Adherence and Utilisation

Accepting the unacceptable: Medication adherence and different types of action patterns among patients with high blood pressure

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Objective: To gain deep insight into what it means for patients to live with drug-treated hypertension and to understand the implications for the doctors’ influence on patients’ adherence.

Methods: Group discussions with 43 drug-treated hypertensive patients. Documentary method was used for interpretative analysis.

Results: Four basic phenomena were identified (fear, ignorance, reluctance to discuss matters with the doctor, impact of illness experiences), which resulted in different types of action patterns: (1) the assertive actor, (2) the unconscious avoider, and (3) the inconsistent actor. The types of action patterns do not refer to any implications for adherence. The patients’ action does not indicate their preferred model of doctor–patient interaction or their acceptance of taking medication.

Conclusion: Adherence must not be seen as meaningless behaviour, which can simply be learned, but rather as the result of subjective experiences on living with hypertension and the ability to accept the diagnosis and its treatment.

Practice implications: It is premature to initiate therapy straight after the diagnosis, before the patient is prepared to take the tablets. Supporting adherence means to stay in dialogue and to give the time, privacy and patience to enable patients to overcome their inhibitions of asking and to accept the therapy.

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1. Introduction

Medication adherence is a major concern in health care research, especially in conditions such as hypertension where drug treatment is the key to prevent cardiovascular morbidity and mortality [1]. However, studies have shown that every third patient with cardiovascular disease including hypertension is non-adherent [2]. Adherence research has unsuccessfully tried to find clear correlations between fixed patient characteristics like age, gender, or education, and adherent or non-adherent behaviour [3].

Going beyond these socio-demographic variables, however, modifiable patient characteristics, i.e. behaviour and attitudes, have been shown to be barriers to medication adherence, e.g. forgetfulness, fear of undesired side effects, reservations towards drug taking, insufficient educational information and understanding about hypertensive drug therapy or drug holidays [4–7]. Nevertheless, corresponding interventions designed to support the daily medication intake such as fixed dose combinations, health education, reminders, or regular self-monitoring still show limited benefit [8]. This failure may due to the idea of adherence as the predictable behavioural result of the interaction of verified internal and external factors. Some authors discussed medication adherence rather as the result of a decision making process – both conscious and subconscious – and too complex to be easily predicted [9,10]. Assuming that adherence is the result of complex psychosocial and cognitive procedures, we consequently do not define it as behaviour, but as motivated and meaningful human action, which needs to be understood.

Beside correlations between fixed and modifiable patient characteristics and medication adherence, the impact of the doctor–patient relationship has been brought into focus: In 2003, the WHO stated in the adherence report, that “health providers can have a significant impact by assessing risk of nonadherence and delivering interventions to optimize adherence [...] For empowering health professionals an ‘adherence counselling toolkit’ adaptable to different socioeconomic settings is urgently needed. Such training needs to simultaneously address three topics: knowledge (information on adherence), thinking (the clinical decision-making process) and action (behavioural tools for health professionals).” [11]. However, this statement calls for a patient-centred interaction with
only limited research findings about the patients’ perspective of experiencing hypertension and the relevance of doctor–patient relationship perceived by the patients themselves.

Our study aims to fill this knowledge gap by referring to a deeper insight into the patient perspectives on living with drug-treated hypertension and the meaning of the doctor–patient relationship within the therapy. We intend to reconstruct and to understand the underlying motives of patients’ action, i.e. the subjective sense of action, instead of just reporting their behaviour. Thus, we will not try to find issues which are able to influence the patients’ behaviour, but give the chance to understand the patients’ sense of action.

As people are not always aware of their motives and the resulting action, a promising way to collect data and understand issues relevant for patients with hypertension involves the method of group discussion for data collection and the documentary method for analysis. Both methods were established by Bohnsack [12,13] and refer to Karl Mannheim’s theory of the specific immanent meaning of a discourse. According to this theory, people with similar biographical experiences are able to understand one another without interpreting what is literally communicated. While the underlying meaning of the communication is often subconscious and therefore non-communicable the documentary method of analysis, however, allows us to analyse these underlying meaning patterns beyond the literal content by an interpretative approach.

