Verbesserung der Therapieergebnisse durch Patientenwissen

Ingrid Mühlhauser
Universität Hamburg
Fachwissenschaft Gesundheit

Themen

Themen

- Methodische Aspekte

Themen

- Methodische Aspekte
- Wann sind Interventionen erfolgreich

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- Methodische Aspekte
- Wann sind Interventionen erfolgreich
- Wenn Patientenwissen zu schlechteren Therapieergebnissen führt

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- Methodische Aspekte
- Wann sind Interventionen erfolgreich
- Wenn Patientenwissen zu schlechteren Therapieergebnissen führt
- Wie viel dürfen Patienten wissen wollen?

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Incorporating referral to cardiac rehabilitation into quality measures that affect reimbursement (pay for performance) could help boost referrals, said Ades, who helped write the 1995 guidelines and who is also one of the coauthors of the Suaya study. "I'm under pressure from the hospital leadership to prescribe aspirin and statins because they get graded on it," he said. "So I think the single most important key is to make referral to cardiac rehabilitation a quality indicator." □

Research Probes Details of Poor Adherence in Antihypertensive Drug Therapy

Mike Mitka

A UNIQUE DATA SET IS PROVIDING researchers with some clues into the murky realm of medication adherence for patients who have hypertension.

Controlling hypertension can be a difficult task and increases the risk for cardiovascular mortality and morbidity. It is estimated that only 30% of patients treated for hypertension achieve their target blood pressure goals. For physicians, the question becomes: are these patients not responding to the initial therapy, or are they not taking their medications in the prescribed manner?

At the European Society of Cardiology Congress on September 1 in Vienna, Austria, Bernard Vrijens, MD, chief scientist with AARDEX Group's research and development center in Visé, Belgium, described a study based on a review of the company's electronically recorded drug dosing histories of 4783 patients prescribed once-daily antihypertensive drug therapy. The data showed that half the patients had stopped their treatment within 1 year and that 50% of those remaining on treatment had occasional, several-day lapses in taking their pills—events that are often undetected with traditional adherence monitoring methods. AARDEX (Zug, Switzerland) manufactures a medication event monitoring system, which collects real-time dosing data by recording each specific instance a patient opens a pill container.

"There is a difference between prescription and use," said Vrijens in an interview. "Almost half the patients make major mistakes; they take drug holidays or interrupt their treatment, and you cannot miss taking medications because that has lifelong implications," he explained.

Vrijens' study found that patients who took their medications mostly in the morning missed 6.7% of their prescribed doses, while patients taking medications mostly in the evening missed 12.0% of their doses. Overall, 7.6% of weekday doses and 9.5% of weekend doses were omitted.

Also, patients who missed many daily doses were more likely to quit treatment early (either formally or informally) than those taking their medications on schedule. Vrijens said 58% of patients who took more than 90% of their daily medications remained on therapy at 1 year. Only 12% of those taking less than 50% of their daily doses remained on therapy after 1 year.

George Bakris, MD, professor of medicine and the director of the University of Chicago Medical Center's hypertension center, said that while adherence's role controlling blood pressure is well known, the specifics surrounding missed doses has been lacking. Such knowledge could allow physicians to intervene in dosing strategies more successfully. If electronic monitoring reveals, for example, that a person is missing his or her evening doses, "as the physician, you can probe a little deeper and perhaps better understand whether it's a personality issue or a lifestyle issue and make arrangements to overcome the problem," said Bakris.

Too often, Vrijens said, the treating physician underestimates the role adherence plays in achieving blood pressure goals. Overestimates of adherence based on patient recall, physician observation, and pill counting (patients will throw away medications and report them as consumed) are common, resulting in the false impression the medication dose is ineffective, which leads to prescriptions of more powerful drug therapies, he said.

Electronic monitoring may help physicians gain insight into adherence, but it is not infallible, noted Allen J. Taylor, MD, chief of the cardiology service at Walter Reed Army Medical Center, in Washington, DC. Taylor, who has studied adherence issues (Taylor AJ et al. *JAMA*. 2006;296[21]:2563-2571), said electric monitoring may register when a patient opens a pill container, but that does not mean the medication is taken. "In terms of functionally improving adherence, the pill bottle is not necessarily the solution," Taylor said. □

JAMA November 14, 2007

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Nur 30% der Patienten mit Hypertonie erreichen Zielblutdruckwerte

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Eine neue Nachricht?
50% der Patienten nehmen nach einem Jahr das Medikament gar nicht mehr. Vom Rest nehmen die Hälfte die Medikamente unregelmäßig.

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Patienten sollen zu therapiegerechtem Verhalten verpflichtet werden

Gesundheitsreform 2007

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ORIGINAL INVESTIGATION

Physician Communication When Prescribing New Medications

Derjung M. Tarn, MD, PhD; John Heritage, PhD; Debora A. Paterniti, PhD; Ron D. Hays, PhD; Richard L. Kravitz, MD, MSPH; Neil S. Wenger, MD, MPH

Background: Communication about taking a new medication is critical to proper use of drug therapy and to patient adherence. Despite ample evidence that medications are not taken as prescribed, few investigations have detailed the elements of communication about new medication therapy. This article describes and assesses the quality of physician communication with patients about newly prescribed medications.

Methods: This was an observational study that combined patient and physician surveys with transcribed audiotaped office visits from 185 outpatient encounters with 16 family physicians, 18 internists, and 11 cardiologists in 2 Sacramento, Calif, health care systems between January and November 1999, in which 243 new medications were prescribed. We measured the quality of physician communication when prescribing new medications.

Results: Physicians stated the specific medication name for 74% of new prescriptions and explained the purpose of the medication for 87%. Adverse effects were addressed for 35% of medications and how long to take the medication for 34%. Physicians explicitly instructed 55% of patients about the number of tablets to take and explained the frequency or timing of dosing 58% of the time. Physicians fulfilled a mean of 3.1 of 5 expected elements of communication when initiating new prescriptions. They counseled the most about psychiatric medications, fulfilling a mean of 3.7, 3.5, and 3.4, pulmonary, and cardiovascular elements, respectively.

Conclusions: When initiating new medications, physicians often fail to communicate critical elements of medication use. This might contribute to misunderstandings about medication directions or necessity and, in turn, lead to patient failure to take medications as directed.

Arch Intern Med

Arch Intern Med, 2006

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Information durch Ärzte defizitär:
Nur in 55% wie viel und wann,
nur in 34% wie lange das Medikament genommen werden soll
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Arch Intern Med. 2006;166:1855-1862

Kann Patientenwissen Therapieergebnisse verbessern?

