PPP must allow patient participation in therapy

by Mark H. Rubinstein, MD
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The new glaucoma guidelines notwithstanding, the patient also has a say in the treatment of his disease.

Glaucoma is a chronic disease that affects every moment of our patients' lives. As physicians we can help patients cope with the condition by educating them and by treating them according to their individual needs. The diagnosis and management of glaucoma is far from being an exact science and has a relatively high failure rate; consequently, it is illogical not to allow our patients to partake in treatment decisions.

Glaucoma is a leading cause of blindness in the United States, either because patients are not complying with medical regimens or because we are mistaken in our belief that intraocular pressure (IOP) reduction impedes or prevents nerve-fiber-layer and vision loss. To minimize the effects of the former, any realistic preferred practice pattern (PPP) for glaucoma must start with patient education and participation in treatment decisions.

It is beyond the scope of this article to review the evidence that establishes IOP reduction as effective in saving vision. Suffice it to say that such evidence exists and supports the current concept of glaucoma management. It is therefore reasonable to speculate that many of those who suffer progressive vision loss or blindness from glaucoma do so because they do not take their medications as prescribed.

Endemic problem

Compliance is a major problem in all fields of medicine. In the Jan. 19, 1990 issue of *American Medical News*, a surgeon is quoted as saying, "Noncompliance is one of the greatest problems we face in transplants. Nearly 50% of patients who died after transplants had failed to follow their prescribed drug regimen." The article, "How often is medication taken as prescribed?" in the June 9, 1989 issue of *JAMA* showed a compliance rate of 39% for four-times-a-day dosages during a 3428-day observation period.

As a major component of treatment failure, compliance needs to be addressed at the onset of treatment instead of after the loss of nerve fiber layer due to noncompliance. I described this briefly in an article in the July 1, 1989 issue, pages 1, 26-27.

Integrating information

If we are to provide the best care for our patients, physicians have to integrate information from various sources and modify treatment to accommodate individual differences among patients. There can never be any one treatment modality that is universally applicable for every patient. When treating glaucoma, for example, there is no definite point at which we know, beyond a shadow of a doubt, to start medical therapy or perform laser or surgical procedures.

Current studies comparing drugs, lasers and surgery as initial treatments for glaucoma at best will only offer us more information to integrate, and may well be inconclusive. As stated in an article entitled, "When does the failure to find a difference mean that there is none?" in the July 1989 issue of *Archives of Ophthalmology*, "While there may in fact be no difference in the clinical outcome of interest, there is always the possibility that the study failed to detect a very real difference."

The worst possible effect that these studies could have would be for us to apply their results with no consideration of previous knowledge or without making appropriate modifications for the individual. A decision to take a patient to surgery or laser—because some study suggests that we should—without properly educating the patient about the disease and other treatment modalities would compromise our role as physicians.

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Quality care

In that light, I believe that medical management is the logical initial treatment modality for adult open-angle glaucoma and provides good results in the compliant patient. However, I also believe that compliance to a medical regimen for this chronic disease is very difficult for most patients and occurs less often than many of us would like to think.

A decision to take a patient to surgery or laser—because some study suggests that we should—without properly educating the patient about the disease and other treatment modalities would compromise our role as physicians.

We must not let the glaucoma PPP make it less likely that we will listen to our patients, or share with them their treatment goals and options. To prevent our patients from partaking in decisions that affect their lives is doing them a disservice. In coming years, PPPs for many medical conditions will be established. If physicians allow PPPs to become any kind of barrier to the informed decision of patients, the quality of care in this country can only be compromised. ■

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