2. Methods

2.1. Context and setting

This qualitative study was accompanied by a quantitative study in primary care which focused on the psychometric quality of self-ratings for medication adherence in high blood pressure. Patient recruitment for this quantitative study was also the basis for the qualitative study and is described in detail elsewhere [14].

Several groups were assembled in order to offer study participants the opportunity to discuss their illness experiences initiated by open-ended questions about the medication intake behaviour of patients with hypertension in general.

All participants gave informed consent. The research ethics committee of the University of Goettingen approved the study protocol.

2.2. Sampling

From the above-mentioned quantitative study, we had complete data sets from 761 patients with high blood pressure from 23 general practices in Goettingen and its catchment area. From this sample, we selected suitable participants for the group discussions. With regard to theoretical sampling [15], the final sample size was assembled according to criteria with empirical relevance, such as age, gender, education, duration of treatment, or adherence. Inclusion criteria were the intake of at least one antihypertensive drug and the minimum of one consultation during the past 12-month period. In agreement with other studies, adherence was defined according to the ‘Hill-Bone Compliance to during the past 12-month period. In agreement with other studies, adherence was defined according to the ‘Hill-Bone Compliance Scale’ [16], the ‘Self Reported Measure of Medication Adherence’ [17], and a self reported blood pressure (with a cut off of $\leq 140/90$ mmHg).

2.3. Data collection

Groups were composed to ensure maximum homogeneity. This is essential for group dynamic and continuous discussion [13] and may motivate participants to “act as co-researchers taking the discussion into new and often unexpected directions” [18]. In particular, group homogeneity with respect to adherence and non-adherence, respectively, should encourage an unrestricted discussion about the participants’ tablet intake behaviour and avoid a social desirability bias.

Each group discussion was moderated by the same two researchers (G.M. and N.W.) and lasted about 2 h. The facilitators’ role was nondirective in order to give participants enough time and the opportunity to prioritise. To encourage discussion at the beginning, the participants were asked to discuss the following: “What do you think, from your own experience, would encourage patients to take antihypertensive tablets?” After discussion ran out, a second topic was introduced: “What do you think, from your own experience, would hinder patients from taking antihypertensive tablets?” As far as possible, all issues mentioned by the participants were visualized on a flip chart and each participant could refer to them at any time. Facilitators also revisited these issues in order to support the discussion in case of stagnation. Data collection was accomplished when saturation was reached, i.e. when further group discussions did not produce any new issues. This method did not follow a predefined concept of adequate drug taking behaviour, but allowed patients to speak with one another about the topics they considered most relevant using their own language.

2.4. Analysis

The group discussions were videotaped and transcribed verbatim (see Table 1); participants were pseudonymized (e.g. “1/3F” = “group 1, participant 3, female”). For the analysis, we used the documentary method according to Bohnsack [12,13], focusing on the patients’ collective orientation patterns by explicating the subjects’ intuitive understanding (meaning-contexts). Instead of exclusively analysing what is literally communicated, this method allows to differentiate between the level of communication and the level of implicit understanding. The implicit understanding within the group bases on what is shared “in their action practice” or what is shared “in their biographical experience” [12]. Thus, the documentary method uncovers the group’s collective experiences and therefore allows a deeper understanding of the underlying thought or action patterns. The interpretative process of analysis requires a two-step approach: (1) the formulating interpretation (i.e. what is said?) which refers to the patients’ action and thinking; and (2) the reflecting interpretation (i.e. how the topic is treated, in what context it is said) which refers to the underlying patterns.

Analysis was carried out by four of the authors (A.S.N., G.M., J.K., N.W.) trained in different disciplines (sociology, psychology, or...
Box 1. Example of the analysis process.