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Systematische Literatursuche
Lenz M, 2007

Ergebnisse

- Heterogen, von sehr effektiv bis Wirksamkeit nicht nachweisbar
- Warum eine Intervention wirkt und eine andere nicht, ist häufig nicht nachvollziehbar

Patienten-Informations-/Schulungs-Programme sind

Komplexe Interventionen

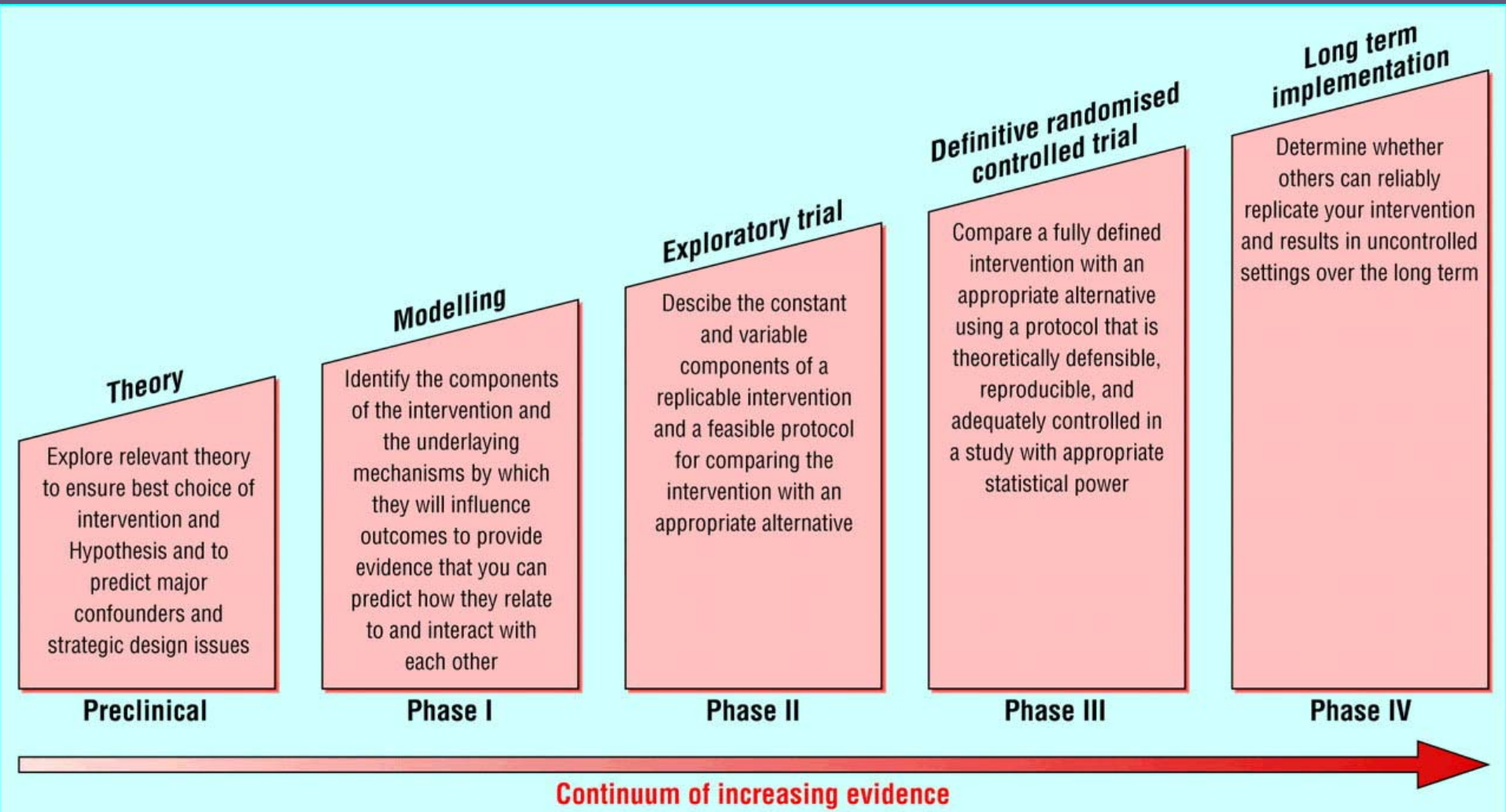
Komplexe Interventionen

Therapieergebnisse hängen ab von:

- Behandlung
- Information/Schulung
- Behandlungsteam
- Soziale Bedingungen
- Gesundheitssystem

Framework for Design and Evaluation of Complex Interventions to Improve Health

Medical Research Council 1999



BMJ 2000; 321: 694-6

Diabetologia (2007) 50:1375–1383
DOI 10.1007/s00125-007-0679-z

REVIEW

Meta-analysis does not allow appraisal of complex interventions in diabetes and hypertension self-management: a methodological review

M. Lenz · A. Steckelberg · B. Richter · I. Mühlhauser

Received: 15 January 2007 / Accepted: 20 February 2007 / Published online: 23 May 2007

Abstract Common methodologies used in systematic reviews do not allow adequate appraisal of complex interventions. The aim of the present study was to describe and critically appraise current methods of systematic reviews on complex interventions, using diabetes and hypertension patient education as examples. PubMed, the Cumulative Index to Nursing and Allied Health (CINAHL), the Cochrane Library and Health Technology Assessment databases were searched. Systematic reviews focusing on diabetes or hypertension patient education were included. Authors were contacted. Two investigators independently evaluated the reviews. The available evidence of three Education programmes were dissected to analyse effects of single components. Different components of identical programmes were used. Interdependencies between components were not explored. Six reviews performed meta-analysis across programmes with heterogeneous educational or organisational approaches. The complexity of efficacy measures was disregarded: e.g. HbA_{1c} was used as an isolated outcome variable without considering treatment goals, effects on hypoglycaemia, body weight or quality of life. Our results indicate that methods of current systematic reviews are not fully equip and self-management programmes. Since these are complex

Diabetologia, 2007

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Ergebnis:
Die Gesamtheit der Evidenz für eine bestimmte Intervention ist derzeit aus den Datenbanken nicht extrahierbar

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Warum sind manche Interventionen wirksam und andere nicht?

