Continued from page 885

Part 4. Patient Non-Compliance with Medical Treatment: Contributory Factors and Management

From the foregoing discussion of the perception of initial symptoms and the meanings of illness, it is apparent that at times the patient may decide not to seek medical help when he should, or he may decide to seek medical help but do so with much ambivalence. The frequency of ambivalence about treatment, whether present from the beginning of treatment or developing later, is evidenced by the fact that a very large number of patients who go to the physician for help fail to comply with the treatment regimen he prescribes. In spite of the fact that noncompliance obviously constitutes a common and important complication in management, most physicians have a low index of suspicion for it.

The factors contributing to compliance or noncomplicance can be grouped according to their relations to (1) the psychologic status of the patient, (2) social and family circumstances, (3) characteristics of the illness, (4) the therapeutic regimen, and (5) the patient-physician relationship. These factors and their management implications are discussed below.[1-4]

Patient's Psychologic Status

In order for the patient to seek treatment and to comply with the therapeutic regimen it is essential that he be (1) sufficiently uncomfortable or concerned about his illness to do something about it, (2) hopeful that effective help is possible, (3) confident in the physician or physicians to whom he has access, (4) unaverted from following through with the treatment plan by the development of strongly negative feelings and attitudes, and (5) thoroughly knowledgeable about his role in the implementation of the treatment plan.

It is not rare for a patient to underestimate grossly the potential importance of his complaints (and therefore the diagnostic evaluation and treatment) because of a lack of factual information. An attitude of inappropriate casualness or obvious indifference alerts the physician to this possibility which can be confirmed or ruled out by tactfully asking the patient appropriate questions to discern his ideas about his condition. *In engaging the patient in an educational dialogue the physician aims to fill in important gaps in information, correct distortions, and promote the formation of a working partnership with him.* In doing this, the physician takes care to avoid engendering unnecessary anxiety or anxiety that is so severe that the patient is frightened away.

Not uncommonly, a blasé attitude or an exaggerated air of indifference, which may herald noncompliant behavior, masks underlying fear. The covertly fearful, potentially noncompliant patient may also appear superficially cold or tend to be hostile, caustic, skeptical, and critical. Here too it is possible for the underlying anxiety to be related to serious factual misconceptions regarding the symptoms, illness, or treatment, in which case the management approach remains essentially an educational one.

An occasional patient may observe his own symptoms and be sufficiently concerned about them to seek medical help while at the same time engaging in *partial denial* of their import. Partial denial is not necessarily maladaptive since it may serve temporarily to cushion the impact of the illness, help the patient to hold himself together while he attends to important personal affairs, and, in general, give him time to muster his resources. For example, the patient, on being informed of some serious or ominous finding, may temporarily seem paradoxically casual or even cheerful, while at the same time appropriately making arrangements for entering the hospital and doing whatever else his physician has advised. In this instance, the physician may be certain that the inappropriate cheerfulness does not reflect lack of information but is part of the patient's adaptation to current stress. As long as the partial denial is not accompanied by behavior which interferes with evaluation and management, the physician is well advised to leave well enough alone.

When, however, denial of illness does result in behavior which jeopardizes the patient's participation in treatment, as was the case in the myocardial infarction patient described in Chapter 3, the physician must attempt to ascertain the factors promoting the denial and develop a management approach. In practice, these two processes of evaluation of patient behavior and management are virtually inextricable and must be tailored to the needs of the individual patient.

One or more of the following are sometimes useful in the management of noncompliance arising from partial denial of illness.

1. Engage the part of the patient's ego which does accept the fact of his illness. By this it is meant that the physician supportively reminds the

Continued on page 889

Continued from page 888

patient that to some extent he obviously recognizes his need for medical attention as evidenced by the fact that he kept his appointment to see the physician or entered the hospital or had the prescription filled and so forth. This acknowledgment is followed by matter-of-factly pointing out that other aspects of the patient's behavior, however, seem to contradict his realistic acceptance of the illness. This comment can then lead into a nonjudgmental inquiry into the patient's feelings, attitudes, and fantasies relating to the illness and treatment.

2. Attempt to allay or reduce underlying anxiety. The most effective way to reduce anxiety is to help the patient bring into the open his concerns and fears such as may arise from some dire interpretation of a particular symptom, a conviction that he will be left an invalid, a feeling that his illness is something to be ashamed of, or that his condition is hopeless. Even if the underlying problem is not completely resolved, and it seldom is, the sharing of it with the physician can be extremely helpful and may enable the patient to face the current stress and to comply with the plan of treatment. The temporary administration of a minor tranquilizer such as chlordiazepoxide or diazepam may be a useful adjunct to this approach.

3. At times, when medically permissible, it may be necessary to postpone or modify the management plan if some aspect of it poses a particular problem. It may be helpful, for example, to delay hospitalization for a day or two if this is likely to promote the patient's acceptance and cooperation. The patient might learn more of what to expect in the hospital by making a visit and talking with some of the nursing staff. Another source of anxiety-relieving information is another patient who has already dealt with the condition; for instance, colostomy clubs can provide invaluable support to patients contemplating this major surgery.

4. Psychiatric consultation may be indicated but should only be instituted after the physician has initiated exploratory discussion of personal feelings and problems with the patient and feels that the consultation is necessary to help understand and alleviate the noncompliant behavior. The physician should fully discuss with the patient the reasons for psychiatric consultation and must be careful to avoid the impression that the patient is being rejected, ie, that the physician wants someone else to pay attention to the patient's personal problems because he himself is not interested in them.

