

The Distance Between Understanding Medication Advice and Being Able to Follow It: Reconsidering Health Literacy, Treatment Workload, and Usable Counselling in Community Pharmacy

Daniel Okafor^{1*}, Lucia Moretti², Ahmed El-Sayed³

¹Department of Clinical Pharmacy and Pharmacy Practice, University of Lagos, Lagos, Nigeria.

²Department of Pharmaceutical Care and Health Outcomes, University of Milan, Milan, Italy.

³Department of Clinical Pharmacy and Therapeutic Drug Monitoring, Alexandria University, Alexandria, Egypt.

*E-mail ✉ daniel.okafor@unilag.edu.ng

Abstract

Medication counselling is commonly evaluated through knowledge, recall, comprehension, or patients' ability to restate instructions. These outcomes are important, yet they do not establish whether medication advice can be enacted within everyday life. This article develops an Understanding-to-Action Theory-Synthesis Framework integrating health-literacy and treatment-burden scholarship to explain why a patient may understand what a medicine is for, when and how it should be taken, and what precautions apply while still being unable to implement that advice reliably. The synthesis distinguishes informational capability from the practical workload of treatment and from the capacity available to perform that work. Medication action is therefore treated as conditionally feasible rather than as an automatic consequence of comprehension. Community-pharmacy counselling becomes usable when it addresses not only interpretation of medication information but also the routines, resources, competing demands, monitoring requirements, access conditions, and service arrangements through which medication use must occur. The framework predicts that comparable comprehension can produce different medication-action trajectories when workload-capacity configurations differ. It also preserves intentional preference-sensitive non-use and health-system constraints as rival explanations rather than misclassifying all nonimplementation as incapacity. This account shifts counselling assessment from whether advice was understood toward whether an understood plan can be performed and sustained under the conditions in which the patient actually manages medicines.

Keywords: Health literacy, Medication literacy, Treatment burden, Patient capacity, Medication counselling, Feasible medication action

Introduction

Medication counselling occurs at a boundary between professional recommendation and patient-managed action. Community-pharmacy encounters can improve access to information and create opportunities for questions, clarification, and participation, but participation itself varies with patient characteristics,

pharmacist behaviour, communication conditions, beliefs, and features of the encounter [1]. The information exchanged during such encounters also requires more than recognition of medicine names or directions. Medication-literacy research identifies a broader set of abilities concerned with understanding and using medication information [2]. Conceptual development in this field has further emphasized that medication literacy is shaped by individual, social, and health-system factors and includes skills necessary to act on medication-related information [3].

These observations complicate any assumption that comprehension is a sufficient endpoint. Health-literacy research has used heterogeneous definitions and measurement approaches, with imperfect

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correspondence between what health literacy is claimed to include and what instruments actually measure [4]. Evidence linking health literacy to medication adherence is similarly nonuniform. A systematic review across chronic diseases found positive, mixed, null, and occasionally negative relationships rather than a single consistent literacy–adherence pathway [5]. The relevant theoretical problem is therefore not simply whether patients understand medication information. It is why adequate understanding can coexist with delayed, partial, inconsistent, or unsustainable medication action.

The distinction matters particularly in community pharmacy because counselling often occurs at the point where a prescription must become a routine. Once the encounter ends, the patient must obtain the medicine, interpret instructions in changing circumstances, coordinate doses with meals and other medicines, manage refills and monitoring, absorb financial and time costs, remember or reconstruct plans, and fit these requirements around other obligations. Some difficulties arise because information was not adequately understood. Others arise after understanding has been achieved.

The argument developed here treats this latter problem as an understanding-to-action gap: a condition in which medication advice is sufficiently interpreted for the patient to know what action is expected, while practical enactment remains constrained. The framework does not presume that every episode of nonadherence reflects insufficient capacity. Beliefs, preferences, uncertainty, intentional refusal, access failures, and system-level barriers can produce similar observable behaviour through different mechanisms. Its purpose is instead to identify when comprehension and feasible action diverge, why that divergence matters theoretically, and how counselling changes when medication advice is treated as work that must be performed.