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Ein Beispiel für Best Practice:
Typ 1 Diabetes – Düsseldorf Programm
Evidenz 1978-2006

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Patienten-Wissen

- muss evidenzbasiert und relevant sein
- muss relevantes Handeln ermöglichen
- ist Teil von Komplexen Interventionen

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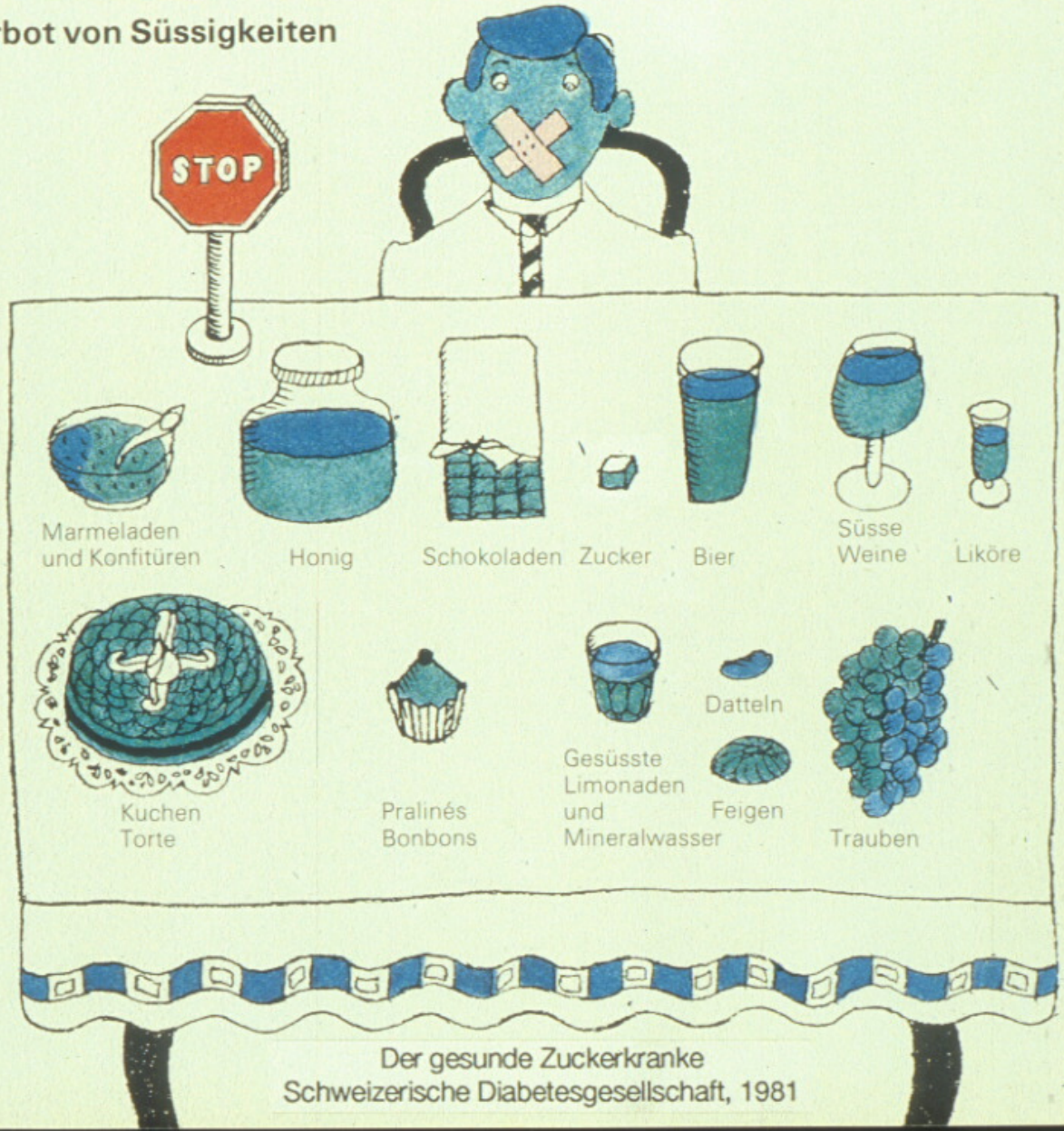
Kohlenhydrate

Verbot von Süssigkeiten



Der gesunde Zuckerkranke
Schweizerische Diabetesgesellschaft, 1981

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Düsseldorf-Programm versus DCCT (USA)

Intensivierte Insulintherapie
bei Typ 1 Diabetes

DCCT – NEJM 1993

Intervention:

- Therapieziel durch Arzt definiert
- Diätpläne
- Vorgaben/Anpassung der Insulindosis durch das Behandlungsteam
- Individuelle Schulung
- Häufige Kontakte mit dem Behandlungsteam

DCCT – NEJM 1993

Ergebnisse:

- Verbesserte Blutzuckereinstellung
- 3x höheres Risiko für schwere Unterzuckerungen
- Keine Verbesserung der Lebensqualität

Düsseldorf-Programm

Intervention:

- Curriculum, 5 Tage, Gruppenschulung
- Patienten bestimmen nach Schulung ihr Therapieziel selbst
- Freie Diät
- Eigenständige Durchführung der Therapie
- Größtmögliche Loslösung von medizinischen Institutionen

Düsseldorf-Programm

Ergebnisse:

- Verbesserte Blutzuckereinstellung
- Gleichbleibendes oder niedrigeres Risiko für schwere Unterzuckerungen
- Verbesserung der Lebensqualität

The British experience in diabetes education (DAFNE)

Simon Heller
University of Sheffield
UK

The Dose Adjustment For Normal Eating (DAFNE) project

BMJ 2002

Stephanie Amiel
Natalie McKeown
Helen Reid
Eileen Turner

Simon Heller
Sue Beveridge
Carla Gianfrancesco
Val Scott
Carolyn Taylor

Sue Roberts
Peter James
Lindsay Oliver
Sue Robson
Jackie Rollingson
Gill Thompson
Frances Wright

Clare Bradley
Jane Speight

Doug Newton

Lynda Newton

funded by

Participants' Comments

- *'...ability to eat with the family whenever I want to (pizza after cinema).'*
- *'… taken away the guilt...'*
- *'For the first time in 25 years I was able to holiday abroad with a sense of freedom.'*
- *'I am now doing a new job which … I could never have managed before the DAFNE Trial.'*
- *'It's given me the real reason for doing blood tests!'*
- *'How have I managed to survive before this week?'*
- *'Spread the word. It really can make a difference! Thanks! Why didn't someone think of this earlier!'*

Düsseldorf-DAFNE-Programm

- Ohne Insulin-Analoga
- Kein Spritz-Ess-Abstand

Kann Patientenwissen
Therapieergebnisse
verschlechtern?

