Clinician–patient relationship and adherence to treatment

by Daniele La Barbera, Caterina La Cascia, Alice Mulè, Salvatore Raspanti, Andrea Rossi

From compliance to adherence

Medication nonadherence, defined as a patient's passive failure to follow a prescribed drug regimen, is a pervasive medical problem and a significant concern for healthcare professionals and patients [1] because it may have serious detrimental effects on the patient's health and quality of life, and may lead to further morbidity or mortality. If a patient does not regularly take the medication prescribed, no potential therapeutic gain can be achieved. Several variables contribute to nonadherence and thus negatively affect treatment outcomes, especially in chronic diseases such as diabetes, hypertension and schizophrenia. These barriers to medication adherence are multifactorial and include complex medication regimens, convenience factors (e.g. dosing frequency), behavioural factors, and the clinician–patient relationship [2].

According to Gould [3], the concept of compliance is itself a barrier because it implies the patient's dependence on the physician and does not help the patient to progress towards better clinical goals.

There is a conceptual difference between compliance and adherence. Compliance is the result of a medical model of health care associated with a one-way relationship with a clinician who prescribes the medical regimen with which the patient is expected to comply [4]. Adherence, however, is defined as the extent to which health behaviour reflects a health plan constructed with and agreed to by the patient who shares health decision making with the clinician [5]. Deciding between the terms adherence and compliance is not just a semantic choice; the terms convey different points of view.

An adherence model implies that the physician develops a collaborative patient-centred relationship with the patient, such that the clinician and the patient together choose their goals, activities, and medication regimen. Patients can discuss and negotiate their treatment with their clinician without any concern that they are being judged. A compliance model, however, implies a clinician-centred relationship such that goals, rules, activities, and medication regimes are established by the doctor.

Medication management is one of the main issues in healthcare plans for adults with chronic diseases; the difference between compliance and adherence has therapeutic implications for drug management. When clinicians focus on compliance, they have medication assumption as their first priority, their main objective being to persuade the patient to follow the prescribed regimen. When clinicians focus on adherence, they must promote and maintain a relationship with the patient based on mutual trust that assists the patient's collaboration and motivation to conform to a plan agreed by both parties. Medication management becomes an important part of the global healthcare plan but is not its only aim [3].

Noncompliance may be seen by the physician as resistance in a 'me-versus-you' scenario. The physician must try to persuade the patient of the medication's safety and efficacy. On the other hand, nonadherence could be seen as a chance to bring new information and communication into the clinician–patient relationship; for example, doctors might ask themselves why some patients adhere to the drug prescription and others do not.

Many factors affect patients' adherence. Bergman-Evans [6] distinguishes between *purposeful* and *unintentional* nonadherence. *Purposeful* nonadherence is related to personal traits, characteristics and values, religious and cultural belief systems, and to patients' choices about the drug prescription (dose, timing, therapeutic and side effects) or the nature of the illness itself. Many other barriers may affect patients' adherence: cognitive, physical, psychological, and economic barriers [3]. Dementia, cognitive impairment, and executive functioning deterioration represent the main cognitive barriers. Specific physical deficits such as being blind or deaf can create difficulties in doing simple tasks such as opening medication containers, reading labels, or understanding the clinician's directions. Furthermore, some patients are compelled to stop treatment because medications are too expensive. Psychological factors may also influence patients' adherence. In specific psychiatric syndromes, as in other chronic diseases, tendencies to deny the chronic nature of the disorder can affect the quality of adherence; the more serious the illness, the higher the risk of patient withdrawal.

The quality of the clinician–patient relationship and patient satisfaction can influence adherence to treatment; both are related to the personal characteristics of both the clinician and the patient, to the severity or the type of illness, and to the clinician's medical and human skills.

The clinician-patient relationship and the role of empathy

Despite the dehumanisation of medical care, there is growing agreement among physicians that the quality of the relationship with the patient is critical in high-quality health care and can influence outcomes. Absence of empathy and compassion in the relationship with the patient

is acknowledged as a predisposing factor to malpractice [7]. Furthermore, there is a general consensus that there are associations between the clinician's caring attitude, the appropriateness and effectiveness of treatment, and the patient's satisfaction [8].

Thus, although the doctor's knowledge and competences are essential, they alone may not achieve high quality clinical goals and the patient's wellbeing. The paradox is that while clinicians express their caring by carefully doing what they have learnt—diagnosis, assessment, treatment—patients feel this as uncaring because they need to be heard and emotionally understood [9]. At the end of a visit, even if the physician's medical input was perfect, if they did not communicate effectively with the patient, the patient is unlikely to fully appreciate their professionalism and, thus, is unlikely to be fully motivated for the next meeting. It seems clear that physicians need to improve their human abilities and communication and relational skills. Is empathy a natural trait or can it be developed? How can a clinician become more empathetic? This is not straightforward.

Empathy can be viewed as an ability to recognise emotions that are present but are not clearly expressed; it allows exploration and awareness of unexpressed feelings so that the patient feels understood [10]; a classical model suggests that this is a complex construct composed of four elements: the first two are emotional and moral components related to the clinician's intrinsic ability and motivation to pay attention to the emotional experience of others [11]. These are the basic and essential components of empathetic communication. The other two elements, which are cognitive and behavioural components, are even more important in the clinician–patient relationship. The cognitive factor implies an accurate understanding of the patient's feelings and emotional condition, the behavioural one takes the form of effective communication with the patient about their feelings so that they feel understood and not alone. Feeling understood is intrinsically therapeutic; it bridges the isolation of illness [11], increases the likelihood of deeper relationships and increases adherence to treatment [10]. Empathetic behaviour helps the patient to accept drug prescription; it can extend the therapeutic effects and reduce the side effects of pharmacological therapy; finally, it is absolutely necessary for psychotherapy or rehabilitation programs.