Why comprehension is an incomplete endpoint

Evidence among older adults illustrates why health literacy cannot be used as a deterministic surrogate for adherence. Studies reviewed in this population have reported heterogeneous associations between self-reported health literacy and medication adherence [6]. Even when literacy is adequate, medication behaviour may depend on how patients understand illness, evaluate medicines, anticipate benefits or harms, and interpret the personal meaning of treatment. In adults with type 2 diabetes, medication beliefs and illness perceptions

remained analytically relevant alongside health literacy and numeracy [7]. These findings make adherence an unsuitable retrospective test of whether counselling was “understood”: similar medication-use patterns can arise from misunderstanding, belief-based choice, treatment burden, forgetfulness, access difficulty, or deliberate preference.

Medication literacy itself also extends beyond literal recall. International consensus work describes it in terms that include obtaining, comprehending, communicating, calculating, and processing medication information so that appropriate decisions can be made [8]. Yet even a broad medication-literacy construct cannot by itself establish whether the decision can be enacted under the patient's actual circumstances. A person may correctly interpret a twice-daily instruction and still lack a stable routine in which the two doses can be separated appropriately. Another may understand monitoring requirements but face transport, work-schedule, financial, or caregiving constraints that make the monitoring plan difficult to complete.

The relationship between informational capability and practical burden is visible empirically. In a population-based study of people with cardiovascular disease, health literacy and multimorbidity were associated with patient-perceived treatment burden [9]. The study does not demonstrate that limited literacy causes burden, but it shows that the informational and workload dimensions can coexist rather than substitute for one another. A patient can therefore face difficulties arising from what treatment demands even when the informational component of those demands is understood.

Teach-back provides a useful example of the inferential boundary. Systematic-review evidence supports teach-back as an implementable communication approach with generally favourable effects on knowledge and several self-care-related outcomes [10]. Its distinctive value is that misunderstanding can become observable during the encounter. Successful teach-back nevertheless establishes only that the patient can reproduce or demonstrate an intended understanding at that point. It cannot by itself show that the patient has the time, physical ability, resources, routine stability, social support, access, or sustained capacity required to carry the plan into daily life.

The analytical distinction becomes clearer when common medication tasks are separated according to what successful understanding actually establishes and what remains unresolved before action.

Table 1. From understood medication advice to executable medication work: distinctions that prevent comprehension from being used as a proxy for feasible self-management

Medication-related task or construct	What successful performance establishes	What remains unresolved after comprehension	Work or capacity question before enactment	Counselling consequence
Interpreting the medicine's purpose	The patient can identify why the medicine is being used	Whether the expected benefit is acceptable and worth the practical demands of treatment	Can the intended treatment be incorporated alongside competing priorities and existing therapy?	Explore how the medicine fits the patient's treatment goals and current workload
Interpreting dose, timing, and administration instructions	The patient can explain the prescribed action accurately	Whether the schedule can be reproduced reliably in ordinary routines	Are appropriate times, meals, devices, assistance, storage conditions, or reminders practically available?	Test the instruction against an actual day rather than stopping after verbal recall
Recognizing precautions, interactions, and monitoring requirements	The patient understands actions or observations expected outside the pharmacy	Whether monitoring and precautionary work can be completed	Can the patient reach required services, obtain tests, observe relevant changes, and act on results?	Clarify responsibility, access, timing, and escalation arrangements
Organizing several medicines	The patient understands individual instructions	Whether multiple correct instructions remain workable when combined	Does the total regimen create conflicting timings, excessive complexity, or repeated coordination work?	Assess the regimen as a combined workload rather than as separate counselling messages
Maintaining supply and continuity	The patient understands that medication should continue	Whether refills, affordability, transport, availability, or administrative requirements permit continuity	Can medicine supply be maintained without recurrent disruption or unsustainable effort?	Identify foreseeable continuity problems and distinguish them from misunderstanding
Responding when routines or health conditions change	The patient understands the current plan	Whether the plan remains usable under illness, travel, caregiving, work changes, or treatment modification	Is there sufficient flexibility, support, and access to reassessment when circumstances change?	Explain how and when the plan should be reconsidered rather than treating the original instruction as permanently self-executing
Patient capacity	The patient has relevant knowledge or skills only insofar as these form part of capacity	Knowledge alone does not establish available time, energy, resources, support, or functional ability	What resources can the patient actually mobilize to perform treatment work?	Assess capability and available resources separately from comprehension
Treatment workload	The expected activities have been explained	Explanation does not establish that the aggregate workload is sustainable	How much practical, cognitive, logistical, financial, and monitoring work does the regimen impose?	Reduce, coordinate, sequence, or escalate burdens where modification is possible
Feasible medication action	The plan can be performed under the patient's current conditions	Sustainability may still change over time	Can the action be initiated, repeated, monitored, and adapted without overwhelming available capacity?	Treat feasibility as a revisable outcome of counselling, not as an assumption following understanding