Patients' responses to risk information about the benefits of treating hypertension

David Misselbrook and David Armstrong

SUMMARY

Background: *The medical profession is often presented with information on the value of treatment in terms of likely risk reduction. If this same information was presented to patients — so enabling them to give proper informed consent — would this affect their decision to be treated?*

Aim: *To examine patients' choice about treatment in response to different forms of risk presentation.*

Design of study: *Postal questionnaire study.*

Setting: *The questionnaire was sent to 102 hypertensive patients and 207 matched non-hypertensive patients aged between 35 and 65 years in a UK general practice.*

Methods: *Patients were asked the likelihood, on a four-point scale, of their accepting treatment for a chronic condition (mild hypertension) on the basis of relative risk reduction, absolute risk reduction, number needed to treat, and personal probability of benefit.*

Results: *An 89% response rate was obtained. Of these, 92% would accept treatment using a relative risk reduction model, 75% would accept treatment using an absolute risk reduction model, 68% would accept treatment using a number needed to treat model, and 44% would accept treatment with a personal probability of benefit model.*

Conclusion: *Many patients may prefer not to take treatment for mild hypertension if the risks were fully explained. However, given that the form of the explanation has a strong influence on*

Introduction

A NUMBER of studies have shown that clinicians' understanding of the effectiveness of treatment can be influenced by the way in which evidence is presented. For example, when findings from clinical trials are presented to clinicians in terms of relative risk reduction and number needed to treat (NNT) it has been found that an apparently large relative risk reduction creates a more favourable view of effectiveness than the NNT statistic,[1] despite the preference of trialists for the latter figure.[2,3]

Given the increasing importance accorded to patients' involvement in decision-making it can be argued that they too have the right to know the risks they accept in undertaking treatment. There is some evidence that positive and negative framing (for instance, '95% of patients survive this operation' versus '5% of patients do not survive') influences patients' decisions[4,5] and that when presented with a hypothetical disease and treatment patients seem more inclined to accept treatment when it is offered in terms of relative risk reduction;[6,7] however, it is not clear what the effect on decision-making would be if patients were presented with the same range of risk int

Br J Gen Practice 2001

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Schlechtere Therapieergebnisse?

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Prävention von Schlaganfall mit Blutgerinnungshemmern

Meta-Analysen - Leitlinien

- Hoher Nutzen für Hochrisikopatienten
- NNT über 5 Jahre 2-7

Prävention von Schlaganfall mit Blutgerinnungshemmern

Unerwünschte Effekte

- Blutungsrisiko
- Hoher Aufwand für Patienten

Präferenzen von Patienten?

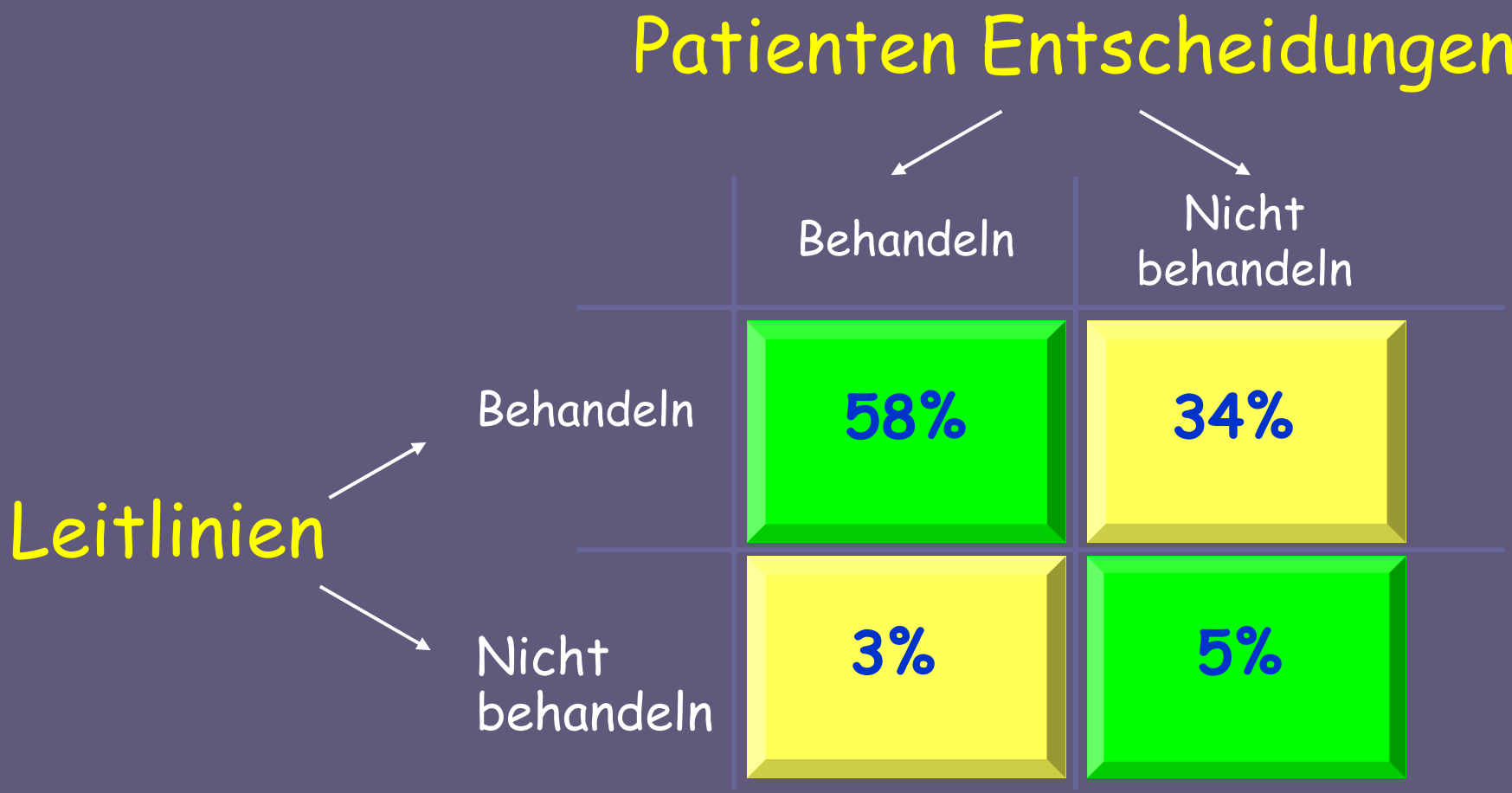
Protheroe et al. BMJ 2000

Präferenzen von Patienten

- 97 Patienten mit Vorhofflimmern aus Allgemeinpraxen
- Alter 70 bis 85 Jahre
- 85% wollen in die Entscheidung einbezogen werden

