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FOCUS-GROUP AS A QUALITATIVE METHOD FOR STUDY OF COMPLIANCE IN CARDIOVASCULAR DISEASE PATIENTS

Preamble

Patient's nonadherence to treatment is one of the most serious issues for modern medicine. WHO experts in the guideline [6] thoroughly analyze the reasons for poor adherence to long-term therapy and outline a wide range of factors influencing adherence to long-term therapy. At that it is emphasized that none of those factors is decisive. It appears to us that all reasons for noncompliance should be divided into two large groups: intentional (or deliberate) and unintentional (unwitting) actions of the patients [3]. One of the reasons of noncompliance can be patient-physician misunderstanding or patient's lack of trust a patient in his/her physician [1, 6].

A focus group could be defined as a group of interacting individuals having some common interest or characteristics, brought together by a moderator, who uses the group and its interaction as a way to gain information about a specific or focused issue and/or motivation for certain actions [2, 4]. Focus-group normally consists of 7-12 individuals who do not know each other [1, 5]. If the number of participants is smaller – it is impossible to gain verifiable information in view of the lack of individuals. If the number of participants exceeds twelve there is not enough time for everyone to speak out. The participants should have some common characteristics which have relevance to the focused issue [4]. An important advantage of this method is that many unconscious attitudes are uncovered during the interview and become conscious over the course of interaction [4].

Study Goal

To study the reasons influencing patient behavior and patient adherence to long-term therapy by means of focus-group interview.

Methods: The study took place in January and October 2012. It involved patients with chronic cardiovascular disease. Altogether 6 groups of patients were interviewed. Three of them comprised of the patients who participated in various clinical studies (conducted in different medical centers of Saratov) for cardiovascular disease: coronary artery disease (CAD), chronic heart failure (HF), arterial hypertension and followed all recommendations of physician (hereinafter referred to as focus-group №1). Three other groups consisted of patients with multiple hospitalizations for cardiovascular events, who were hospitalized again to the Cardiologic Department of Clinical Hospital due to exacerbation of cardiovascular condition, who partially followed, or at times completely ignored out-patient therapy after discharge from hospital (hereinafter referred to as focus-group №2).

All patients who participated in this study were selected by their attending doctors. The number of persons per group varied from 7 to 12. Each of 6 groups was interviewed in turns with the help of moderator (experienced qualified sociologist, without medical education, who did not know the patients). Interviews lasted for about 1.5 hours and were video and voice recorded.

The questions covered the attitude of the patients towards their condition, their awareness of their condition, therapy, participation in medical decision making, motivation for treatment, adherence to therapy as well as patient-physician interaction. All questions were direct. Medical researcher (with rich background in the area of compliance to long-term therapy) followed on-line broadcast of the interviews and proposed additional questions to the moderator via texting or notes submitted through an assistant. Afterwards the interviews were taken down in shorthand. The results were discussed by the sociologist and medical researchers. All patients participated of their own free will and signed informed consent.

This study was based on assumption that noncompliance can be divided into intentional (or deliberate) and unintentional (unwitting) actions of patients [1].

Results

47 cardiovascular patients participated in the study. Median age was 59 years. Focus-group №1 comprised of 25 patients: 17 (36.2%) men and 9 (19.1 %) women, out of which 25 (53.2%) with arterial hypertension, 25 (53.2%) – CAD, 22 (46.8%) – myocardial infarction in the past, 23 (48.9%) – HF, 3 (6.4%) – acute cerebrovascular event in the past, 8 (17%) – chromic cerebral ischemia, 5 (10.6%) – atrial fibrillation (AF), 12 (25.5%) – obesity, 9 (19.1%) – diabetes mellitus, 11 (23.4%) – dyslipidemia. Focus-group №2 consisted of 22 patients: 8 (17%) men and 13 (27.7%) women, out of which 19 (40.4%) with arterial hypertension, 20 (42.6%) – CAD, 6 (12.8%) – myocardial infarction in the past, 19 (40.4%) – HF, 4 (85.1%) – acute cerebrovascular event in the past, 6 (12.8%) – chromic cerebral ischemia, 8 (17%) – AF, 12 (25.5%) – obesity, 5 (10.6%) – diabetes mellitus, 5 (10.6%) – dyslipidemia. It should be noted that the patients from the first group consented without any problems whereas the patients from the second group were less willing to participate. The groups were quite comparable. There were more patients with myocardial infarction in the past in focus-group №1 (p=,00010).

