

## REVIEW ARTICLE

# Patient–Doctor Relationship in Dermatology: From Compliance to Concordance

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**The concept of what the doctor–patient relationship should be has changed increasingly in recent years. Previously, an asymmetric relationship was assumed. Compliance and adherence are terms used currently. The concordance model goes further and examines the effectiveness of the mutual process between the doctor and the patient. In this model the interaction is two-sided and involves finding a decision as partners. The origins of this approach are to be found in psychoanalytic theory. Key words: patient–doctor relationship; compliance; adherence; concordance.**

Accepted May 2, 2016; Epub ahead of print Jun 9, 2016

Acta Derm Venereol 2016; Suppl 217: 25–29.

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The subject of patient compliance has become increasingly important over the past decades. As early as 1994, Steiner & Vetter (1) determined that 200 publications per year appear on this subject. In the publications, the preferred term is compliance, which in translation means consent, agreement, but also submission. Instead, the new term concordance will be proposed. It implies, as will be discussed below, a close complicity between doctor and patient. Conversely, compliance implies that in the two-sided relationship between doctor and patient, the one gives instructions and the other is to follow these instructions. The instructions may consist of the prescription of a medication, the treatment regimen, behavioural rules with respect to certain diets, etc.

In practice, this means that compliance is the patient's willingness to follow a medical recommendation concerning diagnostic and/or therapeutic measures. The conception of what the doctor–patient relationship should be has changed increasingly in recent years. Whereas an asymmetric relationship between the doctor and the patient was originally assumed – the doctor knows best about the disease and treatment, the patient accepts this and follows instructions – nowadays, the opinion is that compliance is to be viewed as a communicative process. The realization has also arisen that compliance factors do not rest alone with the patient, but

that other factors, such as the doctor himself or the type of medication, may influence compliance behaviour. Basically, every patient has the right to accept or reject the recommended examinations or treatments. In this process, value must be placed on linguistic correctness: not “You must take this medication”, but “I suggest that we treat your high blood pressure/skin rash with this medication.” For this reason, it appears desirable that the doctor pay more attention to the problematics of close cooperation with the patient, similar to the high quality of current diagnostics or treatment.

This altered way of looking at things is reflected in the introduction of new terms in the literature. While the compliance model corresponds rather to a paternalistic approach – the doctor has the authority and the largely sole decisional sovereignty – an attempt is made these days to include the patient more strongly in the decisional process.

These new approaches are characterized by the terms *adherence* and *concordance*.

*Adherence* refers to the extent of behaviour with which the patient keeps to the rules that he accepted earlier (2, 3). Adherence means the patient participates in the decisional process of medical rules. This model corresponds more to an informative process, also called a “consumer model” and is strongly characterized by cognitive “interpretation of the doctor–patient relationship, which presumes a largely affect-neutral structure of the information exchange” (4, 5).

The *concordance* model goes further. Here, the basis is a complex idea, with the goal of improving the success or the “outcome” of prescriptions and medical advice. This model has a further reach, since it does not ask, “How much of what the doctor recommends to his patient is actually carried out?” but rather examines the effectiveness of the mutual process between the doctor and the patient.

This model refers in the consultation process not only to the patients and means not only participative decision making – “shared decision making” – but requires rather interaction and communication between the doctor and the patient, with the goal of attaining agreement on appropriate medical diagnostics/treatment as the shared responsibility of the patient and the doctor. The doctor should address emotional and sometimes hardly rational moments in the experience of disease. The interaction

examination is two-sided and requires finding a decision as partners (Fig. 1).

The following factors apply:

- Values and attitudes of the patient and the doctor,
- Medical evidence,
- Knowledge and experience of the doctor,
- Individual patient factors.

These factors illustrate the complex process and should finally lead to a decision. The reasons for a participative decision are numerous: the flood of information in the Internet, doctor's decisions, which are strongly influenced by personal preferences and values and which do not always correlate to the current state of research and knowledge. There is no adequately founded scientific proof for many of the methods established in school medicine. Are patient's questions and wishes sufficiently taken into account? Doing so results not only in increased effectiveness of diagnostics and therapy, but also has clear economic importance (2, 6, 7).

#### THE INTERSUBJECTIVE EXCHANGE: BACK TO PSYCHOANALYSIS?

The origins of this new approach have seldom been discussed to date in Psychodermatology, so the development over the past 20 years in psychology and especially in psychoanalysis is discussed here. No doubt that a series of more complex social and cultural changes are at play, from the 'democratization' of information in contemporary societies, to new role models and the media influence, the consumer society, new sociopolitical attitudes, etc. The point is that psychoanalysis becomes the main body of consolidated thought where the communicative phenomenon has been widely studied with medical purposes. More properly, the topic is intersubjective exchange (8).

