

## Various ways of understanding compliance: a psychiatrist's view

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### Summary

The notion of compliance is commonly considered to be synonymous to the degree to which a patient correctly follows medical advice. Nowadays this definition is criticised for being a remnant of a paternalistic tradition in the relations between physicians and their patients.

The authors discuss the contemporary views on the issue of compliance (seen either as the element of patient-practitioner interaction, self-care behaviour, as a cognitive-motivational process, or as an ideology), and highlight possible implications of those views for psychiatric practice.

**compliance / psychiatry / philosophy**

### WHAT COMPLIANCE IS (OR RATHER: WHAT IT SEEMS TO BE)

#### Classical perspective and its criticisms

The problem of patients' co-operation in the process of treatment and their attitude towards this process has been an object of research since 1950. Depending on the assumed definition, population included in the trial, nosological issues and adopted ways of measurement, compliance rates vary in a wide range between 10 and 85% [1].

Although compliance has been analysed from various perspectives (including medicine, nursing, psychology, sociology, health economics – and even philosophy), there is no consensus around the definition of this notion.

The term 'compliance' was introduced into the field of medical sciences by David L. Sackett in 1976 [2]. His definition of this idea (developed by Haynes, Sackett and Taylor two years later) has been the most widely acknowledged (or at least: the most frequently cited) conceptualisation of compliance so far. It states that compliance is 'the extent to which a person's behaviour (taking medications, following a recommended diet or executing life-style changes) coincides with medical or health advice' [3].

With its relative simplicity (and perhaps proximity to 'common sense') this construct has also been harshly criticised because of its implicit paternalistic background. It seems to be rooted in a tradition of an 'oblique relationship' between patient and physician – with dominant position of the latter. Helvi Kyngäs, Mary E. Duffy and Thilo Kroll point out at a quite radical (but not impossible in the realm of clinical practice) implication of Sackett's hint about compliance. In their opinion the definition quoted above makes it virtually impossible for the patient to be involved in therapeutic process on the basis of partnership. This kind of a 'primary' submission to the authority of healthcare personnel leads directly to a loss of autonomy. Finally, they strongly em-

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phasise (citing opinions of various authors [4, 5, 6]) that: 'this definition has been rejected because of its paternalism and its implication that healthcare personnel have the right to authority over the patient's behaviours and actions' [1]. Hensook S. Kim also noticed that Sackett's perspective on compliance does not take into account the fact that apparently identical behaviours might arise from completely different motivations. Seemingly 'good compliance' might be a result as different processes as coercion, conformity or – poles apart – therapeutic alliance [5].

### **What differs the relationship between patient and physician in psychiatry from similar relations in other fields of medicine? The differences' implications for the issue of compliance**

In the realm of psychiatry the 'geometry of relationship' between a physician and a patient gains paramount importance. The 'oblique (authority-based) relationship', although quite common in somatic medicine, usually leads nowhere in terms of establishing strong therapeutic alliance in psychiatry.

According to the prominent Polish psychiatrist Antoni Kępiński relationship between physician and patient is a reflection of one out of two general cognitive patterns making it possible to explore the outside world.

The first one – 'an oblique (volitional) plane of cognitive contact' – reflects the humane tendency for putting the surrounding universe in order. This can be considered to be the source of scientific cognition: 'The human feels confident if the world acts in accordance to his ideas; if he can manage the environment; if he can influence it; when he feels like being a master. He considers the environment to be an obstacle to his plans and aims. He wants to get rid of this hurdle; he wants to subdue it.' [7]

This cognitive pattern has some undeniable advantages – at least from physician's point of view. It makes it easier for a doctor to avoid the traumatic experience of the encounter with somebody else's suffering. Or – in terms of the philosophy of Emmanuel Lévinas – it serves as a protection from the experience of meeting The Other: 'the fathomless point' [8] calling for ethical responsibility. [9] Lévinas himself expound-

ed this drama in a much more drastic way: 'My relation to the other is not some benign benevolence, compassionate care or respect for the other's autonomy, but is the obsessive experience of a responsibility that persecutes me with its sheer weight.' [10]

As this demand is unfulfillable, then how can the subject weaken 'the devastating burden of superego' [8]? It seems that one of possible strategies bases on separating the disease from the person. It is much easier to take position of a 'scientist' involved in the analysis of somatic pathology at a cost of moving away from the world of someone's subjective experiences – someone who imperceptibly became an object of scientific investigation.