Patients from focus-group №1 assume that their medical condition is their «Fate» or «Catastrophe». The first cardiovascular event was deemed by the patients as «accident» and they were certain that they were «healthy» but reoccurrence of the condition made them realize how serious their condition was and now the think of their medical issue as «a way of life». Information about their condition is important but only in the amount that allows them to react adequately to the changes in their well-being, to feel comfortably (which pills to take, who to call in case of emergency). They do not want to know more (concerning the meaning of the condition, therapy options) – «ignorance is bliss». For the patients of this group the most important part of therapy is their interaction with their physician. They take this interaction in terms of complete, absolute trust in their physician and subsequently they completely rely on physician's opinion in medical decision-making. For them – participation in clinical study means constant control and attention from their physician, health care, «hope for the better», complete trust not only in their physician but in prescribed medications (even placebo «may be of help»). Clinic staff members for them are professionals («Jacks of all trades»). At the same time they do not deny their special sympathy and attachment to a specific physician. In emergency situations they can seek help from another medical researcher, if «their own» physician is unavailable. But they prefer only their regular

physician for long-term therapy. Most of the patients of this focus-group took decision to receive long-term therapy within the framework of clinical studies due to unwillingness to receive therapy in out-patient medical institutions and unavailability of «the same level» therapy, because there are waiting lists, queues and very limited time for interaction with the physician. The patients from this group observe with reverence not only the medication intake routine but day routine and follow-up examinations for clinical study program («it's not much of a hassle»). Some difficulties may arise related to diet – especially for patients with diabetes. These patients are completely satisfied with their therapy. Long-term therapy for them is not only a way to longer and better life, but also prevention of complications and reoccurring events of their condition. Taking medications does not interfere with their life styles and prolongs their lives. Patients of this group emphasize important role of their families in therapy process.

These patients feel that the patients who do not follow medical recommendations have not yet experienced the moment in their lives that can make them reconsider their attitude towards their condition and realize its seriousness («Better never than late»).

Before presenting the results of the interviews with the patients from focus-group №2 it should be noted that the behavior of these patients varied a lot. Patients from the first two groups were characterized by their physicians as patients who were not taking medications regularly and who felt negatively towards therapy. These patients also felt negatively about the interviews. Patients from the third group were characterized by their physicians as patients who were taking therapy regularly but who confessed during the interviews that they did not follow all recommendations. These patients were very similar to those who participated in clinical studies.

For the patients from focus-group №2 their condition is «another stage in their life», lack not only of health but limitations in their professional lives, physical activities, strain on the family budget, recreational limitations – to sum up «invalid life-style». Health in their lives is «not a priority»; priority is work («you should live by the last day»). Hospitalization for them is wasted time. Their condition makes them think that they can lose their job as the main source of income. They do not realize seriousness of their condition, preferring to think about it as temporary exacerbation. They are certain that after treatment they will return to normal life they are used to; they completely deny existence of chronic conditions. Therapy is over for them once they feel better and begins again when they feel worse. These patients state that they would like to know more about their condition in order to overcome it, prevent complications but they do nothing for this and take no efforts to get such information. They justify their laziness by lack of time in view of work, everyday problems, forgetfulness and absence of continuity between hospitals and out-patient services, lack of information provided by out-patient physicians, poor quality of out-patient health care or its absence; they complain that out-patient physicians are «inexperienced», «not caring», «not interested». Patients from this group are not satisfied that there is limited time for patient-physician interaction («you can't do much for 7 minutes»), meaning they are not satisfied with the way this system functions. The change from the hospital to out-patient services is «one long ordeal». Even when their conditions gets worse they do not seek help from out-

patient services but prefer hospitalization. Patients were asked why they seek therapy. Besides out-patient polyclinic services there are other options – private clinics, consultation services. Why they do not look into other options is they «want» therapy? The response was «You need financial resources to seek help from consultation services, to pay for this, one must work and if you work there is no time for health». That is their vicious circle and the fault is not theirs but out-patient physicians'. Patients of the first two «unreliable» groups stopped at that. They took all responsibility for everything off themselves and emphatically and even aggressively refused to talk about it despite all efforts of the moderator. During the interviews with the patients from the third group it became clear that their noncompliance is conscious and marked by laziness, carelessness, nonchalance or, on the contrary, excessive selfishness.