In psychoanalysis, intersubjectivity, according to Stolorow et al. (9), was formulated as an experience-oriented form of psychoanalytical theory and treatment practice, including the self-psychology of Heinz Kohut. This theory differs in various points from the classical concept of Sigmund Freud. Stolorow and others are of the opinion that experience arises and occurs in reci-

procal exchange of subjectivities, in the concrete case for example that of the patient and that of the analyst. The observation position is thereby always within the shared context, that is the analyst attempts to understand the patient from the patient's perspective (empathy) and draws on his own biographical background in reflecting on his posture toward the patient (introspection). This has decisive consequences for psychoanalytical theory and practice, which become clear in central terms of psychoanalysis.

Freud defined, "analytical posture" as a form of "neutrality", closely coupled to the idea of abstinence: the analyst must not permit the patient any gratification which enables formation of a transfer neurosis, whereby "gratification" in this context means everything which the patient wants and desires.

The intersubjective approach is moving farther and farther away from Freud's basic scientific position and seeks the meaning of human behaviour in unconscious interpretations independent of any biological basis. Psychoanalysis understands these directions as a purely psychological hermeneutic science. It looks at intersubjectivity – that is the interpersonal relationship and relatedness as the matrix of the subjective psyche. The self is now understood as a construct arising from the construction of the relationship. In this way, purely interpersonal or intersubjective models of the psychoanalytical processes have arisen.

Intersubjectivity thus means concretely that the participants exert reciprocal influence in their thinking, feeling and acting, consciously or unconsciously. The term intersubjectivism is meant in this sense. The idea of a self as a bundle of capabilities then fades into the background. The self as experience arises where two (or more) experiencing and acting beings meet. The analyst can follow this process in the treatment by means of empathy. He is co-experiencer in a mutual context and not an observer on the side-lines. He shares his experience with the patient and takes a completely different posture than in classical analysis. In this light, the analyst is primarily concerned in treatment with grasping by feeling and self-observation that which promotes the development of the inner world.

This approach founds a new concept in psychoanalysis, which views the individual psyche as a fiction, independent of the relationship. The intersubjective approach turns the relationship between individual psyche and relationship around: in traditional thinking, the relationship arises in the meeting of two individuals. Contrary to this idea, the approach views the relationship as the basis and the individual as the result which is formed in the relationship: What the other person in the meeting and I negotiate as the reality of our relationship determines my self-experience.

As suggested above, other main sociocultural and economic forces have been strongly acting, but perhaps the

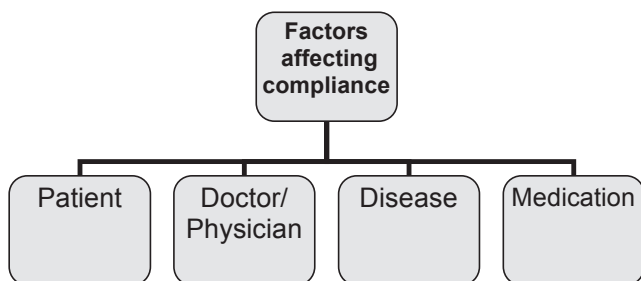


Fig. 1. Factors affecting compliance.

changes in the view of doctor-patient relationships have also taken place in light of this intellectual approach in psychoanalysis: from a neutral and determinative posture (compliance) toward a mutual strategy to combat the patient's disease (concordance). Similar considerations as those of intersubjectivity in psychodynamic therapies are used. Concordance also means picking up on the patient's wishes and ideas, clarifying them and including them in the cooperative treatment plan.

These new considerations, however, assume a type of patient who is intellectually capable and willing to follow the treatment strategy worked out together. In psycho-dermatological practice, we know "difficult" patients, who hardly ever want to or can follow such a treatment concept. As an example, the aggressive patient with his constant dissatisfaction, excessive demands and constant pressure, or the dependent patient, who shows no sign of active coping with disease. Emotionally remarkable patients with agitation, depressive mood and nervousness are unsuitable for a "concordant" treatment strategy. It can thus be noted that the doctor-patient relationship has changed in the direction of intersubjectivity, but a mutual treatment strategy must be selected individually. However, we will continue with the term compliance: on the one hand because the term has become established in the literature, and on the other hand to avoid confusion in terminology.

