Patient Education and the Physician-Patient Relationship

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Noncompliance is a major problem that patient education aims at resolving. The emphasis in patient education upon didactic strategies, educational content, and materials distracts from perhaps the most important factor in the success of patient education, that is, the quality of the physician-patient relationship. In the context of the physician-patient relationship many of the patient's psychological needs, wishes, and fears will be revealed, and these factors have bearing upon compliance and the ability to make use of patient education. When the physician develops a psychotherapeutic attitude characterized by empathic attunement to the patient and his or her underlying psychological reasons for resistance to medical advice, the likelihood of accepting patient education increases.

Major advances in the biomedical sciences have elevated medical personnel to a high level of technical skill. Physicians can treat a broadening range of ailments with an impressive armamentarium of procedures and medical preparations. These technical achievements can be of litte value, however, when patients refuse to accept or properly follow medical regimens. Indeed, abundant medical resources are available to many patients who paradoxically refuse to make use of the life-preserving resources before them. For example, in a recent study 50 percent of the patients surveyed failed to follow through on referral advice, 75 percent did not keep follow-up appointments, and 50 percent of the patients suffering from chronic illness dropped out of treatment within one year.[1] Unfortunately, the noteworthy progress in medical technology has outstripped knowledge regarding the psychology of human nature and man's ability to alter the self-defeating, noncompliant behavior that undermines caregivers and sustains illness.

Knowledge of the psychological principles and techniques of exercising influence upon the behavior and attitudes of patients is essential as an aid in encouraging the maintenance of health-promoting habits. The practice of medicine is most effective when the physical illness is viewed in the context of the patient's psychological reality and the manner in which psychological factors impinge upon and influence the physician-patient relationship. Often the appreciation of psychological factors and interpersonal factors can determine the success of the entire treatment effort. Nevertheless, the significance in interpersonal and psychological variables in patient education has been given relatively little emphasis in the literature. The major aim of this article is to clarify these psychological issues so that perspectives can be illuminated that may increase the effectiveness of patient education efforts.

The problems concerning patient education and compliance are difficult to address and solve, as they lie on the interface, a no man's land, between medicine and behavioral science where professionals from both domains must collaborate. To develop improved strategies for patient education, physicians must develop psychological skills in the management of interpersonal relationships, while social scientists and psychiatrists must try to become familiar with the realities of the examining room and medical practice to which they can apply their knowledge of human behavior. When psychiatric knowledge is brought to bear on medical practice, it becomes clear that patient compliance and response to medical education depend not solely on the physician's technical sophistication, but also on the physician's psychological sensitivity and ability to understand and make productive use of his or her relationship with the patient. Patient education, aiming at increased compliance, is mediated by the interpersonal relationship between the physician and patient, and the quality of this relationship can determine the result of the physician's educational efforts.

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The following is an overview of basic principles concerning the management of the interpersonal relationship between caregiver and patient that can determine the effectiveness of patient education and compliance. An extensive review of the literature is not provided, for excellent recent efforts summarize the empirical data on compliance,[2] communication,[3] and patient education.[4] Rather, principles that constitute the accumulated clinical lore and empirical findings concerning the conduct of psychotherapy, psychoanalysis, and interpersonal psychiatry are applied to understanding and managing the relationship between caregiver and patient in the patient education process. The therapeutic principles derived from psychiatry are of unique relevance to the study of the physician-patient relationship in patient education, as the practice of psychotherapy and psychiatry is, in large measure, a special form of patient education (helping the patient learn about his or her emotional difficulties and finding ways to manage and transcend them), and their most important tool is the use of the physician-patient relationship.

THE INTERPERSONAL CONTEXT OF PATIENT EDUCATION

Patient education occurs within the interpersonal context of the physician-patient relationship, and as such, the effectiveness of patient education is influenced by the vicissitudes of this relationship. Before discussing patient education, a few comments about the nature of the physician-patient relationship are in order.

This relationship generates powerful psychological pressures that can fuel the patient's motivation to adhere to the regimen and even benignly influence the disease process itself. The psychological impact of the physician-patient relationship is potentially of great intensity and far-ranging impact as illustrated in the well-documented therapeutic effect of placebos.[5,6] Additionally, the evidence showing that adjunctive psychological treatment shortens the recovery of medical and surgical patients further demonstrates the responsiveness of physical ailments to the psychological factors mediated by the interpersonal relationship between patient and caregiver.[7] In the related field of psychiatry 30 years of empirical research on psychotherapy shows that the power of these psychological effects is attributable to the influence inherent in the interpersonal relationship between patient and the therapist.[8] These same psychological forces can be marshaled and used to therapeutic advantage in patient education.