Transcript

3m: well, I think a relevant consideration would be also the poor explanations given by doctors so when I now hear on the one hand uh that it is- ah that the diuretic medication is taken in the evening without you knowing that ah that is

5f: (nods) mm, exactly

3m: *certainly a consideration* and for me a consideration was that- I was prescribed medication (1) Beloc-Zok then I first read about

GM: mmm

2m: (nodding) yes

3m: it in *Bittere Pillen* *(1)* that when you *discontinue it* there’s

6m: ah that thing yes

3m: the possibility of severe heart damage ((faster)) because of that I didn’t even start taking them you know, back then I was

6m: (nods) mm I understand

GM: mmm

3m: in my early *forties* and I thought ((faster)) I’m not not crazy and I won’t take them *a-all my life* i-i-if I must be afraid of that you know? and then I changed my doctor and he then told me

GM: mmm

1f: (to GM) I have never questioned it that way- my

3m: about all the *alternatives* there are uh?

1f: medication

6m: (nods) yes

GM: mmm

(Gr 1; Sequ 32; L 759–798)

Analysis

3m does not feel informed by his practitioner; therefore he falls back on other sources (e.g. books) and uses them in order to inform himself about the effect of his tablets instead of asking the doctor. The information in writing, from his perspective, gives the impression of being official and therefore provides more evidence than the doctor’s practical knowledge. This implicitly indicates the absence of faith in his doctor’s prescription practice. Further, the subsequent action (of changing the doctor) can be interpreted as reluctance to communicate with the practitioner about his newly acquired information on the unwelcome effects of his tablets. This seems not to be an appropriate option for 3m. It is rather likely, that the new practitioner initiated the counselling about “alternatives”. 3m interpreted both the doctor’s action and his knowledge about alternatives as medical competence and a required quality criterion. His complaint about the inadequacy of his former doctor clearly reveals uncertainty with regard to both the therapy and the doctor–patient interaction. By questioning “did I?” at the end of his narration, 3m is seeking to obtain positive feedback from the other participants or moderators in support of his action; a further indication of his uncertainty in conversational situations. Additionally and beyond this uncertainty to communicate, especially with his doctor, a restricted or absent acceptance of being treated can be shown. 3m talks about his age of 40 years which he interprets as too young to be diagnosed with hypertension. This non-acceptance intensifies the lack of trust in the doctor’s competence. 3m’s strong clarification “I’m not crazy” verifies his age as being a central problem. Further, it is implicitly shown, that 5f is afraid of taking over responsibility. Her reaction to the 3m’s discourse indicates a self-concept as a patient, who does not have to question the doctor’s competence. Thus, she does not take over responsibility but moreover she surrenders it to her doctor. From her perspective, it is for the doctor to decide what she needs to know or not; and for her, becoming an active patient would be useless. 3m as well as 5f assign a traditional role to the practitioner, which is also seen as a quality criterion. 6m’s reactions show implicitly his critical orientation and knowledge about standard sources of information. At this point, he supports 3m and demonstrates a negative pattern towards 5w. Within the group, he presents himself as competent enough to judge the source of information 3m mentioned before. Probably, his self-assessment is that of a person who is also competent enough to question a doctor’s decision. In this case, his actions would be based on balancing external information against those given by the doctor. 1f’s statement that she has “never questioned” her own medication 1f introduces a negative pattern to the critical orientation of 3m and 6m. Obviously, she does not share their mistrust. Without questioning her medication, she considers her doctor adequately competent, as 5f does. At the same time, she clarifies, that there is no need (or she has no wish) to question her doctor’s advice. The fact, that 1f does not take part in the discussion, but addresses her statement to the moderator (GM), can be interpreted that she, as well as 5f, may be reluctant to ask her doctor. Up to this point, the topic of reluctance has not been openly discussed in the group, so it might be difficult for her to mention her inhibitions at this point.

*Bittere Pillen* is a pharma-critical book in Germany.
The formulating interpretation was carried out by teams of two researchers each and required the sequencing of the discussion transcript and identification of discussion topics for each sequence. The whole research team selected 39 sequences for detailed analysis with respect to the research question. These 39 sequences ranged from 12 to 388 s and were interpreted line by line by two researchers at a time (reflecting interpretation). A third researcher not involved in the previous analysis step reviewed the interpretation and discussed the generated hypotheses with the two interpreters in case of disagreement. Interpretation was based on the approach of abductive reasoning, i.e. reasoning in which explanatory hypotheses are formed and evaluated within and in-between groups [19]. This method does not provide anchor examples to verify the results because they are developed in respect to the whole discourse. The process of analysis cannot be shown completely, but we give brief examples to illustrate the approach (see Boxes 1 and 2). The last step of the analysis was the formation of different types of action patterns on the basis of common features of cases. Additionally, basic phenomena in hypertensive therapy were found that were shared by all different types of actions.