It is obvious that improvement in compliance leads to improved effectiveness in the diagnostics and therapy of disease, and that considerable economic factors can also be involved (10, 11). But how is the quality of compliance to be determined?

## CONCORDANCE AND THE LIMITS OF COMPLIANCE

We are familiar with direct and indirect procedures to determine compliance, which cannot be discussed in detail here (5, 8). Table I presents a summary of these procedures.

Table I. *Methods to determine compliance*

Indirect procedures
1. Patient questioning
a. Subjective information from the patient
b. Patient questioning with standardized questionnaires
2. Calculation of tablets and ointments used
3. Keeping control appointments
4. Measuring effectiveness of therapy
a. Measuring various skin parameters (moisture, skin colour)
b. Questioning the patient about subjective rating (itching scale)
Direct procedures
1. Determination of blood levels of medications administered
2. Measuring medications in urine
3. Operative determination of skin parameters (skin moisture, skin colour)

## FACTORS INFLUENCING COMPLIANCE AND NON-COMPLIANCE

Many studies have reported on factors influencing compliance and factors influencing non-compliance. The criteria gathered from various faculties cannot be transferred without reservation to the needs of dermatology, but they are essentially comparable. The following factors are decisive:

1. Factors in the person and behaviour of the doctor,
2. Factors in the person and behaviour of the patient,
3. Factors in doctor's instructions,
4. Factors in the type of treatment, and
5. Factors of the disease itself.

All of these factors must be taken into account in scientific investigations.

In examining the validity of the measured results obtained, it was proven that the subjective rating of compliance by medical personnel is often inaccurate. Compliance is usually overestimated. Direct observation of the patient requires great effort, can hardly be performed in outpatients and causes a change in the patient's behaviour. Check of medications or metabolites or the marker substances is an examination method that can be easily performed on the day of examination, but it says nothing about use on the other days. Moreover, the range for this test is very broad. This results in limited applicability.

Realizing that many publications have used a wide variety of measuring methods and definitions, that many studies involved patient groups which differed greatly from the norm, that bad news "sells better" than good news and that many published study results are only for those patients who attended control appointments, the extent of non-compliance with taking prescribed medications can be estimated as follows: errors in taking medication are registered on average by 50% of the patients.

The following differences in taking medications can be observed (10):

- 20% of the patients take their medication correctly
- 25% under good conditions (daily plan in place)
- 5% of the patients take too much medication
- 15% irregular taking
- 25% usually inaccurate dosing and
- 10% not at all

These results do not, however, take into account that the instructions may not have been understood. They thus also do not reflect a patient's conscious rejection of therapy. Not understanding the therapy instructions is, however, the most common reason for incorrect and missing use. Moreover, only a mean value is recorded in this connection. In individual cases, compliance is situation-dependent and the interindividual differences are far too great to enable such a simple categorization.

Above we have defined the performances of compliance. To what extent could the new term concordance develop a more advanced way of thinking on the relationship between patient and doctor? That's the essential question. To answer it we will take Dermatology as a defining arena.

#### *Taking special compliance issues in dermatology into account*

In various studies, some extensive, more than 250 interacting variables could be identified which may influence compliance or non-compliance, and subsequently concordance as well. This illustrates the fact that the process is extremely complex, which may appear obvious in the individual case, but which may lead to differing statements in a group assessment.

#### INFLUENCING FACTORS WITH RESPECT TO PERSONALITY AND SOCIAL ENVIRONMENT

There is as yet apparently no definite proof that certain personality characteristics of the patient enable prognosis of compliance behaviour. Neither the patient's sex, family status, educational level, intelligence, religion, income nor knowledge appears to have clear influence on compliance behaviour. Sociobiographical data may, however, give hints concerning the necessity of special treatment or communication strategies (10).

The patient's need for information remains high; it can in most cases rarely be satisfied, at least by the doctor alone, simply for lack of time. Nonetheless, the doctor is of course obliged to adequately inform the patient about the diagnostics and therapy. Patients deal ever more critically with recommendations and instructions from doctors. It has become the general custom to seek a second, or even third, opinion from doctors or health facilities. Moreover, the patient these days often seeks his own information. This is obtained especially in the Internet, but also from self-help groups or from the lay press.

Compliance is negatively influenced if the doctor brusquely rejects the sometimes unscientific or alternative procedures. This does not promote trust and it is better to discuss the advantages and disadvantages of alternative medicine with the patient.

The patient may obtain additional information from relatives, friends, at work, or in the pharmacy, which may have an unrealistic effect on the expectations or feared side effects of the medication.