Over the years considerable efforts have been aimed at establishing the value of patient education as a support for effecting patient compliance, although the importance of the interpersonal relationship and its psychological impact in patient education has been largely ignored. The literature on patient education primarily affirms its value, explains basic learning principles, and offers practical guidelines for establishing patient education programs along with describing brochures, audiovisual aids, and programmed learning devices designed to help teach the patient.

This mass of educational material, however, has created an illusion of effectiveness based on the assumption that most patients will learn when clear and simple information is provided, and that given such information, the patient will rationally guide his behavior toward health-promoting habits. The patient is offered information, sophisticated educational material, and advice while the patient's experience of his illness and relationship to the physician and medical team are often overlooked. Subsequently, the educational information and advice frequently fall upon deaf ears as the patient begins to feel isolated, sensing that important aspects of his experience and concerns regarding his illness are not empathically appreciated.

Understandably caregivers can grow anxious as they, often helplessly, watch the patient exacerbate his illness through failure to adhere to the medical regimen. Frequently, as one recent review found, treatment personnel "blame noncompliance on the patient's personality and express little desire to understand and little sympathy for the uncooperative patient."[11] Likewise, in the face of this reaction the patient also becomes anxious and defensive and perhaps terminates treatment. Thus, the development of elaborate educational programs and devices, with their alluring promise of a clear and structured means of changing the habits and behavior of patients, has distracted caregivers from sufficiently attending to the interpersonal context and psychological meaning of patient education and the importance of the therapeutic relationship with regard to this aspect of treatment.

More important than offering educational material, the treatment team must succeed is establishing a treatment alliance comparable to that aimed at in a psychotherapy process. For those patients who ignore their physician's advice and do not adopt health-promoting behavior, patient education must be more than a didactic program. In these instances the physician or nurse would gain therapeutic leverage by employing principles that have been found to be the primary enabling factor in facilitating change in psychotherapy.[8] Here the physician-patient relationship itself becomes the curative instrument with which the patient is influenced to change. Just as the success of psychiatric treatment depends upon quality of the alliance established between the patient and the therapist,[9] the degree to which medical patients respond to patient education is likely determined, in large measure, by the

quality of the relationship with the caregiver. It is the very quality of this relationship and treatment alliance that makes for the success of the physician's educational efforts, more so than the didactic material provided and the content of the medical explanations.

THE THERAPEUTIC ALLIANCE IN PATIENT EDUCATION

It is most important to isolate and identify the determining therapeutic element inherent in the physician-patient relationship. Although this task remains a continuing goal in current psychotherapy research, evidence has accumulated pointing out that the degree to which the therapist is able to construct a therapeutic alliance in which the patient feels understood and acknowledged is a pivotal factor in the effectiveness of psychotherapy in alleviating psychiatric disorders.[8] Similarly, considerable empirical evidence demonstrates that medical compliance is largely a function of the nature of the physician-patient relationship, with the significant factors being the extent to which the relationship is characterized by support, negotiation, satisfaction, and mutual agreement.[3,10,11]

Thus it is likely that patient education is apt to succeed insofar as the physician or other members of the medical team implementing the educational interventions are able to generate an alliance, the main ingredient of which is "the empathic attitude."[12] This approach aims at an empathic attunement with the patient and the psychological factors that prevent the patient from making use of the educational offerings. The caregivers must learn to meet the patient's resistance to educational advice with noncoercive concern and concerned curiosity whereby the physician demonstrates his ability to appreciate and understand the patient's experience and perspective. This empathic receptivity involves more than building rapport, it means the establishment of a healing climate in which the physician makes a genuine and continuous effort to view the situation through the patient's eyes and communicate that understanding to the patient.

The development of empathic rapport is not based upon a routinized technique such as behavior modification, the boundaries of which can be concretely prescribed. The basic principle, however, guiding the physician toward empathic attunement specifies the importance of the caregiver making a concentrated attempt to identify with the patient by immersing himself or herself in the patient's experience. An internal model of the patient's thoughts, feelings, and fantasies is slowly constructed whereby the caregiver gains an intimate knowledge of the patient's psychological world. This knowledge is then demonstrated by simple and sincere statements reflecting an understanding of the patient's experience, eg, "I guess you must be feeling . . . . ," or "After what you have been through, I imagine you are thinking that . . . ." In response, the patient then recognizes that the nature of his or her dilemma has been grasped and appreciated.