Clinician–patient relationship and the role of communication

The model of relationship-centred care reflects the idea that good treatment aims can be pursued only if doctors do their best to engage in a collaborative relationship with the patient; the relationship with the patient should be the first therapeutic aim. According to Beach's definition, relationship-centred care is founded on several core principles: 1) relationships in health care ought to include the authenticity of the clinicians; 2) affect and emotion are important components of the relationship; 3) all healthcare relationships occur in the context of reciprocal influence; 4) as in any other relationship, cognitive and emotional processes are present in the relationship with the patient [12].

Emotions, mood and feelings are revealed through nonverbal behaviour, which influences the therapeutic relationship and important outcomes, including satisfaction, adherence and clinical goals [13]. A high quality clinician–patient relationship depends on the emotional context especially nonverbal communication and emotion-related communication skills. Nonverbal communication includes behaviours that are independent of the linguistic content, and includes paralinguistic characteristics (such as speech rate, pauses, loudness, interruptions) and physical behaviours (such as facial expressivity, eye contact, postural position, smiling) [14]. Emotions, feelings and mood are more readily expressed through nonverbal behaviour than by words particularly within the clinician–patient relationship where the patient may be worried that they are being judged by the doctor.

According to Watzlawick [15] "One cannot not communicate" meaning that we communicate even if we do not intend to. Furthermore, we can control our linguistic communication, but we can't be sure that our bodies are not conveying our thoughts and emotions. In the physician–patient relationship, both the clinician and the patient show their emotions and, consciously or unconsciously, judge each other's emotions. Doctors may use a patient's affective cues in the diagnosis or evaluation of their clinical course [16]; on the other hand, the expression of the clinician's emotions can help the patient in their decision to see their doctor again, and to build a collaborative relationship and a truthful communication rather than to stop the therapeutic relationship.

Clinicians' skills at communicating their emotions and feelings to patients and at understanding patients' verbal and nonverbal communication are crucial to positive relationships. Physicians who understand and are aware of their own feelings, and can read and correctly interpret other people's nonverbal cues, have more satisfied patients who are more likely to attend their next appointment than are those of doctors less skilled in these areas [17]. Some specific nonverbal behaviours of clinicians may affect their relationships and the satisfaction of their patients. Less time spent in reading medical notes, more nodding, more gestures, closer interpersonal distances, more gazing, more smiling, more eye contact, and an expressive tone of voice and face [18,19] may all improve the patient's trust in the physician and their motivation to adhere to treatment.

Communication can be considered a therapeutic action, and when doctors are aware of this, patients' satisfaction and adherence to treatment can be improved, regardless of the severity or type of illness. Other elements including age, gender, education, economic and socio-cultural status moderating clinician–patient communication, should always be considered. According to several studies, female patients prefer a more 'feeling-oriented' clinician than do males [20]. Clinicians must consider these factors in choosing the most appropriate approach to the patient.

Strategies to improve patients' adherence

A patient's adherence to treatment is related to their personal characteristics, their disease, and to the clinician's >

> communication skills and ability to understand the patient's requests [21]. Ley [22] adds a cognitive component to patient adherence: simple and clear communication improves patients' satisfaction by helping them to understand and remember medical information.

With this aim, Ley suggests four strategies:
1. providing simple written instructions;
2. explicit categorization of the material presented;
3. repetition of important material;
4. use of concrete-specific rather than general advice statements.

Bergman-Evans [6] outlines four outcomes for high-quality treatment:
1. reducing inappropriate prescribing;
2. decreasing polypharmacy;
3. avoiding adverse events;
4. maintaining functional status.

To achieve these outcomes, five elements are needed: assessment, individuation, documentation, education and supervision (AIDES Model). Assessment, individuation and documentation are useful to ascertain the patient's disorder, capabilities, and willingness to be treated, and thus to understand the patient and try to develop a collaborative relationship. Education and supervision also help to improve adherence to treatment. Every step of this model requires the continuous participation of the clinician. Besides these conscious elements of clinical practice, clinicians should re-examine their personal aims, qualities, attitudes and their amenability to change; the latter is not easy to improve, but may be more important than any other aspect of the relationship with the patient.

In addition to learning about diagnosis, pharmacology and medical illnesses; physicians should also improve their personal attitude and communication skills. Physicians may use words like *uncooperative* or *untrustworthy* when discussing patients but nowadays, patients may take similar views of their clinicians, which could affect their adherence to treatment and their general satisfaction. Furthermore, in the internet era, patients are more aware of the nature of their illness and treatments, because of the wide diffusion of medical information on the web; many websites are developed by patients for patients, so patients may be much more knowledgeable and empowered in their relationships with clinicians. Furthermore, social networks such as facebook and twitter provide a means of direct communication for patients and physicians.

Conclusion

Patient adherence to treatment is a complex construct related to the doctor's communication abilities and personal skills in building effective relationships. Besides the technical skills, irreplaceable in helping the patient, relational skills are fundamental to high-quality medical care.

The patient's satisfaction is influenced by the clinician's verbal and nonverbal behaviours. The best pharmacological prescription is not enough for the patient and does not lead to acceptance of their disorder. The patient needs to feel understood, listened to and to be the focus of the treatment and care. It is not easy for a clinician to obtain a patient's trust, willingness and satisfaction. Formulating the correct diagnosis and choosing the best pharmacological treatment is just the beginning of a complex therapeutic relationship that should be characterised by a deep understanding of the patient's needs and by the progressive development of a trusting relationship.

On the other hand, the patient has an increasingly active role in motivating the physician and building a relationship of trust.

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