Note: The distinctions concerning what remains unresolved after comprehension represent the present article's proposed theoretical synthesis. They do not constitute a validated screening instrument or numerical actionability scale.

Health literacy beyond information recognition

Once comprehension is treated as an intermediate achievement, health literacy can be used more precisely. Medication-literacy evidence suggests that acting on medication information depends on several abilities operating together rather than on information recognition alone. Among community-dwelling older adults with hypertension, medication literacy was associated with personal and social-learning factors, reinforcing the view that the construct is embedded in a wider environment rather than contained entirely within individual cognition [11]. The implication is not that medication literacy should be expanded until it absorbs every determinant of medication behaviour. Doing so would erase the distinction this article is intended to clarify. Instead, informational capability should be separated from the material and organizational conditions under which information is enacted.

Community-pharmacy practice already contains elements that can support this broader informational task. Pharmacists interviewed about health-literacy-sensitive communication described using approaches such as Teach-Back, Chunk and Check, Simple Language, and visual aids, with Teach-Back particularly valued after training [12]. These strategies address whether information is accessible, interpretable, and sufficiently understood. Their use does not make treatment feasible automatically, but it improves the quality of the informational foundation on which further feasibility assessment can occur.

The consultation environment also matters. Qualitative evidence from pharmacists and patients has identified communication, time, manpower, continuity, collaboration, and professional-patient interaction as influences on patient-centred pharmacy consultation [13]. Although those findings derive from hospital pharmacy and require cautious transfer to community practice, they reinforce a general point: what a patient can obtain from counselling depends partly on how the encounter is organized.

Health literacy within the present framework therefore performs a bounded theoretical function. It concerns the patient's ability to access, interpret, evaluate, communicate about, and use medication information sufficiently to know what action is expected. It does not subsume the time required to perform that action, the physical resources needed to complete it, the capacity to coordinate it with other treatment work, or the institutional arrangements that permit it. Preserving that

boundary makes it possible to ask the next question without blaming every implementation problem on communication: what work does the treatment require once its instructions are understood?

Treatment workload and patient capacity

Medication use outside the consultation is an active form of self-management. Qualitative work with older people living at home shows that medication self-management involves continuing decisions across initiation, execution, and discontinuation rather than passive obedience to a fixed instruction [14]. The patient must integrate medicines into routines, respond to problems, interpret changes, organize supplies, and sometimes coordinate assistance. A systematic review of medication self-administration errors in older adults similarly found that medication complexity interacts with cognitive, physical, knowledge, belief, and support factors [15]. Correctly explaining a regimen during counselling therefore cannot establish how successfully that regimen will survive the transition into everyday practice.