The personality structure probably plays a role in the quality of the doctor-patient relationship. Is the patient readily willing to follow the doctor's advice, or does he want to be involved in the decision, or perhaps even make the decision alone?

For me, the following question has proven valuable in practice: "What do you think is behind your disease and what makes it worse?"

Patients who answer, "I'm not the doctor", "I don't know" are likely people who want the decision made for them. On the other hand, there are patients who propagate unrealistic theories with the greatest conviction: "This little bump on my cheek (diagnosis: basal cell carcinoma) was caused by a branch that hit my face." In dealing with self-assured, responsible patients, the doctor still has to be careful not to be talked into unjustified treatment. In the final analysis, the doctor is still held responsible for failure. The broad dissemination of irrational concepts about diseases or medication side effects is also – or perhaps especially – known in dermatology.

The so-called cortisone fear is typical. The special worry about side effects is not entirely unjustified, since cortisone, whether taken internally or applied externally, is not always prescribed with the required care and necessary knowledge.

Thanks to economic constellations, the doctor feels sometimes compelled to exaggerate the effects of medications or to play down side effects. This should be avoided, since it has a negative influence on compliance, at least for a time.

With respect to the disease and especially skin disease, it can be noted that compliance with the treatment of acute diseases is better than that in chronic diseases. It is also known that compliance decreases more, the longer a certain therapy scheme is applied. Compliance in long-term medication, such as is often required in chronic skin diseases (e.g. psoriasis or neurodermitis), is about 50%, even for cooperative patients. Dermatoses on visible parts of the body or associated with severe subjective complaints (itching, burning of the skin) are in a class by themselves. In these cases, compliance is considerably higher. However, it has not yet been clearly proven that compliance increases with the severity of the course of disease (10).

In dermatology, there are certainly special factors for non-compliance. Unlike, say, a diseased liver, skin diseases are usually easily visible, can be felt, and are recognizable as a disease for the patient. Skin diseases on visible parts of the body may also have a stigmatizing effect. Topical treatment usually requires a lot of time and energy from the patient. Possibly there are also tensions in the social environment, if the patient spends an hour in the bathroom, for example. Many patients say they would prefer to have a tablet or injection prescribed to treat the skin disease. Care should be taken that the most-easily used external preparations are prescribed (such as shampoo, sprays or body lotion). As with internally administered medication, topical medications may lead to contact dermatitis due to ir-

ritation or allergy. Patients then usually terminate the treatment quickly on their own (10, 12).

#### WHAT APPROACHES ARE AVAILABLE TO IMPROVE PATIENT CONCORDANCE IN DERMATOLOGY?

Compliance improves when the patient is offered "structured structures". Among these are doctor's appointments, visits, provision of information, and type of therapy. How can this be realized in practice?

- Appointments and follow-up appointments should be made in writing.
- Written instructions of how treatment is to be applied (ointment A in the morning, ointment B in the evening) increases correct application from 20–30% to more than 70% in our opinion.
- At the initial appointment of the patient in the practice, confidence is created by a thorough anamnesis and careful physical examination.
- The patient's own competence should always be strengthened. If the patient has the positive impression that he will be successfully treated, the probability of successful treatment increases.
- If it appears difficult to reach the patient, it is reasonable to include family members in the treatment strategy in many cases.

In discussions during appointments, we have noted that the explanation to the patient about the necessary diagnostic and therapeutic measures is very important and promotes compliance. Written instructions have proven valuable as a support. Also, questioning the patient to be sure he has understood the instructions and recommendations is helpful and promotes concordance. In this connection, mention should be made about patient training, such as that known for patients with diabetes mellitus. In dermatology, patient training for neurodermitis patients has become increasingly established over the past 10 years. The training program for patients with neurodermitis (atopic dermatitis) represents a preventive-medical model for the prophylaxis of this chronic skin disease, which includes multifactorial somatic and emotional influencing factors (5).

The program consists of two components: an intensive dermatological training program, developed for performance in the dermatological practice, and psychological training developed especially for patients with neurodermitis. It has been found that patients can be better motiva-

ted to cooperation through neurodermitis training, so that improved compliance can also be expected as a result.

In conclusion, concordance is offered as a basis of a complex idea, with the goal of improving the success or the "outcome" of prescriptions and medical advice. It implies a close complicity between doctor and patient. This model, historically developed by psychoanalysis, goes further as it does not ask, "how much of what the doctor recommends to his patient is actually carried out?" but rather examines the effectiveness of the mutual process between the doctor and the patient. It is the power of communication, of mutual understanding, playing in favour of the healing process.

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