The second cognitive pattern pointed out by Kępiński ('horizontal or volitional plane of cognitive contact', as he called it) derives from the ability of recognising other people's emotional states, gained in the environment of the early relationship between mother and child. Although knowledge achieved this way is much more difficult to verify than data gained by using 'the scientific method', the author claims that reliability of 'emotional information' achieved this way cannot be underestimated. Kępiński argues that: 'Not only it is the oldest way of recognising the surrounding world, but also the most important one. (...) Objectivity and truthfulness of the cognition of somebody else's psychological state is the necessary condition of staying alive.' [7]

The evolution from the 'oblique' to the 'vertical' attitude towards patient seems to be a defining element of psychiatric practice. But this kind of regression 'from a scholar to a child' (the process of regaining the ability of feeling other people's emotions regardless of masks, curtains and entanglements) has its price. The cost is a direct, traumatic (in a Lévinasian sense, where 'a trauma is something that comes from outside the self, the irruption of a heteronomous fact that can strike without warning, like a terrorist explosion' [10]) exposition to the world of the other's emotions. In the realm of emotional interplay between two subjects it is much more difficult (if not impossible) to defend ego behind the firewall of authority of 'A Doctor'. Nevertheless, the ultimate award is also high: only this kind of relationship makes it possible to pass from 'compliance' in a conservative sense (i.e. 'following

the instructions of a physician-mentor') to 'concordance' – the partnership between a physician and a patient, where the latter person is a rightful subject, fully engaged in the two-way communication with a doctor and actively shaping the decision-making process. [11]

### **BEYOND RELATIONSHIP: ALTERNATIVE PERSPECTIVES ON COMPLIANCE**

The history of research on the issue of compliance can be succinctly described as the history of attempts to define this notion, as well as related terms. So, there is nothing peculiar in the fact that there do exist much wider conceptions of compliance than those that just confine to the microcosm of relations between patient and physician.

According to Kyngäs et al. compliance can be seen:

1. as the element of the patient-practitioner interaction,
2. as self-care behaviour,
3. as a cognitive-motivational process,
4. as an ideology [1].

Each of those perspectives are discussed below.

#### **Untangling the onomastic maze**

First of all, let us tidy-up the mess around the meaning of words closely related to 'compliance'.

As we mentioned above, such terms as 'compliance', 'adherence' and 'therapeutic alliance' are often considered to be synonymous. Nevertheless, they do not mean the same.

According to B.P. Madden both 'compliance' and 'adherence' refer to the interaction between patient and physician, while 'therapeutic alliance' is related with the process of interaction itself [1, 12].

In the interpretation given by J. Fawcett the difference between 'compliance' and 'adherence' comes down to different layout of responsibilities. While 'adherence' emphasise physician's role in the establishment of therapeutic relationship, 'compliance' seems to stress pa-

tient's responsibility for following doctor's instructions (yet again, this perspective is rooted in the conservative point of view, where patient's actions are a function of physician's authority) [1, 13]. Both notions of 'adherence' and 'compliance' seem to apply to the 'oblique relationships' between patient and practitioner, although the word 'adherence' is intended to be less judgmental [1, 14] J. Wilder, R. Plutchnik and H. Conte suggested that in the term of compliance responsibilities of patient and physician focus in equal parts (quote: 'compliance [is] as much a function of their [patients] interactions with psychiatric personnel and of the suitability of the recommendations as it is of personal characteristics of the patients themselves.' [15, 16]. 'Concordance' seems to be a much more modern term, stressing partnership between patient and practitioner. According to R. Gray, T. Wykes and K. Gournay: 'Concordance emphasizes patient rights, the need for information and the importance of two-way communication and decision-making. In stark contrast with a compliance model, a concordance model suggests that patients have the right to make decisions (such as stopping medication) even if clinicians do not agree with the decision.' [11])

#### **Compliance in the context of interaction between physician and patient**

In the viewpoint of Dracup and Meleis (1982) compliance is a dynamic process in which patient and physician together make decisions about a suitable healthcare regimen. They define the notion as: 'The extent to which an individual chooses behaviours that coincide with a clinical prescription, the regimen must be consensual, that is, achieved through negotiations between the health professional and the patient.' [1, 4].

