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Hypertensive patients' preferences for complementary and alternative medicine and the influence of these preferences on the adherence to prescribed medication

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A B S T R A C T

Purpose: This study aimed to understand hypertensive patients' perceptions of and adherence to prescribed medication.
Methods: A qualitative research study based on 23 purposely selected participants from a community health clinic in Malaysia. The participants underwent in-depth semi-structured interviews, and the data were analyzed using qualitative content analysis method.
Results: The participants were presented with six types of perceptions of medication. The majority of the participants had negative perceptions of Western medicine (WM), self-adjusted their prescribed medication with complementary and alternative medicine (CAM) and concealed their self-adjusting habits from their doctors. Participants who thought positively of WM took their prescribed medication regularly. Most of the participants perceived the nature of WM as not being curative because of its side effects. Patients have the right to choose their preferred medication when they understand their illness.
Conclusion: Local health care systems should provide patients with alternative health services that suit their requests.

1. Introduction

It is acknowledged that hypertension increases the risk of cardiovascular diseases and is the third leading killer in the world [1]. Although considerable empirical research studies have proven that antihypertensives are efficacious in the treatment of hypertension, studies have shown that fewer than 25% of patients being treated for hypertension achieve an optimum blood pressure [2]. The main reason for the observed suboptimal blood pressure control is poor adherence to prescribed medication [2–4], which reduces the patients' quality of life and wastes healthcare resources.

In Malaysia, the Third Malaysia National Health and Morbidity Survey [5] showed that the overall estimated prevalence of hypertension is 42.6%. Among the hypertensive population, the percentage of patients currently on treatment is 31.4%. Only 26.3% of the hypertensive population currently receiving treatments have their blood pressure (BP) under control. Non-adherence has been identified as the main cause of the failure to control hypertension [6].

Patients seek information when they require knowledge about diseases, treatment, better adherence to treatment and when they change their medication practices to suit their social environment [7]. Important indicators of improved adherence to medication use, include patients' perception and assessment of the medication as well as the extent to which drug side effects are experienced during therapy [8–10]. Before accepting a medication, most patients appear to test the medication, particularly when the medication is designed for long-term therapy [8]. Both qualitative [8,10–13] and quantitative research studies [14–18] have produced consistent findings that a belief in treatment efficacy similarly encourages adherence. In contrast, belief that a medication causes adverse effects and dependence are the main reasons for non-adherence [10–17]. Patients continue to weigh and balance the long-term effects of a medication and the value of continuance. Fear of dependency and tolerance are important factors that motivate people to take less

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than the prescribed dose [12,19–21]. Moreover, patients never reveal their thinking or behavior when these contradict the advice of their doctor because of their powerless position; rather, they actively adjust their medication regimen without their doctor's knowledge [22]. Additionally, their experiences with their illness and their subjective understandings of a medication greatly influence their adherence behaviors [10,23]. Furthermore, patients do not believe that all of the treatments that are deemed necessary by their doctors are in their best interests [24].

Local studies [6,25–29] of adherence to hypertensive medication that have measured factors related to non-adherence have utilized the quantitative research method. These previous studies have demonstrated that the problem of adherence is multifaceted and that it is appropriate to use research designs that emphasize the exploration of multiple realities to understand the problem holistically from the patient's perspective. Accordingly, it is hoped that the use of qualitative research will uncover the hidden and implicit meanings underlying a patient's attitude toward adherence.

1.1. Research questions

What perceptions toward prescribed medications are held by patients?
How do patients take medications every day?

1.2. Purpose of the study

The purpose of the study is to understand the perceptions that patients hold toward their prescribed medications and the influences of these perceptions on their medication-taking behavior.

2. Methods

2.1. Theoretical framework

This study adopts an idealist ontology and a social constructionist epistemology. The former assumes that multiple realities are present in any social context. Human beings are meaning makers. In everyday life, social actors create social realities through the shared and negotiated interpretation of meanings [30]. The latter posits that meaning making in social reality is created by groups of people or that reality is socially constructed. Multiple realties can only be understood through typification in everyday life. [31] The typification or classificatory system is a result of the everyday interactions between people [32]. Therefore, researchers working from a constructionist epistemology focus on gaining an understanding of a person's interpretation of reality, which is derived from his/her social interactions and interpersonal relationships.

2.2. Study location

The study location was a community health clinic that is maintained by the Ministry of Health (MOH) in Selangor, Malaysia.

2.3. Sample selection

The purposive sampling technique was initially used, and theoretical sampling was then employed. The former was performed using the following inclusion criteria: over the age of 30 years, registered with the clinic, main diagnosis of hypertension, and been on medication for at least one year. The latter was sampled until the theory-saturation point was reached, at which time, the author had gained an understanding of the situation and was able to generate an appropriate explanation.

2.4. Data collection

Twenty-three semi-structured interviews were conducted between June 2010 and June 2011. Each interview lasted approximately one hour and was scheduled as three sessions on different dates. Additionally, non-participant observations that occurred in the clinic, the participants' home settings, and during the interview process were also recorded. The objective of the non-participant observation in the clinic was to acquire specific knowledge related to the community clinic through specific incidents, behavior, expressions, and the interactions between the staff and the patients. The researcher also observed the participants and their interactions with family members in their home settings to quickly assess these physical environments. During the face-to-face interviews, the researcher concentrated on listening, looking, interacting, and attending to more than just the words provided by the participants. The researcher obtained ethical clearance from the ethical committee of a local university, the Faculty of Medicine and Health Sciences, and the National Medical Research Registry. Subject information sheets and informed consent documents were prepared in three different languages (English, Bahasa Melayu, and Chinese) to cater to the multicultural background of the participants. The respondents were asked to choose a pseudonym such that the data could not be traced back to any individual (Table 1).

2.5. Data analyses

All interviews were audio recorded and transcribed verbatim. Four bilingual academic staff members translated the qualitative text. Conventional qualitative content analysis was used to derive the codes and themes directly from the data [33]. The first step of the analysis commenced with reading all the data repeatedly to obtain an overall understanding [33]. Next, was line-by-line open coding on text followed by arranging the codes into categories. To determine how the different codes and categories were related and linked, the researcher adopted the clustering method of qualitative analysis [34] by cross-tabulating the emergent categories into meaningful clusters. NVivo 7 was used to assist in coding, categorizing and formulating sociological typologies.

2.6. Trustworthiness

The trustworthiness of the study was ensured through credibility, transferability, dependability, and confirmability [35]. Four types of activities (peer debriefing, prolonged engagement, non-participant observation, and member checks) were performed to ensure the credibility of the study. The researcher produced detailed contents or thick descriptions to enhance the degree of fittingness in transferability. An audit trail was used to maintain the dependability of the study. The researcher maintained every record of the enquiry process to aid the verification of the findings and maintain conformability.

3. Results

3.1. Perceptions of the prescribed medications

The biographic profiles of the participants are summarized in Table 1. The age range of the participants was between 38 and 64 years. None of the 23 participants dropped out from the study. The focus of this research was to understand the perceptions of the patients toward their prescribed medications. However, in a spontaneous manner, the participants compared their use of CAMs with the use of their prescribed medications to create meaning from their experiences with taking the medications. The