3. Results

Saturation of data collection was reached after conducting eight group discussions with a total of 43 patients (age: 42–79; 20 females) from 19 general practices. Eighteen participants were classified a priori as adherent to medication treatment. In the course of the study, duration of treatment and age were shown to be additional relevant factors. For patients over 60 years of age, homogeneity according to gender was also important to ensure unrestricted talking. Table 2 shows the assemblage of the eight groups.

3.1. Basic phenomena in hypertensive therapy

Analysis revealed several phenomena which were relevant for all patients, including fear, ignorance, reluctance to ask the doctor, and impact of illness experiences. Even if we describe them individually in this paper, it is clear that they are influenced by each other in patients’ everyday life. These phenomena were sometimes verbalized by the participants themselves, others were

<table>
<thead>
<tr>
<th>Box 2. Example of the analysis process.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transcript</strong></td>
</tr>
<tr>
<td>5f: I think that one should not constantly measure because um then- then um then you say oh now it’s too high now you must must stay calm.</td>
</tr>
<tr>
<td>2m: yes for um in principle you’re right but(1) um</td>
</tr>
<tr>
<td>5f: you make yourself a little bit dependent on them</td>
</tr>
<tr>
<td>6m: m this m</td>
</tr>
<tr>
<td>2m: doing that but you should already be doing that regularly</td>
</tr>
<tr>
<td>6m: doing that you quasi have the blood pressure ((louder)) out of</td>
</tr>
<tr>
<td>2m: ((louder to 6m then to GM)) we’re not measuring it</td>
</tr>
<tr>
<td>6m: your life right?, you didn’t first ((more quiet)) go to the doctor</td>
</tr>
<tr>
<td>2m: constantly, not every ten minutes or every quarter hour, but</td>
</tr>
<tr>
<td>GM: ((to 2m)) mm mm</td>
</tr>
<tr>
<td>2m: mornings afternoons and (1) because my wife’s a high risk diabetic</td>
</tr>
<tr>
<td>also evenings</td>
</tr>
</tbody>
</table>

(Gr 1; Sequ 36–37, L 1094–1123)

**Analysis**

This sequence clarifies, that 5f – in contrast to 6m and 2m – tries to avoid being intensively and routinely involved in her high blood pressure management. This orientation is motivated by her wish to avoid the assumed danger of being ruled by blood pressure and its measurement. Obviously, she does not want to be involved in order to prevent herself from being uncertain or worried, as her words imply (“now must must stay calm”). By refusing to measure her own blood pressure, she evades these feelings. This can be interpreted as passive coping. Instead, 2m and 6m distinguish themselves as patients who accept their hypertension and the associated blood pressure measurements. They do not feel threatened by doing so. Moreover, and in sharp contrast to 5f, 6m believes that blood pressure self-measurement does not reflect the idea of being ill, but keeps the illness “out of life”, because he does not need to visit the doctor frequently. Furthermore, as mentioned in a prior sequence, he has discovered that home-measurements show a lower blood pressure reading. In this discourse sequence, we witness opposing orientation patterns: while 5f explicitly considers daily blood pressure measurement as unnecessary, for 6m home-based blood pressure measurement is indispensable. This shows, that 5f implicitly avoids being involved in controlling her blood pressure, while 6m prefers to take over responsibility for his hypertension management. For 6m and 2m, knowing the actual reading apparently imparts a feeling of safety, whereas 5f seems to be fearful of such knowledge. According to the participants’ arguments, both actions represent manifestations of different strategies to cope with hypertension-related fears.