Taking medications for most patients is linked with fear to get addicted and gain «a bunch of other health issues» – «fix one thing and break another». Feeling bad and invalid life-style is their motivation for long-term therapy. These patients state that they want to cooperate with their physician, take part in medical decision-making, but out-patient physicians «do not inspire confidence»; they feel hurt because they are not understood and subsequently refuse to receive therapy. They would be satisfied with therapy process if they could get sufficient information about their condition, regular control, if the out-patient physicians were more careful and attentive. To the question «If you were offered to participate in clinical study, where you were provided with sufficient attention and control – would you agree?» the patients from the third group answered positively.

Discussion in both groups was focused on conscious compliance with medical recommendations i.e. conscious continuation of long-term therapy. High rate of routine observance in the first group (i.e. low rate of missing medication intake) is related to conscious willingness of the patient to receive therapy. The issue of how regular the patients from the second group took medications was not discussed because they refused follow-up therapy.

Discussion

There is certain dynamics in how chronic condition patients feel about their condition [5] and this was uncovered in our interviews. Patients from both groups show successive change of clearly defined stages [5] in terms of their attitude towards their condition: premedical phase, stereotype breaking phase, phase of adjustment to condition, surrender phase, phase of establishing compensatory mechanisms to adjust to life. Only the patients from focus-group №1 completely experienced and lived through theses phases whereas the patients from focus group №2 are somewhere between stereotype breaking phase and surrender phase. Patients from the first group show adequate and calm reaction to their condition, they unconditionally trust their physician, follow all medical recommendations and are grateful for help. Patients from group №2 show negative and destructive reaction; they either do not take recommendations seriously or completely ignore them, all that leading to adverse consequences in the future. Patients of this group are most likely something between ergopathic and anosognostic types – they want to be able to work and try to ignore thoughts about their medical condition.

All patients show signs of paternalistic model of physician-patient interaction i.e. physician is the main part in therapy and someone who takes all responsibility. Trust is physician is absolute and patents are willing to do everything they are told by their doctor. But this model functions differently in study groups. The patients from the first group end up following all recommendations and the patients from the second group feel that they had not received adequate help in a polyclinic, their trust had been undervalued and subsequently they end up refusing follow-up treatment.

Patients from both groups emphasized that out-patient polyclinic physicians lack time for physician-patient interaction. Of course patients' complaints about physicians and health care system can be justified by polyclinic work overload, understaffed clinics, red tape, lack of necessary equipment but these complaints lead to utterly negative clinical and economic problems.

There are certain personal characteristics related to social skills of the patients in both groups. Patients participating in clinical studies – are intelligent, quite easy-going people with good communication skills. First two groups of focus group 2 are «unreliable», marked by internal personal attitude and negative attitude towards therapy since the very beginning. Patients from the third group are similar (in terms of personal characteristics) to the patients who participate in clinical studies. They are aware that the problem of not following recommendations is their own problem; they just have not yet met the right physician who would inspire them to follow long-term therapy recommendations even in clinical studies.

Cardiovascular disease patients' compliance depends on severity level and reoccurrence rate of the condition. Feeling of well-being encourages the patients from the first group to follow recommendations of the physician whereas the patients from the second group discontinue therapy.

Perhaps one of the factors that influenced the results of this study was that the patients for the second group were selected by their attending physicians. We can assume that these physicians intuitively divided patients into two groups: more and less sympathetic. This division can be considered as 'intuitive predictor' for compliance. On the other hand – prejudice of the physician about patients can inspire negative behavior of patients in the future.

Conclusion

All patients show signs of paternalistic model of physician-patient. The patients from the first group end up following all recommendations and the patients from the second group feel that they had not received adequate help in a polyclinic, their trust had been undervalued and subsequently they end up refusing follow-up treatment. Feeling of well-being encourages the patients from the first group to follow recommendations of the physician whereas the patients from the second group discontinue therapy. Much depends on the physician, on his/her willingness and ability to explain therapy, highlight key points and establish trust-based relations with the patient.

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