In addition to lack of accurate information and denial-producing anxiety, there are other aspects of the patient's psychologic status which may promote noncompliant behavior. Prominent among these are lack of trust in physicians and others, an attitude of rebellion against authority figures and restrictive therapeutic regimens, difficulty in accepting a relatively dependent role, and perception of the treatment plan as an intolerable frustration of important psychologic needs. These will be discussed further later in this chapter and in the following chapter in which various psychologic reactions during hospitalization and their management are described.

Occasionally, noncompliance with the therapeutic regimen is associated with depression. In these instances, the noncompliant, depressed patient may feel guilty and thus feel that he does not deserve or want to get well. If his depression has gone unrecognized, the patient may also feel that the treatment plan prescribed for him is not directed at his main difficulty. The key to management rests upon recognition of the depression and the institution of appropriate treatment for it by the physician or by referring the patient to a psychiatrist.

Social and Family Circumstances

The physician should always pay careful attention to the patient's family situation and socioeconomic background. Lack of money or transportation and preoccupation with pressing family or occupational demands may gravely interfere with the patient's ability and willingness to comply with the management plan. In this situation it is sometimes tempting for the physician himself to ignore these aspects and to rationalize this posture by saying that his job is to prescribe treatment, the patient's to carry it out. However, tactful but frank discussion of the home and job situation may well lead to the discovery of practical aids to facilitate participation in treatment. A skilled social worker is often invaluable in the assessment of these problems and in the utilization of community resources in their solution.

Characteristics of the Illness

It is likely that when the illness produces considerable discomfort such as pain, shortness of breath, or weakness which is substantially improved by the prescribed drug and which recurs when the medicine is not taken, the patient will comply with treatment. However, if the illness or problem is relatively "silent," such as uncomplicated essential hypertension or hypercholesterolemia, the likelihood of noncompliance is enhanced. In these instances, noncompliance should be anticipated and counteracted by a clear explanation of the benefits of treatment and by follow-up visits in which compliance is reinforced by informing the patient of the results of ongoing treatment.

Characteristics of the Therapeutic Regimen

Treatment plans most likely to evoke noncompliant behavior are those which are complex, require substantial changes in the patient's daily habits, and in which the benefits are imperceptible to the patient or are slow to appear. When the therapeutic regimen has one or more of these features the physician should anticipate possible noncompliance and encourage the patient to express his feelings about the treatment and to ask questions about any aspects of it. Not only are complicated treatment plans more apt to cause the patient inconvenience, but they are also hard-

Continued on page 890

Continued from page 889

er to understand. It is always necessary to describe the treatment in comprehensible terms and, through tactful discussion, ascertain that the patient in fact does comprehend the treatment plan. If it is medically sound to simplify the treatment and to reduce its interference with the patient's daily routine, this should be done. For example, single daily administration of a drug is more apt to be complied with than three or four divided doses. If it is anticipated that the administration of a drug should be continued for some time after symptomatic remission has been achieved, it is important to discuss this with the patient for many people "forget" the medicine as soon as they are feeling better.

Sometimes the therapeutic regimen does not merely create inconvenience in the patient's daily life but actually conflicts with important psychologic needs. For example, adhering to a low-calorie diet is made doubly difficult if the overweight patient is in the habit of seeking relief from depressive feelings through eating. In such a case, treatment of the depression should accompany or take precedence over a strictly dietary approach to the patient's problem with excessive weight.

The adolescent patient with diabetes may find a restrictive therapeutic regimen particularly onerous because it conflicts with his age-appropriate need to be "like" his peers and with his struggle for autonomy. The physician may avert or minimize behavior management problems with the diabetic adolescent if he lets him know that he is aware that the patient may have troubling feelings about his illness and its treatment, that at times he may be unhappy or angry. This interest in the adolescent's feelings must be genuine, ongoing, and manifest to the patient but must not be smothering or intrusive. It is an inviting but not coercive interest and is accompanied by a willingness to consult with the patient about various practical aspects of the treatment plan and to respect his observations and suggestions.

Strict bed rest or instructions to "slow down" may seem impossible to the person whose feeling of worth has been almost entirely derived from being active and competitive. This situation may pose exceedingly difficult dilemmas for both patient and doctor and may make it necessary to "negotiate" a compromise treatment plan which, while it falls short of the ideal, has a better chance of being carried out.

Patient-Physician Relationship

In the last analysis, the quality of the patient-physician relationship is probably the most crucial variable in determining compliance with treatment plans. In the daily work of the busy practitioner, failure to take the time for truly adequate communication is perhaps the most common and damaging deficiency of modern medicine. If the physician is to maximize his effectiveness, he must cultivate a relationship of mutual respect, offer explanations in a clear manner, invite questions and expressions of feelings and ideas, and be alert to evidence of psychologic and other obstacles that stand in the way of full patient cooperation. *A relationship in which trust and rapport are established enhances the likelihood that the patient will be able to talk about his misgivings and tensions rather than express these feelings through noncompliant behavior.* Tactful exploration of the patient's values, habits, lifestyle, and relationships with other people, including past experiences with other physicians, provides important clues to the probability of noncompliant behavior and to the tailoring of treatment plans to the individual patient.

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Continued on page 893