Treatment-burden theory provides a vocabulary for the work involved. The minimally disruptive medicine tradition treats treatment burden as the workload created by healthcare and examines that workload in relation to the patient's capacity to undertake it [16]. Capacity is broader than comprehension. Mixed-methods work in patients with chronic conditions identifies multiple capacity domains involving resources, abilities, biography, environment, and access to care [17]. Information may contribute to capacity, but it cannot stand in for these other resources.

The practical value of this distinction is that burden can be made visible rather than inferred from adherence failure. The Multimorbidity Treatment Burden Questionnaire was developed to measure the effort involved in looking after health among people with multimorbidity [18]. In UK primary care, high treatment burden was associated with limited health literacy, financial difficulty, greater numbers of long-term conditions, and greater medication load [19]. These associations should not be converted into a universal causal sequence, but they demonstrate why a person who understands a treatment plan may nevertheless face substantial obstacles to performing it.

Workload-capacity fit is also dynamic. Follow-up research shows that treatment burden can change over time rather than functioning as a stable patient characteristic [20]. Measurement research reinforces the

need for caution: a scoping review identified multiple treatment-burden measures but also important gaps in validity, responsiveness, interpretability, and representation across contexts [21]. No burden score can therefore be treated as a universal cut-point separating actionable from unactionable advice.

The stakes extend beyond medication-taking accuracy. Among patients with multimorbidity, greater treatment burden has been associated with poorer health-related quality of life [22]. Because much of this evidence is cross-sectional, the association does not establish that reducing burden will necessarily improve quality of life. It does establish that treatment work is itself patient-relevant and should not be considered merely an inconvenience surrounding the “real” therapeutic intervention.

Within an Understanding-to-Action account, workload and capacity form a relational condition. A demanding treatment plan is not necessarily infeasible when resources, routines, support, and functional ability are sufficient. Conversely, a seemingly simple instruction may become difficult when capacity is constrained. The relevant question after comprehension is therefore not whether the patient possesses a generalized ability to follow instructions, but whether the total work required by this treatment can be performed under the conditions currently available to this patient.

Counselling as work that must be made usable

If medication advice creates actions that must be performed, counselling has consequences for workload as well as understanding. Healthcare professionals working with low-income rural populations have described how financial, geographic, service, and social circumstances shape treatment burden and patient capacity [23]. Some of these conditions lie beyond the pharmacist's control, but they affect whether recommendations can be implemented. A counselling encounter that ignores them may produce an accurately understood plan whose practical requirements remain incompatible with the patient's circumstances.

Minimally disruptive medicine offers examples of how services can be organized around this problem. A qualitative case study of an HIV clinic examined a care model that operationalized workload- and capacity-sensitive principles through service configuration rather than merely through additional education [24]. Such evidence is illustrative rather than proof that one service model should be transferred to community pharmacy. Its

theoretical importance lies in showing that treatment work is partly designed by healthcare services themselves.

Patients and clinicians describing type 2 diabetes care similarly identify medication regimens, appointments, lifestyle requirements, administrative processes, access limitations, and social resources as interacting components of treatment workload and capacity [25]. The resulting burden cannot always be solved inside a counselling encounter. Nevertheless, counselling can determine whether these demands are noticed, whether an avoidable component is simplified, whether responsibilities are clarified, and whether a problem requiring clinical or system-level action is escalated.

The distinction between a better conversation and a better downstream outcome must remain explicit. In a pilot study of the ICAN Discussion Aid, consultation content changed and workload–capacity issues became more visible, yet the study did not demonstrate an improvement in later medication adherence [26]. This is not evidence that such conversations lack value. It illustrates why proximal achievements and downstream action should be measured separately.

Usable medication counselling can therefore be defined as counselling that produces an understood plan whose practical requirements have also been examined against the circumstances in which the patient is expected to perform them. This does not require the pharmacist to solve every barrier. It requires a different stopping rule for the encounter. The question is no longer exhausted by “Can the patient explain what to do?” It also asks what doing it will require, which parts of that work are modifiable, what resources are available, where the plan is vulnerable, and who is responsible when feasibility depends on decisions outside the patient's or pharmacist's control.