B. Vivian points out at the important role of a nurse in the process of compliance. In the author's opinion the nurse's task is to assist the patient and his or her family with compliance [17]. This statement assumes an active role (i.e. the joint responsibility) of all parties involved in the therapeutic process [6].

In the article published in 1989, L.C. Hussey and K. Gilliland linked compliance with the idea

of mutuality. According to their definition 'compliance' is: 'The positive behaviour that patients exhibit when moving toward mutually defined therapeutic goal' [1, 18]. The term of mutuality can be understood as: 'A connection with or understanding of another that facilitates a dynamic process of joint exchange between people. The process of being mutual is characterised by a sense of unfolding action that is shared in common, a sense of moving toward a common goal, and a sense of satisfaction for all involved' [1, 19]. As we can see, an implementation of mutuality to the theoretical construct of compliance shifts the latter idea from the region of paternalism into the realm of autonomy and empathy.

### Compliance seen as self-care behaviour

'Self-care behaviour' is one of the most important concepts in health promotion. It is used to describe decisions and actions that an individual can take to cope with a health problem or to improve his or her health [20]. Compliance can be understood as an element of self-care behaviour, while noncompliance is a self-care deficit [21]. Nevertheless we have to note that while self-care 'by definition' is performed on behalf of maintaining health and well-being, than compliance might be just an effect of following orders of a physician [1]. Sometimes it might have more in common with passive aggression than with self-care. On the other hand, while lack of self-care always is a threat for well-being, than in some situations compliance deficit may be helpful as a reflection of patient's 'common sense' as a form of defence against healthcare professional's wrong decisions.

### Compliance as a cognitive-motivational process

Within the cognitive-behavioural paradigm compliance can be conceptualised as a resultant of patient's attitudes and opinions leading to concrete intentions towards recommended therapeutic plan. In this perspective, Kyngäs et al. gave the following perspective on the notion: 'Compliance has been defined as the patient's active, intentional and responsible process of self-care, in which the patient works to maintain his or her health in close collaboration with health-

care staff. This definition includes both self-care behaviour as an outcome of the patient's process and actions (activity, responsibility and collaboration with healthcare personnel) and a commitment to self-care.' [1, 22, 23]

It is important to note at this point that cognitive-behavioural therapy (CBT) has been proven to be very effective in enhancing compliance. Acquisition of new skills and knowledge is the cornerstone of this therapeutic paradigm. By gaining insight into the assumptions of treatment, as well as by understanding his or her role in this process, it is easier for the patient to get involved into collaboration with the clinician and – at the same time – to become a subject within the relationship with the healthcare professional. [24]

### Compliance as an ideology

In his intriguing considerations on the role of ideology in contemporary culture and politics, Slavoj Žižek (one of the most prominent representatives of Frankfurt School's Critical Theory [25] these days) noted that the most elementary definition of ideology can be found in Karl Marx's *Capital*: 'Sie wissen das nicht, aber sie tun es' – 'They do not know it, but they are doing it' [26]. This observation leads to the conclusion that: 'The very concept of ideology implies a kind of basic, constitutive *naïveté*: the misrecognition of its own presuppositions, of its own effective conditions, a distance, a divergence between so-called social reality and our distorted representation, our false consciousness of it.' [27]

In the realm of healthcare, ideology is understood as 'a system of shared beliefs concerning behavioural norms and values' [1, 28]. Let us add: very often it is a system of implicit beliefs based on the recognition of physician's authority. J.A. Trostle pointed out that this ideological bias finds its reflection in research strategies, interpretation of outcomes of clinical trials and their implications for the clinical practice. The reason for this status quo is the fact that: 'Research has defined patient behaviour in terms of professional expectations, and has ignored health-related behaviour that contradicts the profession's view of its own centrality in health care.' [1, 28]

Thankfully, this pessimistic view does not seem to be fully valid anymore. As we mentioned

above, in recent years there has been a major shift in the opinions about the nature of compliance and patient's role in this process. Nowadays 'compliance is a decision taken by the patient' [1, 29] and this opinion is being systematically built in the system of healthcare professionals' assumptions (also the implicit ones) about their occupations – creating a new ideology.