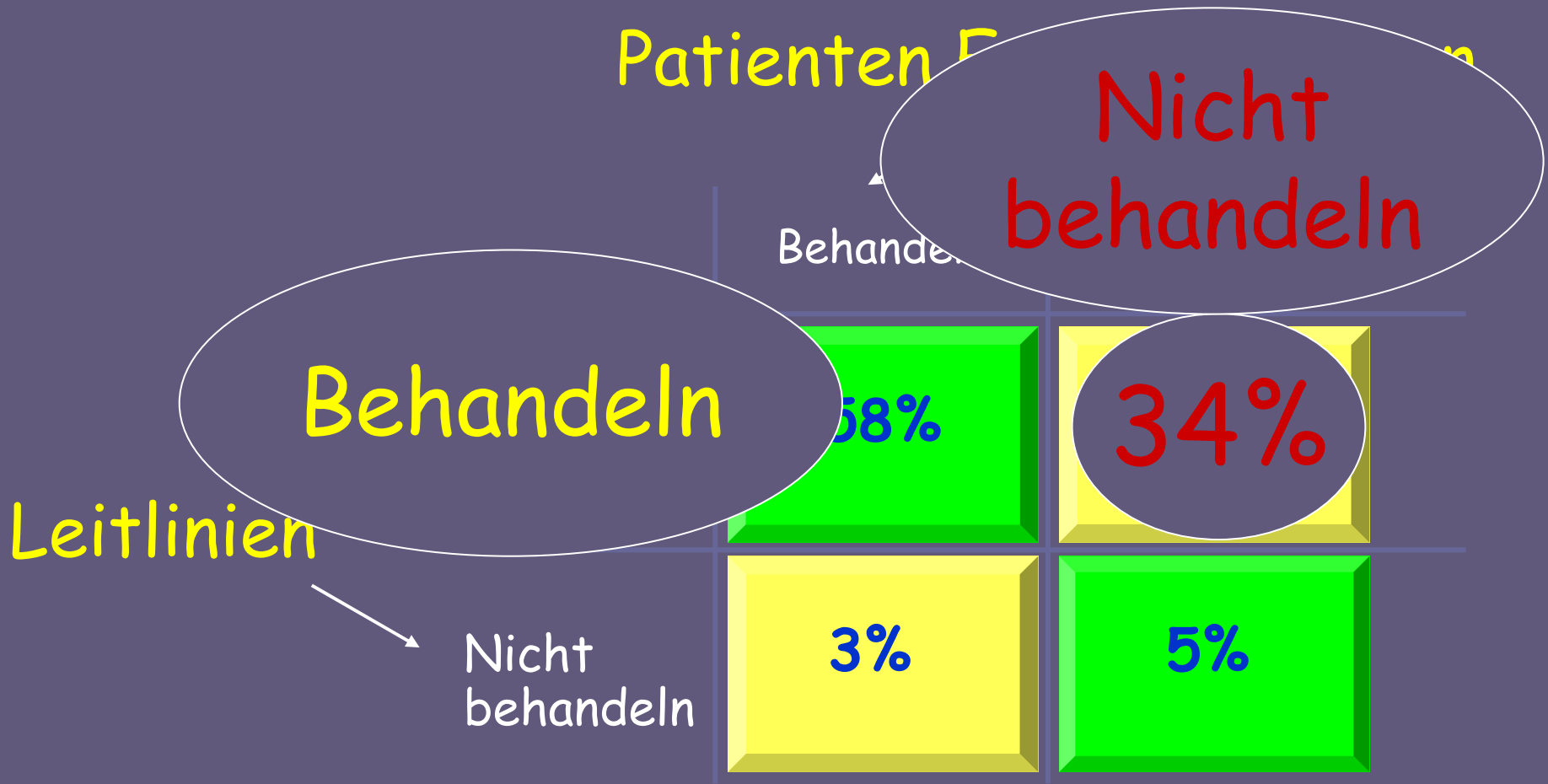
Protheroe et al. BMJ 2000

Präferenzen von Patienten



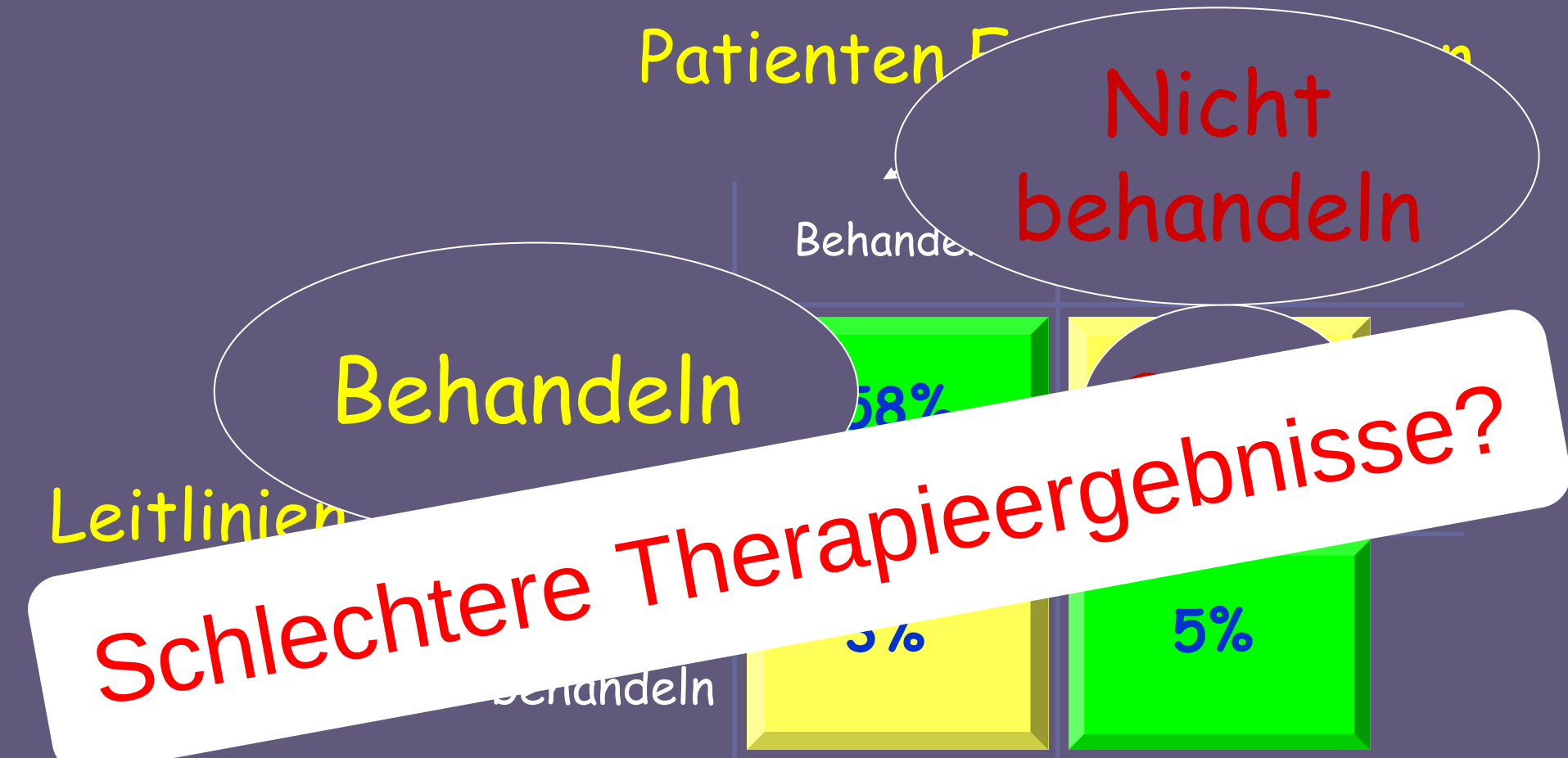
Protheroe et al. BMJ 2000

Präferenzen von Patienten



Protheroe et al. BMJ 2000

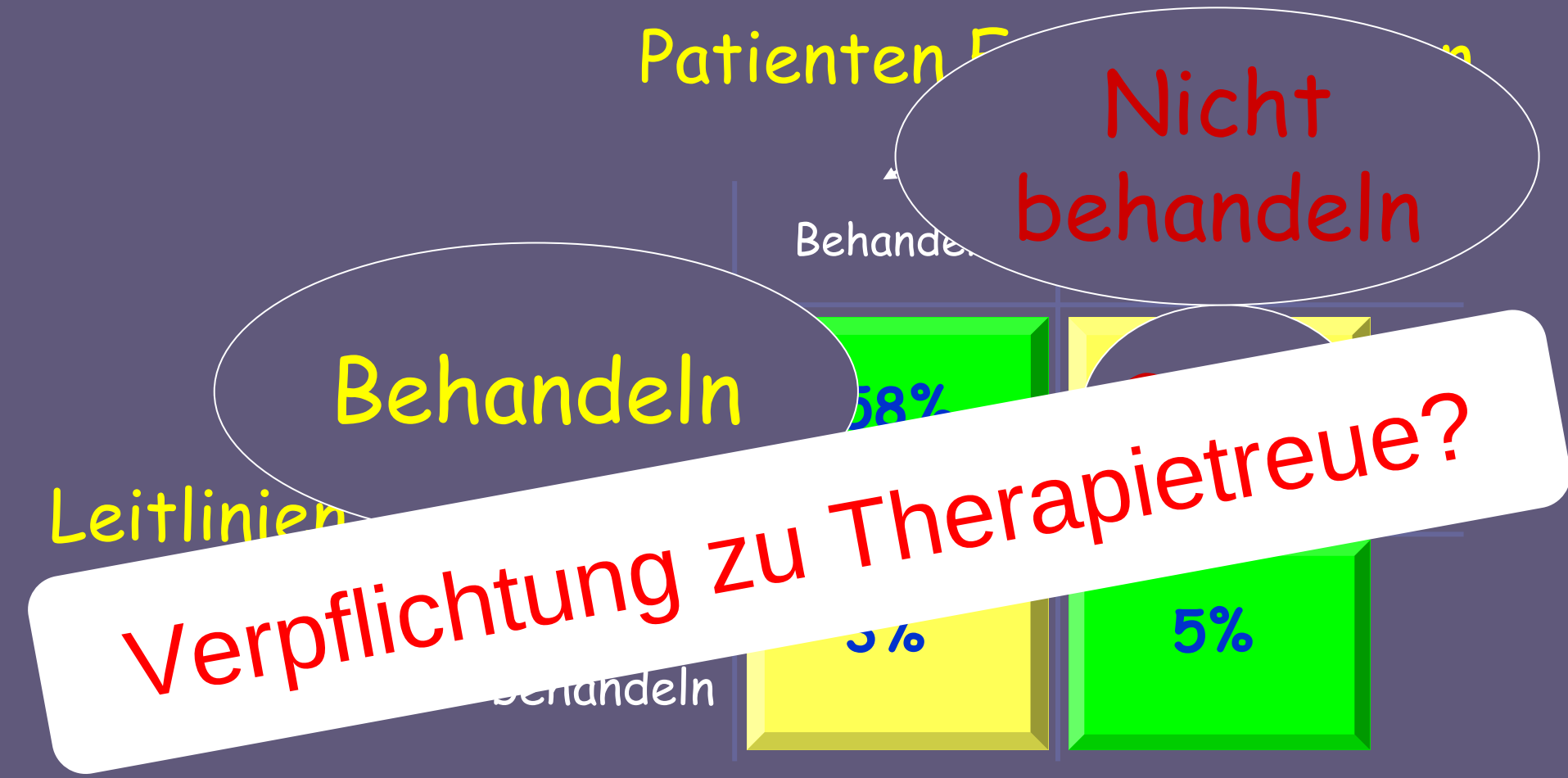
Präferenzen von Patienten



Schlechtere Therapieergebnisse?

Protheroe et al. BMJ 2000

Präferenzen von Patienten



Verpflichtung zu Therapietreue?

Protheroe et al. BMJ 2000

Themen

- Methodische Aspekte
- Wann sind Interventionen erfolgreich
- Wenn Patientenwissen zu schlechteren Therapieergebnissen führt
- Wie viel dürfen Patienten wissen wollen?

"I'M SORRY DOCTOR, BUT AGAIN I HAVE TO DISAGREE."

BMJ 1999

drate

sigkeiten

I HAVE TO DISAGREE."

