these are focused on the clients’ duties and the professionals’ technical knowledge. The threat centred on the pathology, was also ineffective in the evaluation of the causes of non-adherence. Beyond the fact that, yet today, the communication between health care professionals, especially among doctors and nurses, is much more focused on the passing of information than on the knowledge of the client’s expectations about the clinical encounter; the customer’s significance about the illness; the client’s expectations about the treatment; the client's perception of the costs and risks of the treatment versus benefits; the level of the client’s knowledge on the skills and practices related to health; the level of the client’s adaptation to the illness; the client’s sense of hopelessness and lack of self-efficacy; the involvement and significance of the family (Santos, 2001). Many are the authors that advise these professionals to take into consideration the way how clients subjectively experience and understand their own illness, in order to make their attending more efficient.

Some studies have sought to understand adherence using cognition and transactional models focusing on the individual meanings of health and illness processes. Especially
in the promotion of prevention behaviours of the illness, of health maintenance and rehabilitation. Leventhal and his colleagues (1980) created the Model of Illness Representation, defining five structural components which together determine the psychological representation of the illness: the identity; and causality; the duration; the consequence and the cure. Ley (1981, 1989) cited by Ogden (2004), developed the Model of Cognitive Hypothesis of Adherence, emphasizing the comprehension, the memory and the client’s satisfaction regarding the information that is provided and ensuring that the client wants information on his illness, treatment and the risks associated. However, it seems that the health care professionals (doctors and nurses) do not satisfy their clients’ needs for information, or because they do not provide it or because they do not ensure that it is transmitted in a way to be understood and remembered by the person.

Melo (2005), also confirmed in her studies that the clients who are more informed about their medical condition (diagnosis and surgery) presented a higher level of satisfaction, in face to the information they held about the same during the period of hospitalization. Adding this study that more than half the sample did not have much information on their clinical situation, 56.1% regarding the diagnosis and 62.8% regarding the surgery. For the author, this may be because the health care professionals are not doing their duty to provide information to the client or the information that the client had was not the most complete or the most appropriate.

Pointing as one of the reasons for clients not being informed, the predominance of the biomedical model in the practice of health care, and advocating an integrated approach of the client in view of the holistic model, that supports a systemic or multidimensional approach, where the emotional, behavioural and social processes are jointly implied in the development, evolution and prognosis of the illness.

Moreira and Araújo (2002) sought to understand adherence through King’s model, realizing that despite the great need for treatment adherence, it is not always perceived as so by clients, who have their own perception of the illness, by not taking proper cautions and pointing as main difficulties the lack of time; the quickness of medical consultations; the communication with the health care professional and the excessive stress in the contact with some relatives. This study has also reinforced the importance of the clients’ participation in the treatment and the need for a holistic approach, highlighting the involvement of the family.

One of the characteristics of the nursing models is the belief that the individuals have the right to be involved in the decisions taken about them and about their future. For Orem (1980), the client has the right to be involved in the choice of what will happen to him, the freedom to identify his own needs and decide how they will be met. Most of the models support the partnership, the ability to teach, motivate, communicate, as well as an understanding of psychology and sociology, as the techniques and knowledge that nurses have to develop for nursing practice. Nowadays, nurses are strategically placed within the multidisciplinary team, both institutionally and domiciliary, and naturally as privileged elements in the accompanying of the client throughout his therapeutic process. Dunbar-Jacob (1999), defends the nurses’ contribution in their role as educators, defining five strategies to be used by them to ensure that their clients take the medication correctly, this is, assess difficulties in following the therapeutic table; start
the teachings during hospitalization; know the client's life; promote self-monitoring and continue to monitor the client after hospital discharge. Indeed, understanding adherence is to accept the client as partner in health care, being the client's action decisive for the promotion or protection of his health, for the prevention or treatment of his illnesses.

REFERENCES