Integrating health-literacy and treatment-burden theory

Health-literacy and treatment-burden theories become most useful together when their explanatory jobs remain distinct. Medication literacy addresses the informational capabilities required to obtain, understand, process, communicate about, and use medication information. Treatment-burden theory addresses the work created by healthcare, while patient-capacity concepts address the resources and abilities available for carrying out that work. A systematic review of treatment-burden assessment confirms that this work extends across understanding treatment, organizing care, monitoring,

adjusting, coordinating, spending time and money, and relying on caregivers or other support [27].

The synthesis proposed here therefore separates two questions that are often collapsed during medication counselling. The first is informational: does the patient understand the medication-related action sufficiently to know what is expected? The second is enactive: can that understood action be performed, repeated, monitored, and adapted under the patient's present workload–capacity conditions? Failure on the first question produces a comprehension problem. Success on the first combined with failure on the second produces the specific phenomenon this article seeks to explain.

This formulation also prevents treatment burden from becoming a catch-all explanation for nonadherence. Patients may understand and be capable of performing a treatment while deciding that its benefits, risks, meanings, or priorities do not justify doing so. Others may be willing and capable yet encounter medicine shortages, unaffordable costs, inaccessible monitoring, or service rules they cannot change. The framework must therefore preserve preference-sensitive and system-constrained pathways alongside workload–capacity mismatch.

The theoretical gain is not the addition of another counselling checklist. It is a change in the unit of explanation. Medication advice is treated as a proposed action embedded in a configuration of information, work, resources, routines, services, and patient priorities. Understanding is one necessary achievement within that configuration. Whether understanding becomes medication action depends on what the plan subsequently demands and on the capacity available to meet those demands. The next stage of the argument specifies how these relationships form the proposed Understanding-to-Action Framework and how different configurations can produce comprehension without feasible action.

Proposed understanding-to-action framework

The proposed Understanding-to-Action Framework begins from a deliberately limited claim: successful

comprehension establishes that medication advice has been interpreted sufficiently for the intended action to be understood, but it does not establish that the action is feasible. Translation into practice occurs only after that understood action encounters the workload generated by treatment and the capacity available to perform it. Because both workload and capacity may change, the relationship is dynamic rather than a one-directional sequence.

The framework contains six analytically distinct elements. Comprehension concerns whether the patient correctly understands what is expected. Medication and health literacy concern the informational abilities used to obtain, interpret, evaluate, communicate about, and apply medication information. Treatment workload concerns the practical, cognitive, logistical, financial, monitoring, and coordination work generated by treatment. Patient capacity concerns the resources and abilities available to perform that work. Counselling usability concerns the extent to which professional communication exposes, clarifies, adapts, coordinates, or escalates practical requirements rather than merely transmitting accurate information. Feasible medication action concerns whether the resulting plan can actually be initiated, repeated, monitored, and adapted under the patient's circumstances.

These elements should not be treated as successive stages that every patient traverses in the same way. Workload may increase after an initially feasible plan is established; capacity may fall because of illness, caregiving, financial change, or competing demands; and counselling may reveal that an apparently individual difficulty originates in a service arrangement. System changes can alter treatment burden in heterogeneous ways, demonstrating that burden is not created solely by patients' characteristics or their medicines [28]. The model therefore includes feedback and reassessment rather than assuming that one successful counselling encounter permanently resolves feasibility.