Training in wissenschaftlicher Kompetenz für Patienten- und Verbrauchervertreter

Universität Hamburg 2002-2005

14 Kurse, 5 Tage

161 TeilnehmerInnen

30 Brustkrebsaktivistinnen
KOMBRA
Workshop Sep. 2006

AKTUELL
PARLAMENT
ABGEORDNETE
AUSSCHÜSSE
WEHRBEAUFTRAGTER
DOKUMENTE
WISSEN
LIVE
PETITIONEN
EUROPA UND INTERNATIONALES
SERVICE
PRESSE

Jugend
Ausstellungen
Architektur und Kunst
Geschichte

Impressum / Datenschutz

DEUTSCHER BUNDESTAG – Petitionsausschuss -

[zurück]

Öffentliche Petitionen

Gesundheitswesen: Behandlungsleitlinien und wissenschaftliche Studien

Hinweise	Übersicht über Öffentliche Petitionen	Öffentliche Petition einsehen und mitzeichnen/unterstützen	Diskussionsforum
Mitzeichnungsliste einsehen	Stand der Bearbeitung	Postkarte	

Gesundheitswesen: Behandlungsleitlinien und wissenschaftliche Studien
Eingereicht durch: Brita Tenter am Montag, 2. Oktober 2006

Die Petentin fordert, dass für Patientinnen und Patienten die Aussagen von Behandlungsleitlinien und wissenschaftlichen Studien (diagnostische und therapeutische Fragestellungen) umfassend und in verständlicher Sprache und Form erstellt und zugänglich gemacht werden. Bei der Erstellung müssen kompetente Patientinnen und Patienten des jeweiligen Krankheitsbildes von Beginn an beteiligt werden.

Begründung:
Patientinnen und Patienten haben vor allen diagnostischen und therapeutischen Maßnahmen das Recht auf eine gemeinsame Entscheidungsfindung (Shared Decision Making) mit ihrem Arzt oder ihrer Ärztin. Um dieses Recht zu wahren ist es unabdingbar, dass alle Beteiligten dieses Entscheidungsprozesses über die gleichen Informationen verfügen. Diese müssen aktuell und qualitätsgesichert sein sowie auf der Basis der besten zur Verfügung stehenden wissenschaftlichen Daten (= Evidenz basierte Medizin) beruhen.

Leitlinien der jeweiligen medizinischen Fachgesellschaften geben Ärzten und Patienten qualitätsgesicherte Behandlungsempfehlungen, die auch als Grundlage des ärztlichen Beratungsgespräches dienen sollten. Untersuchungen belegen, dass Patienten bei einer ausschließlich mündlichen Informationsvermittlung bereits nach kurzer Zeit nur noch einen geringen Prozentsatz der Information erinnern können. Schriftliche und für Laien verständliche Behandlungsleitlinien müssen deshalb als Entscheidungshilfen für PatientInnen zur Vorbereitung und/oder Nachbereitung von Aufklärungs- und Beratungsgesprächen zur Verfügung stehen.

Petition:

Die Petentin fordert, dass für Patientinnen und Patienten die Aussagen von Behandlungsleitlinien und wissenschaftlichen Studien (diagnostische und therapeutische Fragestellungen) umfassend und in verständlicher Sprache und Form erstellt und zugänglich gemacht werden.

Forderungen und Begründung:

- Recht auf Shared Decision Making
- Für Alle gleiche Informationen
- Diese müssen auf EBM beruhen
- Schriftliches für Beratungsgespräche
- Alle Behandlungswege einschließen

Forderungen und Begründung:

Patienteninformationen sollen die Ergebnisse medizinischer Forschung (Studien) und deren Bewertung transparent machen. Das beinhaltet u. a. eine klare Darstellung der Art und Qualität einer wissenschaftlichen Studie.

Forderungen und Begründung:

Die Ergebnisse müssen in absouten Zahlen und nicht mit irreführenden relativen Prozentangaben genannt werden. Dies gilt auch für Nutzen und Nebenwirkungen der geprüften Behandlung. Graphische Darstellungen müssen eindeutig und ohne verzerrende Maßstäbe sein, die zu falschen Schlussfolgerungen führen können.

Brita Tenter

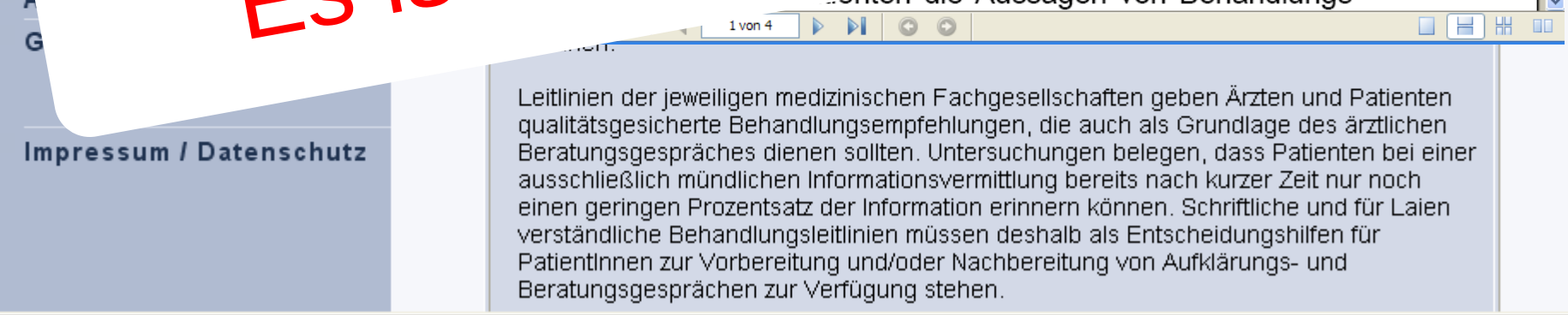
21465 Reinbek

Gesundheitswesen

Der Deutsche Bundestag hat die Petition am 25.10.2007 abschließend beraten und beschlossen:

Das Petitionsverfahren abzuschließen, weil er dem Anliegen weitgehend entsprechen konnte.

Es ist alles gut wie es ist …



Impressum / Datenschutz

DEUTSCHER BUNDESTAG – Petitionsausschuss -

[zurück]

Öffentliche Petitionen

Gesundheitswesen: Behandlungsleitlinien und

Begründung:

Therapiefreiheit des Arztes
Informationen durch den behandelnden Arzt
Unabhängige Patientenberatung
Afgis
IQWIG

Juge
Auss
Architektur
Geschichte
Impressum /

Das Petitionsverfahren abzuschließen, weil er dem Anliegen weitgehend entsprechen konnte.