## CONCLUSIONS

Although the issue of compliance has been an object of research for the past sixty years, the interpretation of this notion still raises controversies. The existence of numerous (vague at times) terms related to compliance (e.g. adherence, concordance, mutuality, or therapeutic alliance) does not make the task any easier.

The earliest definition of compliance (provided by D.L. Sackett) is being increasingly rejected nowadays, as it confines the problem to the dichotomy between (dominant) physician's recommendations and (submissive) patient's 'positive' response. This historic assumption (being a kind of a cornerstone of an 'oblique relationship' between a healthcare professional and a patient) seems to be particularly inadequate in psychiatry, as it usually leads nowhere in terms of creating strong therapeutic alliance. Establishing concordance (the partnership between a physician and a patient, where the latter person is a rightful subject, fully engaged in the two-way communication with a doctor and actively shaping the decision-making process) seems to be a much more suitable way of achieving therapeutic progress in the discipline of psychiatry.

Apart from the construct of compliance as an intrinsic feature of the patient-practitioner interaction, the notion can also be seen as a variant of patient's responsibility (self-care behaviour) or psychological (cognitive-motivational) process.

In the field of Critical Theory compliance can be analysed in terms of ideology, i.e. a system of shared implicit beliefs concerning behavioural norms and values (in this case: organising interpersonal relationships in the realm of the healthcare).

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**Table 1.** Various definitions of compliance and related terms

Term	Definition	Reference
Compliance	The degree to which the patients adhere to the regimen recommended by their physician.	Encyclopaedia Britannica Online, 2011
	The degree to which a patient carries out the recommendation of the treating physician.	Sadock & Sadock, 2007
	The extent to which a person's behaviour (taking medications, following a recommended diet or executing life-style changes) coincides with medical or health advice.	Haynes, 1978
	The patient's active, intentional and responsible process of self-care, in which the patient works to maintain his or her health in close collaboration with healthcare staff.	Kyngäs, 2000; Maćzka, 2009; Maćzka, 2010
	The extent to which an individual chooses behaviours that coincide with a clinical prescription, the regimen must be consensual, that is, achieved through negotiations between the health professional and the patient.	Dracup & Meleis, 1982
	The positive behaviour that patients exhibit when moving toward mutually defined therapeutic goal.	Hussey & Gilliland, 1989
Adherence	'Adherence to (or compliance with) a medication regimen is generally defined as the extent to which patients take medications as prescribed by their health care providers. The word "adherence" is preferred by many health care providers, because "compliance" suggests that the patient is passively following the doctor's orders and that the treatment plan is not based on a therapeutic alliance or contract established between the patient and the physician.'	Osterberg & Blaschke, 2005
Concordance	The partnership between physician and patient, where a latter person is a rightful subject, fully engaged in the two-way communication with a doctor and actively shaping the decision-making process.	Gray, 2002

<p>Mutuality</p>	<p>The connection with or understanding of another that facilitates a dynamic process of joint exchange between people. The process of being mutual is characterized by a sense of unfolding action that is shared in common, a sense of moving toward a common goal, and a sense of satisfaction for all involved.</p>	<p>Henson, 1997</p>
<p>Therapeutic alliance</p>	<p>In psychotherapy, therapeutic alliance is the synthesis of three related components:              client and therapist agreement on goals of treatment,              client and therapist agreement on how to achieve the goals (task agreement),              the development of personal bond between the therapist and client.</p>	<p>Bordin, 1979, as cited in Andrusyna, 2001</p>

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