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.

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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 medical knowledge. 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).

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

<table>
<thead>
<tr>
<th>Indirect procedures</th>
<th>Direct procedures</th>
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<tbody>
<tr>
<td>1. Patient questioning</td>
<td>1. Determination of blood levels of medications administered</td>
</tr>
<tr>
<td>2. Calculation of tablets and ointments used</td>
<td>2. Measuring medications in urine</td>
</tr>
<tr>
<td>3. Keeping control appointments</td>
<td>3. Operative determination of skin parameters (skin moisture, skin colour)</td>
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<tr>
<td>4. Measuring effectiveness of therapy</td>
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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 neurodermitis. It 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 motivated 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.

REFERENCES