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Practical Methods to Improve Client Compliance in General Medicine

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Abstract

There is a gap between theoretical knowledge about strategies and the techniques or methods to apply in the practice of the consultation to improve compliance. Within the framework of these strategies, a number of techniques to be used in certain situations can be cited: 1) Assessing readiness to change, importance and confidence; 2) Instruments for decision support; 3) Technique of the "pros and cons"; 4) Auto-monitoring techniques; 5) Technique of "information exchange"; 6) Feedback technique; 7) Brainstorming; 8) The "typical day"; and 9) Practical reminder systems for taking medication. A certain technique is not a universal procedure, but it is usually refined by trial and error, based on past experiences, and their choice and design are the responsibility of the general practitioner.

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Introduction

Several terms associated with the concept of adherence to treatment are used: therapeutic alliance, cooperation, compliance, mutuality, and collaboration; among others [1]. This situation indicates that there is no total consensus on its meaning. In addition, terminology currently used in prescription adherence research employing electronic databases lacks consistency [2].

Medication compliance and medication persistence are two different constructs. Medication compliance (synonym: adherence) refers to the degree or extent of conformity to the recommendations about day-to-day treatment by the provider with respect to the timing, dosage, and frequency. It may be defined as "the extent to which a patient acts in accordance with the prescribed interval, and dose of a dosing regimen." Medication persistence refers to the act of continuing the treatment for the prescribed duration. It may be defined as "the duration of time from initiation to discontinuation of therapy." No overarching term combines these two distinct constructs [3].

By "discontinuity of pharmacological therapy" is meant the interruption of the therapeutic scheme followed by a patient. The discontinuity of the treatment indicates in some way a discontinuity of the doctor-patient relationship. Each type of doctor-patient relationship implies a different relationship with pharmacological treatment; but also, the doctor-drug approach style imposes a doctor-patient relationship [4, 5].

Medication non-adherence is a major impediment to the management of diseases and risk factors. Pharmaceutical treatment is essential to the management of most chronic diseases, but patients' failure to take medications as prescribed often results in failure to meet treatment goals. Medication non-adherence has been associated with a worse evolution, a greater number of relapses and a higher economic cost. Even in the case of diseases where the treatment saves the patient's life, many of them do not comply adequately. Suboptimal adherence can result not only in progression of disease, but in drug resistance, often to multiple classes of drugs. Improving adherence is thus of vital clinical and public health importance, and leads to preventable costs and hospitalizations [6-8].

Adherence to treatment can be analyzed from different perspectives considering different explanatory models: psychological, biological, or sociological [9, 10]. From these models, strategies to improve compliance arise, but the techniques, methods or practical tools to use in consultation with patients are often forgotten, especially at the level of general medicine. In this way, the general practitioner (GP) can have knowledge about compliance theories, and can be aware that there are reasons (of the patients) that the reason (of the doctor) does not understand. And those medication-making decisions are not the subject of rational choices by patients, influenced only by the attributes of treatments and psychosocial, sociodemographic, and disease-related factors, etc. The GP may know that the more we delve into the reasons on compliance, the more we could understand why patients "do not want, do not know, or can not" comply with our prescriptions; it will be better for compliance. But, knowing "reasons of reasons" can only be done by "tuning in" with the patient and with ourselves. If the patient feels that their voice is listened to carefully, they will begin to identify more clearly the meaning of each symptom and event related to their illness [11].

However, there is a certain gap between these theoretical knowledge and the techniques or methods or tools to apply in the practice of the consultation to improve compliance. In this scenario, this article, which is a personal view, aims to conceptualize and summarize some of the techniques or methods that can be used in general medicine to improve therapeutic compliance, based on an unsystematic or opportunistic search for information and the author's experience.

Methods

The comments in this article should be considered as a personal point of view, based on the author's experience during 30 years of work in general medicine, plus an unsystematic or opportunistic search for information.

The search for information was based on a non-systematic review considering the bibliographic references of selected articles, reviews of books related

to the topic and opportunistic searches on the Internet.

This non-systematic review was carried out, which aimed to explore, describe and discuss the topic of practical methods or techniques to improve client compliance in general medicine, in a broad way.

Discussion

Theoretical Frameworks and Strategies to Improve Compliance

In the theoretical framework or model where the therapeutic alliance, patient-centered consultation and shared decision-making overlap, is where the strategies to increase compliance during the consultation in general medicine are inscribed. The strategies are guides of action, in the sense that it guides it in obtaining certain results. A strategy is, in a strict sense, an organized, formalized and oriented procedure to obtain a clearly established goal [12]. Its application in daily practice requires the improvement of procedures and techniques or methods whose detailed choice and design are the responsibility of the GP.

Procedures, Techniques or Methods to Improve Compliance

The three terms are often used interchangeably. A method is a target plan or set of orderly procedures that are based on a credible approach. It reveals what needs to be done in a systematic way and how to focus on achieving those goals. A technique is a precise work, concrete trick or a tested and trusted tip that's designed to help you reach your goals. It could be any activity that you have to do to complete the mission. Method refers to the type of practical solution that is adopted. Technique refers to the technology or skilled action that we actually deploy to accomplish what is wanted.