Begründung

ONKOLOGIE

Dreistufenmodell optimiert Behandlung unter Kostendeckung

Wie die künftigen Strukturen der onkologischen Versorgung in Deutschland aussehen sollten

Deutsches Ärzteblatt | Jg. A 3004 ft 44 | 2. November 2007

Matthias W. Beckmann, Guido Adler, Peter Albers, Johannes Bruns, Gerhard Ehninger, Axel Hauschild, Peter Neuhaus, Wolff Schmiegel, Stephan Schmitz, Hans-Joachim Schmoll, Michael Weller, Thomas Wiegel, Michael Bamberg

Die künftige onkologische Versorgung in Deutschland unterliegt vielfältigen, sich ständig verändernden Einflüssen und Variablen, die eine kontinuierliche An-

tung durch externe Organisationen eher unterlegen. Ziel muss es sein, auf der Basis qualifizierter Leitlinien interdisziplinäre Versorgungsstrukturen aufzubauen und Qualität

ment-Programm (DMP) Mammakarzinom, als qualitätsgesicherte Versorgungsstrukturen zu definieren, ist abzulehnen. Das DMP Mammakarzinom ist heterogen, die

gruppen. Alle Beteiligten müssen bereit sein, den derzeitigen Strukturwandel gemeinsam mitzutragen. Dieses schließt neben den klinischen Leistungserbringern auch die sich anvertrauenden Patientinnen und Patienten mit ein.

Zitierweise dieses Beitrags:
Dtsch Arztebl 2007; 104(44): A 3004–9

Anschrift für die Verfasser
Prof. Dr. med. Matthias W. Beckmann
Frauenklinik Universitätsklinikum Erlangen
Universitätsstraße 21–23, 91054 Erlangen

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„Alle Beteiligen müssen bereit sein, den … Strukturwandel gemeinsam mitzutragen. Dieses schließt … auch die sich anvertrauenden Patienten mit ein."

Anschrift für die Verfasser
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Universitätsstraße 21–23, 91054 Erlangen

European Commission

Enterprise & Industry DG

Information to patients in Europe, The Pharmaceutical Forum as one of the drivers for change?

Health Action International - Open Seminar

Brussels, 12 October 2007

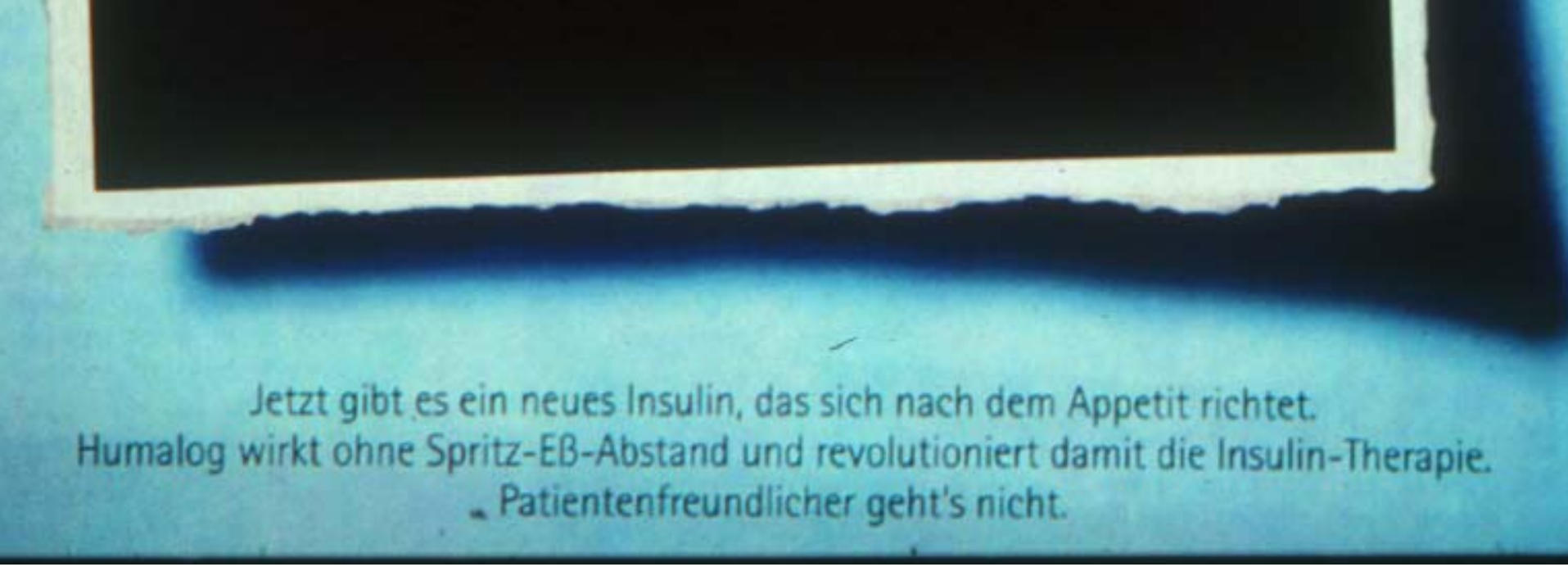
Christian Siebert,
Head of Unit: Competitiveness of Pharmaceuticals Unit

Direct-to-Consumer Advertising of Pharmaceuticals

Direct-to-consumer advertising

- Nachfrage nach Medikamenten nimmt zu
- Ärzte verschreiben gegen eigene Überzeugung
- Nutzen für Gesundheit nicht nachgewiesen
- Hohe finanzielle Aufwendungen der Industrie


Jetzt gibt es ein neues Insulin, das sich nach dem Appetit richtet.
Humalog wirkt ohne Spritz-Eß-Abstand und revolutioniert damit die Insulin-Therapie.
Patientenfreundlicher geht's nicht.



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das sich nach dem Appetit richtet.
Humalog wirkt ohne Spritz-Eß-Abstand
und revolutioniert damit die Insulin-Therapie.
Patientenfreundlicher geht‘s nicht.

Ebm@school

Kritische Gesundheitsbildung
für Schülerinnen und Schüler

Schlussfolgerung

- Wissen muss relevant und evidenzbasiert sein
- Muss relevantes Handeln ermöglichen
- Kann nur als Teil komplexer Interventionen beurteilt werden

Schlussfolgerung

- Patienten wollen mitentscheiden
- Die notwendigen Informationen stehen nicht zur Verfügung
- Keine Verpflichtung von Patienten zu „therapiegerechtem Verhalten“!
- Keine Medikamentenwerbung durch die Industrie!
- Kritische Gesundheitsbildung für Alle!