3.1. Impact of illness experiences

3.1.1. Fear

Almost all participants showed fear of, or uncertainty with their diagnosis. Fear was in some cases framed by a particular idea or situation, e.g. to succumb to a heart attack or a stroke or to suffer from unwelcome effects from the medication. In other cases, fear could arise from the discrepancy of feeling healthy but being aware of the possible long term risks and undesired drug effects. This may be true for a person who has not felt any symptoms prior to the diagnosis, but is now confronted with a possibly fatal heart attack or stroke. Patients who were not aware of their fear sometimes tried to avoid talking about possible consequences or related the situation in which to talk about their questions or concerns. For example, a friend with hypertension who acts against medical advice by refusing to take tablets and still feels well might cause uncertainty of one’s own situation and the doctor’s recommendation.

3.1.2. Ignorance

Many participants talked about possible causes of hypertension and often tried to give an explanation for their condition. Some patients did not understand the doctors' difficulty in explaining the development of essential hypertension. For others, it seemed hard to accept being diagnosed with a chronic condition they could not even feel. The group discussions revealed further that patients knew little of the effects of their medication. Some did not know about the side effects at all; others did not feel any improvement from their therapy. Furthermore, some patients were unsatisfied with receiving pharmacotherapy and looked for, and sometimes used, alternatives including, for example, yoga.

3.1.3. Reluctance to ask the doctor

Patients indicated that they were reluctant to ask the doctor for information. They experienced the consultation as an unpleasant situation in which to talk about their questions or concerns. Therefore, they looked for alternative sources of information including pharmacies, patient information leaflets, books/journals, friends, the internet, and health insurance providers. In the sense of pre-emptive obedience, patients considered the doctor’s lack of time and felt obliged to keep the consultation short. In fact, they were uncertain about their right to ask at all.

3.1.4. Impact of illness experiences

Group discussions showed that severe events such as a heart attack or a stroke confirmed that hypertension is a risk factor for vascular diseases and led to concrete fear. After such an experience, the doctor's advice of taking antihypertensive drugs was more likely to be accepted and implemented. Self-experienced events had a higher impact than those of others.

3.2. Types of action patterns

Three types of action patterns resulting from the above described phenomena, i.e. fear, ignorance reluctance to ask the doctor and illness experiences, could be developed: the assertive actor, the unconscious avoider, and the inconsistent actor. As well as the basic phenomena, these types emerged during the iterative process of interpreting the group discussions; a further example is given in Box 1.

3.2.1. Assertive actor

The assertive actor scrutinizes his or her doctors’ recommendations and interventions. He or she seeks any information about high blood pressure or medication. The attained knowledge is appropriate for a discussion with the doctor because the assertive actor wants to be informed and expects the doctor to act accordingly. During the consultation he or she seems to be interested in active verbal interaction and participation. The assertive actor can be a critical-active patient or an alternatively orientated patient. The first type accepts the diagnosis of high blood pressure and the standard treatment (i.e. lifestyle changes and standard medication) and takes responsibility for his or her condition by daily self-monitoring. Alternatively orientated patients, instead, look for alternatives to standard medical therapy (such as yoga or esoteric therapies) or adopt a different treatment option in parallel to drug treatment. These patients accept neither a long-term illness nor a long-term therapy and hope to recover. Although they seek alternatives autonomously, they want their doctor to take on responsibility for any kind of treatment.

3.2.2. Unconscious avoider

The unconscious avoider does not want to get any information about hypertension and accepts the prescribed medication. In the consultation he or she adopts a passive position and therefore seems not to have any questions. The unconscious avoider prefers the paternalistic model of the doctor–patient relationship. Emphasized faith in the doctor is essentially a synonym for ‘not getting involved’. Such a course of action may be facilitated by experiencing cardiovascular events. Within this type, our analysis revealed three subtypes: uncritical-conformed patients do not want to be informed by their doctor but want him or her to take on responsibility for their condition. However, they are not aware of their passive avoiding action. In contrast, uninterested patients have made a conscious decision not to engage themselves. Thus, they feel no need to ask the doctor or others for further information or to talk about their condition at all. Understanding patients do want to talk about hypertension with their practitioner, but it should be their doctor who initiates the dialogue and invites them to ask questions. Nevertheless, understanding patients want their doctor to accept responsibility, because they feel confident in the health care system and their doctor.