The concept of technique is considered as a practical procedure that is applied to help realize a part of the objective pursued with the strategy. Therefore, in the compliance scenario, they are the practical procedures, inscribed in a certain theoretical and strategy, to achieve the goal of improving therapeutic compliance. The techniques are limited to the achievement of improved compliance in delimited areas of the medical care course, while the strategy covers more general aspects.

The techniques or methods are particular resources that the GP uses to carry out the planned purposes from the strategy, that is, the improvement of therapeutic compliance. Techniques are procedures that seek to obtain effectively, through a certain sequence of steps or behaviors, one or more precise products in relation to improving compliance [13, 14].

Specific Techniques or Methods or Tools

What method will be employed? That depends on your theoretical framework. Although there are many models that attempt to explain the phenomenon of therapeutic compliance, currently, in practice, compliance falls within the model of therapeutic alliance or patient-centered consultation or shared decision-making. These concepts overlap by sharing many elements, and in essence they rest in the doctor-patient relationship, so that they take into account the patient's beliefs about the medication, the perception of the efficacy of the medication and the possible adverse drug reactions (ADRs), the perception of the risk of the disease, and the affectation of the activities of the daily life by the disease and the medication [1]. Within the framework of these strategies, a number of techniques to be used in certain situations have been cited. These would be (Table 1):

Assessing Readiness to Change, Importance and Confidence

The readiness to change is a concept about if the patient is motivated for compliance [1]. Prochasca and Diclemente proposed a model of behavior change that postulates a series of cyclical states of change or relapse that constitute the real experience (for example, an average smoker relapses about 7 times before definitively quitting smoking), and suggests an educational approach that adapts to the "state of change" of that particular patient. This model conceptualizes intentional behavioral change as a process involving movement through a series of 5 discrete stages that define the "readiness" to adopt a new behavior: i.e., precontemplation, contemplation, preparation, action, and maintenance [15-18].

In the model, the first state is "pre-contemplation", where the patient has not yet considered modifying their behavior. The patient does not consider that his behavior (smoking, drinking, eating

Table 1. Practical Methods To Improve Compliance In General Medicine

Practical Methods to Improve Compliance in General Medicine	
1	Assessing readiness to change, importance and confidence
2	Instruments for decision support
3	Technique of the "pros and cons"
4	Auto-monitoring techniques
5	Technique of "information exchange"
6	Feedback technique
7	Brainstorming
8	The "typical day"
9	Practical reminder systems for taking medication

fatty diets..., to having therapeutic compliance, etc.) is a problem. Some "trigger" events can raise awareness of the problem and thus reach a state of "contemplation", where the patient accepts the existence of the problem and assesses whether or not to take an action. Explore how to do it. In the "action" state, the patient does something and experiments with different ways of doing it. After the successful action, the patient enters a state of maintenance in which the change is maintained, his lifestyle adapts, and the change is integrated. If the change is not maintained, the patient "relapses" and the negative behavior is restored to a greater or lesser extent, repeating the cycle. In this model, it is important that the educator adapt his efforts to the phase of the patient's cycle.

There are a number of questions and phrases that can help the educator identify the state of readiness to perform the action:

From Pre-Contemplation to Contemplation

Agree on the problem, personalize the message, assess the degree of awareness and agreement on priorities, assess and clarify knowledge and understanding of the problem, assess feelings, concerns and expectations , assess how prepared you are for change:

- "The diagnosis / problem are..."
- "This does mean for you..."
- "I can help you through..."
- "Where do you want to start…?"
- "What do you know about...?"
- "How do you feel about...?"
- "What do you have the will to do?"

From Contemplation to Action

Negotiate a plan for action. Explain the options and alternatives and provide specific recommendations, ask for the decision and start negotiating a plan for a test, assess and reinforce the skills and resources to execute the plan, anticipate possible problems and help find solutions, identify and mobilize support:

- "Your options are..."
- "I recommend..."
- "Which option do you choose?"
- "How do you want to do it…?"
- "What problems could appear…?"

- "Who or what could help you?"

From the maintenance action: reaffirmation and follow-up

Offer support and make a follow-up appointment, check and reaffirm the agreement with the plan:

- "I'd like to see him again in..."
- "Until the next visit, what will you do?"

But, assessing "readiness to change" can be done quickly and even replace the previous method and its questions in the course of the interview, by focusing on the main components of "readiness to change", the importance that the patient attaches to the problem of health and compliance, and the patient's confidence in achieving compliance.

In this way, the "stages of change" can be seen as a conjunction of the patient's assessment of the "importance" of the intervention, and their "confidence" in their ability to make the changes that the intervention requires. This is clinically important as it can help the GP to direct his interventions to the needs of the patients. There may be patients who prefer to discuss more about the importance of the intervention, and others who are more interested in the aspect of their confidence in their ability to achieve it effectively. Thus, there may be patients who feel confident in their ability to achieve compliance, but doubt the importance of therapeutic intervention (for example, whether it is time to start with anti-hypertensive medication); and vice versa, patients who are clear about the importance of therapeutic intervention (for example, anticoagulation to prevent a stroke), but hesitate to accept it because they are not confident that they can comply with the treatment [1].