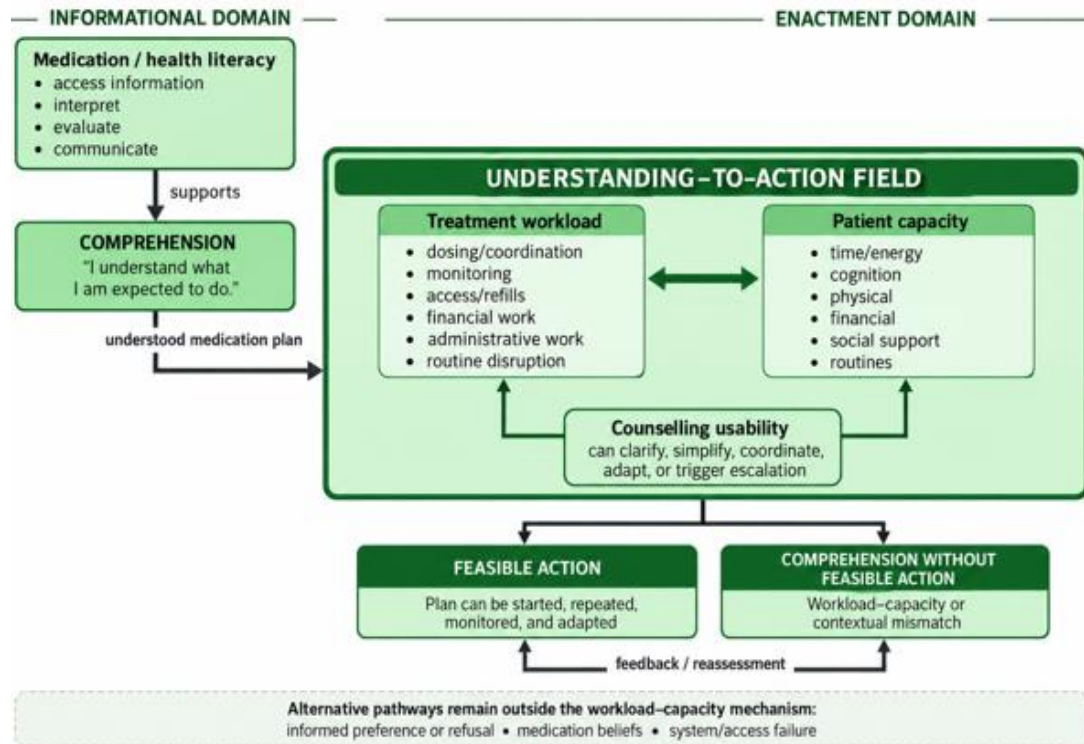


Figure 1. Understanding-to-Action Theory-Synthesis Framework: why understood medication advice may or may not become feasible medication action

Conditions producing comprehension without feasible action

Comprehension without feasible action occurs when informational success is preserved while some other requirement for enactment is not. One configuration is workload overload: the patient understands each element of treatment but the aggregate schedule, monitoring requirements, coordination, administrative work, or lifestyle demands exceed what can be sustained. A second is capacity constraint, in which the plan is understood but time, energy, physical ability, cognitive resources, money, transport, support, or routine stability are insufficient. A third is service-created mismatch, where the obstacle arises from appointment systems, medicine availability, fragmented responsibilities, inaccessible monitoring, or requirements that the patient cannot modify.

These configurations can produce superficially similar outcomes. A missed dose could follow misunderstanding, an incompatible work schedule,

inability to obtain the medicine, exhaustion from competing treatment tasks, or an informed decision not to take it. Patient and clinician priorities in multimorbidity do not always coincide, and patients may legitimately weight outcomes or treatment demands differently from professionals [29]. Preference-sensitive non-use must therefore remain conceptually distinct from incapacity. Calling every informed rejection a feasibility failure would convert the framework into a compliance model and erase patient agency.

The same boundary applies to medication beliefs. A patient may possess sufficient capacity yet decline treatment because expected benefits are judged too small, adverse effects too important, or the treatment inconsistent with personal goals. Conversely, a patient may strongly prefer to follow a regimen but be unable to do so under existing service or resource conditions. The observable behaviour—nonimplementation—cannot identify the mechanism without further assessment.