The empathic effort in itself provides an atmosphere of safety where the patient can grow more secure over time to permit himself and the treatment team to discover and explore the underlying reasons for the resistance to treatment and patient education. As the patient's trust develops, so does the courage to examine previously hidden feelings, anxieties, and attitudes with regard to the illness, caregivers, patient status, and process of being helped that contributed to the resistance to patient education. These feelings can come to light and be acknowledged only when the patient is convinced on an emotional level that his inner experience is likely to be understood and approached with respect and nonintrusive concern. The illumination of these issues can then permit the patient to evaluate whether the feelings and attitudes generating resistance to patient education are indeed rational or consistent with reality.

Most patients, to varying degrees, experience and demonstrate resistance to patient education, although in some cases this resistance manifests itself as an overt refusal or negligence, often with potentially dire consequences. Such self-defeating behavior, when observed by the more rational perspectives of the treatment team, appears to defy explanation and common sense. One certain finding of psychiatry and the study of human behavior, however, is that irrational factors, frequently hidden from conscious awareness, can determine significant actions and attitudes, such as the patient's view of his or her illness and, of course, patient education.

The internal psychological sources of the patient's resistance to patient education and treatment are numerous and range from denial of illness, a struggle against the physician for control, resentment over the physician's authority, unconscious aims to remain ill, and in some cases, even masochistic wishes to punish the self through illness. For example, a patient who was vulnerable to infections as a result of recent permanent physical disability was instructed on the proper means of self-care and the importance of personal hygiene. He was of superior intelligence and yet unable to follow the prescribed regimen. The team shifted strategies away from trying to convince the patient of the importance of self-care to an approach aimed at understanding his puzzling negligence. Exploration of this issue with the patient uncovered his dependent wishes to be nurtured by the medical team, which was frequently needed to treat his infections. His dependent wishes had been stimulated by his recent disability, which had not yet been mourned. The recognition of his previously unconscious motives helped the patient adhere

to his self-care routine and develop more suitable channels for the expression of his dependency.

When the physician maintains empathic attunement with the patient, rather than trying to force him to comply with the regimen, the climate of psychological safety established is such that the patient feels understood. In this therapeutic atmosphere the patient is apt to grow, over time, more able to examine, with the assistance of the treatment team, the nature of his resistance to the educational suggestions and more able to communicate his concerns to the physician. As the true underlying reasons for the patient's resistance emerge, he is clearly more able to evaluate his self-destructive behavior and make more sound decisions concerning self-care. For example, a medical team's attempts to encourage a patient to cease smoking and reduce his weight were met with apparent agreement, but were actually ignored. The increasingly insistent efforts of the team in the form of providing didactic information, and then warnings, edged this patient and his caregivers into a struggle for control whereby the patient became increasingly angry and provocative. At this point the physician and nursing staff began to grow irritated and withdrawn from the patient. A consultation with another physician who had previously treated this difficult patient with success revealed his exquisite sensitivity to any form of external coercion or criticism to which he reacts with defiance in order to protect his fragile sense of autonomy. The team was slowly able to reestablish rapport with the patient as they reduced their educational pressures and made an effort to understand the difficulties in the alteration of his eating and smoking habits. The patient was then able to reveal the anxiety and depression that generated his oral behavior. Over time, the patient began to experience his relationship with the team as genuinely supportive and then took interest in their educational offerings and made an effort to abide by their advice.

This psychotherapeutic attitude allows the patient to maintain his relationship with the caregivers rather than flee in the wake of the team's dismay over their frustrated efforts. When the physician can at least maintain an empathic treatment relationship with the resistant patient over time, the nature of the patient's resistance may eventually be clarified and change may occur in the self-defeating, noncompliant behavior.

THE THERAPEUTIC VALUE OF PATIENCE

It is probably more important for the physician and treatment personnel to be patient than it is for the patient receiving treatment. In many cases the team's educational efforts may be ignored, and the most helpful response for the therapist may then be an inquisitive exploration of the resistance, some gentle encouragement, and a demonstration of a tolerant ability to wait and bear with the patient. Such circumstances can strain the anxiety tolerance of treatment personnel, and their curative efforts are frustrated, and they are tempted to respond with attempts to control the resistant patient. Irritation, derision, or withdrawal and disengagement from the patient may follow as the caregivers try to cope with their sense of helplessness and the frustration of their medical mission. When these disturbing reactions are held in abeyance, the physician and treatment personnel can maintain their roles as empathic helpers, causing the patient to feel more secure to examine and consider the reasons for self-defeating noncompliance. Although at such difficult junctures the empathic tolerance of caregivers is put to the test, the treatment alliance can be strengthened as the patient recognizes that his or her psychological needs have been adequately met. Patients almost inevitably welcome this atmosphere of psychological safety by signs of relief over finally being understood. Thus, the most important tool in patient education remains the caregiver and his or her empathic capacity.

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