adiposity measurements and the varied mechanisms underlying the substrates supporting atrial fibrillation (4,5).

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Medication Adherence Is Not Our Problem?

I would respectfully disagree with the decision to exclude medication adherence from the position statement on performance measures for adults with coronary artery disease and hypertension (1). After reviewing the reasons outlined by the writing committee, I am concerned that this decision may have been made without a detailed review of the best available evidence. I believe that medication adherence should be considered an important outcome of care rather than an inevitable destiny for one-half the patients who receive prescription medicines.

Three reasons were provided for excluding nonadherence as a performance measure for physicians. First, “adherence is largely not in the individual physician’s locus of control” (1). On the contrary, a significant body of research suggests that physicians have powerful influence over medication adherence. Although factors underlying the positive elements of this association have not been clearly defined, evidence suggests that patient–physician relationships (2), follow-up visits (3), communication (4), and medical management skills (5) are important determinants. Therefore, it would appear that physicians are not just innocent bystanders in this public health epidemic.

Second, “because patient autonomy is the overriding ethical and pragmatic principle governing the patient–physician relationship, the patient is free to decide whether to take medications as prescribed” (1). Few would argue that patients have the final say in the matter of adherence. However, upholding the principle of patient autonomy does not preclude physicians from helping patients make good decisions. If physicians (or other health care professionals) opt out of the decision-making process, patients are left to navigate the Internet or newspapers to help inform their choice of whether to take medications regularly. At a minimum, engagement in the decision-making process will ensure that physicians are aware of the final decision. Perhaps acknowledging that a final patient decision about adherence is understandable might even improve compliance with the ethical principle of patient autonomy.

The final reason provided was phrased as follows: “a measure of patient adherence could cause physicians to avoid caring for patients with a history of nonadherence or a perceived likelihood of being nonadherent” (1). In contrast, I believe that a measure of adherence could begin to promote the idea that good adherence is an outcome of external factors. I would hope the anecdotal risk for refusing care to patients would be speculative at best, whereas the value of mobilizing a highly skilled profession toward an “age-old” problem would be priceless.

Medication adherence is a complex phenomenon with a multitude of causes that are probably slightly different for every patient. Nonetheless, a physician’s influence is likely an important factor, even under conditions of high copayments or poor employer benefit plans (2). Ultimately, I am concerned that the messages contained in the medication adherence section of the document (1) will reinforce a longstanding myth that physicians have no role to play in addressing this public health problem.

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