Table 2. Configurations in which medication advice may be understood but action remains difficult, partial, delayed, or unsustainable

Configuration	Comprehension status	Dominant mismatch	Likely observable pattern	What should not be inferred	Counselling response
Aggregate workload overload	Preserved	Total treatment work exceeds available capacity	Omissions, simplification by the patient, delayed monitoring, inconsistent execution	That instructions were necessarily misunderstood	Identify the most burdensome tasks; coordinate, simplify, or escalate modifiable demands
Routine incompatibility	Preserved	Dosing or monitoring requirements conflict with work, sleep, meals, caregiving, or other routines	Recurrent difficulty at particular times or situations	That the patient lacks motivation globally	Reconstruct the plan against the patient's real routine and seek permissible alternatives
Physical or cognitive capacity constraint	Preserved wholly or partly	Required action exceeds functional ability even when its purpose is understood	Device difficulty, organizational errors, inability to complete multistep tasks	That repeated explanation alone will solve the problem	Assess practical performance; involve aids, support, prescribers, or other services where appropriate
Financial or access constraint	Preserved	Medicine, transport, monitoring, or service requirements are unaffordable or inaccessible	Delayed collection, interrupted supply, missed testing or follow-up	That nonuse reflects informational deficiency	Identify access problem explicitly and escalate to appropriate financial, prescribing, or service pathway
Fragmented service responsibility	Preserved	Patient must coordinate tasks that services have not coordinated	Repeated calls, duplicated visits, uncertainty over who should act	That the patient alone owns the coordination failure	Clarify responsibility and transfer unresolved service problems to the responsible professional or organization
Temporally changing capacity	Preserved	A previously workable regimen becomes difficult after illness, life change, new treatment, or loss of support	Declining sustainability after an initially successful period	That earlier feasibility guarantees later feasibility	Reassess rather than simply repeat the original counselling
Belief- or preference-sensitive non-use	Preserved	Patient's evaluation of benefits, harms, meanings, or priorities differs from the proposed plan	Intentional modification, delay, or refusal	That the patient is incapable of following the plan	Explore preferences and support informed decision-making rather than treating the issue as a capacity deficit
Mixed configuration	Preserved or variable	Workload, capacity, beliefs, and system factors interact	Unstable or context-dependent medication use	That a single causal label explains behaviour	Separate contributory mechanisms and address each at the appropriate level

Note: These configurations are theoretically derived categories for research and counselling analysis. They are not validated diagnostic classes and do not imply numerical thresholds of workload, capacity, or adherence.

Implications for community-pharmacy counselling

The framework changes the endpoint of counselling without requiring community pharmacists to assume responsibility for every determinant of medication use. A comprehension check remains necessary because an infeasible plan cannot be distinguished from a misunderstood plan unless understanding is first established. The next step, however, is to test the practical implications of the understood instruction.

A feasibility-aware consultation can ask how the medicine will fit into an ordinary day, what other treatment work competes with it, what monitoring or refill tasks it creates, and where the patient anticipates difficulty. This moves the conversation from hypothetical capability to situated performance. It also permits the pharmacist to distinguish interventions available within the encounter—clarifying instructions, simplifying communication, helping organize medicine use, identifying avoidable duplication, or coordinating supply—from changes requiring prescriber or system action.

Importantly, this is not an argument for asking every patient an exhaustive burden inventory. The intensity of assessment should be proportionate to the regimen, patient circumstances, and signals of difficulty. Nor should community pharmacy be positioned as able to correct structural barriers that lie outside its authority. The framework instead assigns counselling an epistemic role: identifying which part of the understanding-to-action relationship is failing and avoiding an automatic return to more explanation when the problem is practical rather than informational.

Propositions and research agenda

The synthesis produces testable propositions rather than a claim that feasibility has already been established as a validated construct.

Proposition 1. Among patients with comparable comprehension of medication advice, differences in workload–capacity fit will be associated with differences in the feasibility of medication action.

Proposition 2. Comprehension-focused communication interventions will have stronger effects on proximal informational outcomes than on sustained medication action when important workload or capacity constraints remain unchanged.