In this way, it can be Asked

- How important is it to take the medicine?
- What would you need to increase your assessment of the importance of taking the medication?

The patient may express doubts and errors about the medication, such as sexual function impairment, or other possible ADRs:

- Do you think it will be difficult to comply with the treatment?
- What would you need to increase your assessment of your confidence in complying with taking the medication?

The patient may express, for example, that since he has a bad memory, it will be difficult for him to comply with the therapeutic regimen as prescribed [1].

Instruments for Decision Support

Although instruments can never replace a physician's judgment, they may provide a clear starting point for a discussion on competence in daily practice assessments [19].

A tool that is going to help a great deal to overcome some of the most important difficulties of the shared decision process is the so-called decision support instruments. These are informative documents, in different support, with the necessary information, presented in an aseptic, simple and understandable way for the majority of patients in a way that allows them to acquire enough information to be able to make a decision based on their own criteria. Instruments for decision support such as pamphlets and videos, which describe the options, are designed to help people know the options, consider the personal importance of possible benefits and harms, and participate in decision making. For example, Cate's plot can help interpret data visually [20]. The choice for the most appropriate instrument can best be based on the instrument's content and characteristics such as the perspective that they assess [21-24].

Technique of the "Pros and Cons"

Physicians who routinely involve their patients in treatment decisions (presenting options, discussing the pros and cons of the options, exploring patient preferences, and reaching jointly agreed treatment plans), are classified as having participatory style or that allow shared decisions. These professionals tend to be more successful in providing patient safety, and as a result, they obtain better health outcomes than non-participatory doctors [25, 26].

To helping the patient to think clearly, one suggestion is to write or to think about the arguments for and against, as do it Daniel Defoe in the novel "Robinson Crusoe" or as Stevenson in "The wrong

box" [27, 28]. This technique aims to achieve a framework where the risks and potential advantages of the intervention converge. The discussion of this ambivalence as expressed by the patient can help to take an action. When considering a medical intervention, many GPs can take into account only its advantages and disadvantages of not performing such an intervention, but the possible negative effects such as ADRs and cost are generally not discussed. So, if little importance is attached to compliance, a advice to the GP can be: use the "pros and cons" technique [1].

Auto-Monitoring Techniques

These can include diary of headaches, blood pressure self-control, blood glucose, INR in anticoagulated patients with warfarin, etc. [29-32].

Technique of "Information Exchange"

Between doctor and patient: What does the patient already know about this topic? And this must include giving clear and updated information by the doctor [33-35].

Feedback Technique

It means feedback of the information given by the doctor to facilitate the compression of the patient and for the doctor to confirm the understanding of the information given [36].

Brainstorming

It is useful when appropriate to look for new solutions and change attitudes. For example, in case of there is a low confidence to comply with the pharmacological treatment. Generally, what is done is that the GP says what he thinks the patient should do; But that procedure does not usually work. With the solutions of brainstorming that problem is avoided. The basic element is that ideas that come from the patient are probably more easily accepted. On the other hand, there are usually several possible courses of action in a medical intervention. In this way, the patient is asked to identify as many options as he can. The patient can be helped by mentioning options that have worked in other patients. Subsequently, the patient is asked to select the most appropriate option for him [37].

The "Typical Day"

It is about obtaining a complete picture of the patient's life and how the required compliance fits his or her. It can be especially useful if there is low confidence [1].

Practical Reminder Systems for Taking Medication

They are methods to prepare the medication taking in relation to the dose, the schedule of medication shots, etc., and also, drug packaging techniques with calendar, alarms, diaries, and the help of family members or caregivers [1].

Conclusion

Medication non-adherence is a major impediment to the management of diseases and risk factors. Pharmaceutical treatment is essential to the management of most chronic diseases, but patients' failure to take medications as prescribed often results in failure to meet treatment goals.

Adherence to treatment can be analyzed from different perspectives considering different explanatory models: psychological, biological, or sociological. Within the theoretical framework or model where the therapeutic alliance, patient-centered consultation and shared decision-making are overlap, some strategies to increase compliance during the consultation in general medicine are inscribed.

There is a certain gap between theoretical knowledge about strategies and the techniques or methods or tools to apply in the practice of the consultation to improve compliance. So, within the framework of these strategies, a number of techniques to be used in certain situations can be cited: 1. Assessing readiness to change, importance and confidence; 2. Instruments for decision support; 3. Technique of the "pros and cons"; 4. Auto-monitoring techniques; 5. Technique of "information exchange"; 6. Feedback technique; 7. Brainstorming; 8. The "typical day"; and 9. Practical reminder systems for taking medication.

Finally, it must be remembered that a certain technique is not usually a universal procedure, but is usually refined by trial and error, based on past experiences. Thus, the application in daily practice of these techniques or tools requires their improvement and choice and design which are the responsibility of the GP.

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