Table 2
Composition of the eight groups with 43 participants.

<table>
<thead>
<tr>
<th>Group</th>
<th>Number</th>
<th>Age in years</th>
<th>Sex</th>
<th>Education</th>
<th>Adherent</th>
<th>Duration of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6</td>
<td>41–49</td>
<td>Male/female</td>
<td>Heterogeneous</td>
<td>No</td>
<td>–</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>61–63</td>
<td>Male/female</td>
<td>Heterogeneous</td>
<td>No</td>
<td>–</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>52–70</td>
<td>Female</td>
<td>Higher</td>
<td>No</td>
<td>–</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>50–79</td>
<td>Male/female</td>
<td>Higher</td>
<td>No</td>
<td>–</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>62–69</td>
<td>Male</td>
<td>Lower</td>
<td>Yes</td>
<td>–</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>42–52</td>
<td>Male/female</td>
<td>Heterogeneous</td>
<td>Yes</td>
<td>–</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
<td>47–57</td>
<td>Male/female</td>
<td>Heterogeneous</td>
<td>Yes</td>
<td>&lt;3 years</td>
</tr>
<tr>
<td>8</td>
<td>6</td>
<td>42–56</td>
<td>Male/female</td>
<td>Heterogeneous</td>
<td>No</td>
<td>&gt;5 years</td>
</tr>
</tbody>
</table>

* As defined by the ‘Hill-Bone Compliance to High Blood Pressure Therapy Scale’ (see Ref. [15]), the ‘Self Reported Measure of Medication Adherence’ (see Ref. [16]) and having a self-reported blood pressure <140/90 mmHg.

3.2.3. Inconsistent actor

The inconsistent actor accepts the medication as an interim solution but does not accept hypertension as a lifelong condition. He or she sees the cause of hypertension in psycho-social conditions and therefore hopes to recover by implementing lifestyle changes. Thus, the inconsistent actor accepts responsibility for the cause of hypertension and the lifestyle changes. In contrast to the assertive actor he or she does not question the appropriateness of the medication. He or she wants to be informed but instead prefers to consult other sources such as the internet, books and television rather than ask the doctor. Like the unconscious avoider, the inconsistent actor therefore adopts a passive position in the consultation and appears not to have any questions.

4. Discussion and conclusion

4.1. Discussion

Our qualitative analysis of eight group discussions with 43 drug treated hypertensive primary care patients revealed basic phenomena of living with hypertension: fear, ignorance, reluctance to ask the doctor and the impact of illness experiences. These basic phenomena lead to three types of action patterns: the assertive actor with the subtypes of critical-active or alternatively orientated, the unconscious avoider with the subtypes uncritical-conformed, uninterested, or understanding, and the inconsistent actor.

4.1.1. Relevance of having hypertension

The patient perspective of hypertension clearly differs from that of professional health care providers. From the doctor's point of view, the pharmacotherapeutic breakthrough has limited the impact of hypertension to the prescription of the appropriate drug. For patients, the diagnosis of hypertension has major implications, such as living with a lifelong and life-threatening condition. The knowledge about the risk of suffering a heart attack or stroke was omnipresent and evoked fear in nearly all the patients involved in our study. Fear was a basic phenomenon in all different types of action patterns. This concrete or latent fear may be caused by the unpredictability of the individual course of the disease, a major concern in other chronic conditions such as relapsing multiple sclerosis [20] or juvenile arthritis [21]. In a recent study with women suffering from breast cancer this situation is called “living under the shadow of death” [22].

4.1.2. Relevance of being informed

Our study showed a level of ignorance in all study participants, but from the patients' perspective this knowledge gap is not consistently associated with an information need. The unconscious avoider wants the doctor to take on responsibility and therefore does not feel the need for information. Moreover, information may, at least in some patients, increase worries and uncertainties [23]. It has been shown that limited patient knowledge of hypertension as a risk factor are associated with lower medication adherence [24]. However, patient-centred information to increase knowledge does not necessarily influence medication adherence [25].