Proposition 3. Feasibility-aware counselling will identify practical barriers that are not detected by comprehension assessment alone and will therefore alter the type of intervention or escalation selected.

Proposition 4. The relationship between comprehension and feasible medication action will vary over time because treatment workload and patient capacity are dynamic rather than fixed.

Proposition 5. Beliefs, preferences, and health-system constraints will explain a proportion of apparently infeasible medication behaviour independently of workload–capacity mismatch.

Testing these propositions requires measurement designs that do not collapse comprehension, burden, capacity, adherence, and feasibility into one outcome. Studies could first establish medication comprehension and then compare patients with approximately similar informational performance but differing workloads or capacities. Prospective designs could determine whether an intermediate measure of practical feasibility predicts subsequent implementation beyond comprehension alone.

Intervention studies should likewise distinguish communication success from action feasibility. A useful comparison would contrast comprehension-focused counselling with counselling that also assesses routine fit, required treatment work, and capacity. Outcomes should include proximal comprehension, identified feasibility problems, modifications or escalations generated by the encounter, subsequent ability to perform required medication work, and distal medication-use outcomes. Such designs would test whether the proposed construct adds explanatory or practical value instead of presuming that it does.

Results and Discussion

The central contribution of this article is to separate understanding medication advice from being able to enact it. Health-literacy scholarship establishes that medication-related information must be accessible and interpretable, but empirical relationships between literacy and adherence are heterogeneous [5]. Treatment-burden scholarship establishes that healthcare requires work and that patients possess unequal and changing capacity to perform that work. Combining these literatures without collapsing their constructs produces a specific theoretical claim: comprehension can be successful while enactment remains infeasible.

This distinction also refines interpretation of common counselling strategies. Teach-back can expose misunderstanding and strengthen confidence that a patient has interpreted advice as intended [10]. It cannot

by itself establish whether that advice can be incorporated into the patient's life. Conversely, the absence of adherence does not retroactively prove inadequate comprehension. The ICAN feasibility study is instructive because changing what is discussed in consultations did not automatically translate into improved later medication adherence [26]. Proximal conversational outcomes and distal medication behaviour should therefore remain analytically distinct. The framework has several boundaries. Much of the treatment-burden and patient-capacity evidence comes from multimorbidity, primary care, chronic-disease management, or other health-service settings rather than direct tests in community pharmacy. Transfer to community-pharmacy counselling is therefore theoretical and requires empirical evaluation. The framework also does not establish a universal threshold at which treatment becomes infeasible. Existing treatment-burden measures have important measurement and interpretability limitations [21].

A further boundary concerns attribution. Some medication difficulties originate in service design, supply, affordability, prescribing, monitoring access, or coordination requirements. Pharmacists may detect such problems without possessing authority to correct them. Feasibility-aware counselling should therefore not become another mechanism for shifting system-generated work onto patients or frontline pharmacists. Finally, the framework is falsifiable in principle. Its contribution would be weakened if workload and capacity add no explanatory value once comprehension, preferences, and system constraints are measured; if patients with comparable comprehension show no meaningful variation in action associated with workload-capacity configurations; or if counselling that identifies practical work does not alter intervention choice, escalation, or any intermediate measure of feasibility. These are empirical questions rather than assumptions built into the model.

Conclusion

Medication advice does not become usable merely because it has been understood. Patients must convert an interpreted recommendation into repeated activity within routines, resources, competing demands, service arrangements, and personal priorities. Health and medication literacy explain an essential part of this process, but they do not exhaust it.

The Understanding-to-Action Framework therefore distinguishes informational success from practical feasibility. It proposes that treatment workload, patient capacity, counselling usability, preferences, and health-system conditions determine whether understood advice can become sustainable medication action. For community pharmacy, the resulting question is not only whether a patient can explain what to do, but whether the plan that has been explained can actually be lived.

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