4.1.3. Relevance of the doctor–patient relationship

The modern ideal of the doctor–patient relationship is a model of equal partnership. Concepts such as patient empowerment, informed consent and choice, shared-decision making, and consumerism, mark the paradigm shift from paternalism to concordance [26]. This equal partnership demands a patient being willing and able to actively participate. However, empirical evidence reveals that reality in everyday practice is somewhat less ‘advanced’ [27]. Actually, our study showed the patient types unconscious avoider and inconsistent actor both adopting a passive position in the consultation. The unconscious avoider either does not want to be involved in the treatment process or is reluctant to ask his or her doctor. Even if ignorance may exist, he or she does not feel the need for information. The inconsistent actor, however, does require information, but avoids talking to the doctor. Our study further demonstrated that the assertive actor, who shows an active action in the consultation, seeks information, and wants to discuss it with the doctor. Although being active, the assertive actor has to overcome his or her inhibitions to initiate the communication. Thus, the inherent hierarchy of the doctor–patient relationship supports passive patients in their preference of a more paternalistic approach, but forces even active patients to overcome their inhibitions. As Strull et al. has already shown in 1984, being active does not imply a desire for shared-decision making, but for being informed about and involved in one’s own health care [28].

4.1.4. Strengths and limitations

We composed the eight groups of participants according to the principles of theoretical sampling and varied according to age, gender, education, duration of illness, medication adherence as defined by two scales, and the self-reported blood–pressure level. The data collection continued until saturation was achieved. This would assure the theoretical generalization of our results and allow their application to other contexts comparable to our project [29]. The documentary method proved to be an appropriate technique to gain a deep insight into patients’ cognitions and feelings, and to facilitate a real understanding of their motivation to act in a particular way. This interpretative, qualitative approach enabled us to go beyond a simple abstraction and summary of ‘talking about’ to get to the underlying subjective meaning and relevance of the discussed topics.

Our sampling procedure did not consider ethnic variation because this was not a focus of our research question. The group discussions were also videotaped though patients may not have been comfortable with this in a social situation. However, studies have shown, that video recording is an accepted technique for study participants [30].

4.2. Conclusions

In this study, we have found four basic phenomena associated with patients suffering from hypertension: fear, ignorance, impact of illness experiences, and a reluctance to discuss the illness with the doctor. All of these phenomena are interwoven and have different impact on the patients’ acceptance of having hypertension. Accepting the diagnosis and the necessity of being treated seems to be a prerequisite for being able to take the tablets as agreed in the consultation. If we consider adherence as meaningless behaviour, which can simply be learned or conditioned, we ignore the individual process of accepting. However, our analysis reveals that hypertension is not a routinely diagnosed and treated health problem for patients like it is for their general practitioner. Thus, it may be insufficient just to inform about the diagnosis and treatment. It rather seems to be necessary to offer a continuing dialogue about these topics. As our types of action patterns (assertive actor, the unconscious avoider, and the inconsistent actor) demonstrate, they do not reliably indicate the patients' preferred way to interact and to be involved in the management of hypertension. In addition, the patients' preferences and expectations concerning the doctor–patient relationship vary from paternalism to inconsistent autonomy, independently of the socioeconomic status. The types of action patterns do not refer to any implications for adherence.
4.3. Practice implications

Doctors need to consider three conditions: (1) patients’ preferences of interaction in the consultation are different and need to be recognized individually; (2) the action in the consultation may not reflect their wishes and concerns; (3) patient’s agreement to medication intake in the consultation does not indicate the ability to stick to the arrangement. Against this background, it is doubtful that a toolkit which focuses on shared decision making will be helpful to implement the WHO postulation. The only chance for doctors to support patient adherence is to stay in dialogue and to give the time, privacy and patience to enable patients to overcome their inhibition of asking and to accept the diagnosis and therapy. It is premature to talk about medication straight ahead after the diagnosis and to initiate antihypertensive therapy, before the patient is really prepared to take the tablets.

Conflicts of interest

None disclosed.

Acknowledgements

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We confirm all personal identifiers have been removed or disguised so the persons described are not identifiable and cannot be identified through the details of the story.

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