Web Connect

Linda Norton and R. Gary Sibbald Answer a Question on

Fostering Treatment Adherence

Linda Norton

R. Gary Sibbald

Linda Norton, BSc OT, OT Reg (ONT), has been working in the area of seating and mobility for approximately 14 years. She is the Rehabilitation Education Co-ordinator for Shoppers Home Health Care and is currently working on her Master of Health Science degree.

R. Gary Sibbald, BSc, MD, FRCPC (Med), FRCPC (Derm), MACP, DABD, MEd, is Associate Professor of Medicine and Director of Continuing Medical Education, Department of Medicine, University of Toronto (U of T). He is a board-certified internal medicine and dermatology specialist in both Canada and the U.S. based at the U of T and in private practice in Mississauga. He has had a special interest in wound-care education, research and patient care for the past 15 years.

Q I often get frustrated when I try to implement a plan of care and the patient doesn't comply with the plan. What can I do to make sure patients follow the instructions I set out for them?

A The treatment of a person with a chronic wound involves treating or correcting the cause while considering patient-centred concerns. The traditional concept of compliance (providers' perspective: to obey an order or command) has been replaced by adherence (patient's perspective: to stick to a treatment/regimen) and coherence (to negotiate a treatment with both perspectives considered). Coherence is a concept related to one of the main components of the Preparing the Wound Bed paradigm addressing patient-centered concerns.[1] The choices the patient makes ultimately can affect whether or not the wound will heal.

Nurses were surveyed[2] regarding "non-compliance." There was a sense that, "a situation would never improve; a wound would never heal, because the patient was, for whatever reason, acting in a manner which would prevent healing."[2] Evidence suggests that adherence rates for clients with chronic conditions are lower than those with acute conditions.[3] As a result, coherence in chronic wound management becomes of paramount importance.

Labelling clients as "non-compliant" or "non-adherent" may stigmatize the patient in future health-care interactions.[3] The focus of care may shift to discharging the patient rather than exploring alternative approaches. This approach also places "blame" for poor outcomes on the patient and removes responsibility from the health-care provider. ("Of course his or her wounds are worse, she or he is non compliant!"[2])

Client characteristics such as depression, comprehension of the treatment regimen, and insight into their condition influence coherence. In addition, health systems and health-care provider issues have proven influential.[3,4] A literature review has revealed common themes that impact treatment adherence (see Web Connect below).

Treatment Accommodation

Treatment accommodation has been defined as "the extent to which a standardized treatment approach can address the complex and unique demands of patients' lives"[4] and is concerned with three domains:

- the purpose/goal of treatment
- the content of treatment
- the method by which the treatment is delivered.

Patient and family values, along with the desired outcomes, must be reflected in the purpose and goals of treatment.[4] Involving the client in the treatment planning

Web Connect

For a diagram illustrating treatment adherence, please visit the *Wound Care Canada* section of the CAWC Web site at www.cawc.net.

process[3,5,7,8,9,10] and their belief in the treatment plan[3,4,7,11,12] have been shown to foster adherence. For example, a patient with a pressure ulcer may rate the ability to participate in everyday activities higher than healing the pressure ulcer. If the treatment plan is focused on healing the ulcer, the patient may choose not to adhere to that plan as it does not reflect his or her priorities. Negotiating a treatment plan that supports the patient's life choices, while striving toward best wound-care practices, will foster adherence.

The patient "must [also] see the content of treatments as relevant to them and their condition."[4] Patients have increased access to health-care information though resources such as the Internet,[20] and may have opinions regarding the treatment plan.[10,21] Health-care providers have a responsibility to be informed of the best practices and to educate the patient as to the options available and their relative efficacy.

In terms of treatment delivery, when appointments are scheduled and how the health-care provider interacts with the patient are important. Appointments that fit into the patient's routine are more likely to be attended and are more likely to be productive. Keller and Carroll[21] have developed a model of physician-patient communication that focuses on the four E's: engage, empathize, educate and enlist. Engaging involves eliciting and understanding the patient's story.[21] Empathy is an active concern for and curiosity about the emotions, values and experiences of another.[21] Education is more than giving information—"it does not take place until the patient is able to utilize the information in an effective manner."[21] Enlistment involves encouraging adherence and increasing the patient's responsibility and competence to care for their own health.[21]

Keller and Carroll[21] report that six specific actions increase patient adherence:

1. Keep the regimen simple.
2. Write out the regimen for the patient.
3. Motivate the patient and give specifics about the benefits of following treatment and the timetable for recovery.
4. Prepare the patient for side effects and for optional courses of action.
5. Discuss with the patient any obstacles to moving forward with the regimen.
6. Get feedback from the patient.

Conclusion

The "non-compliant" label needs to be removed from the vocabulary of health-care providers as it places the blame for not achieving the desired outcomes on the patient without looking at the underlying causes, including the roles of the health-care provider and the health-care system.

The patient's perspective and their concerns should be a major focus of the treatment and intervention process. Health-care practitioners should reflect on the patient, health-care provider and system characteristics that influence treatment. These issues need to be addressed to foster adherence.

We need to encourage patient participation in treatment planning along with adherence to the established patient-centered care plans to improve outcomes.

References

1. Sibbald RG, Williamson D, Orsted HL, Campbell K, Keast D, Krasner D, Sibbald D. Preparing the wound bed—Debridement, bacterial balance, and moisture balance. *Ostomy/Wound Management*. 2000;46(11):14.
2. Hallett CE, Austin L, Caress A, Luker KA. Community nurses' perceptions of patient "compliance" in wound care: A discourse analysis. *Journal of Advanced Nursing*. 2000;32(1):115.
3. Osterberg L, Blaschke T. Adherence to medication. *The New England Journal of Medicine*. 2005;353(5):487.
4. Clay DL, Hopps JA. Treatment adherence in rehabilitation: The role of treatment accommodation. *Rehabilitation Psychology*. 2003;48(3):215.
5. Jette AM, Rooks D, Lachman M, Lin TH, Levenson C, Heislein D, Giorgetti M, Harris BA. Home-based resistance training: Predictors of participation and adherence. *The Gerontologist*. 1998;38(4):412.
6. Mohr DC, Goodkin DE, Likosky W, Gatto N, Baumann K, Rudick R. Treatment of depression improves adherence to interferon beta-1b therapy for multiple sclerosis. *Archives of Neurology*. 1997;54(5):531.
7. Collins NC. Nutritional non-adherence and wound healing. *Advances In Skin Wound Care*. 2003;16(7):367.
8. Phillips B, Zhao H. Predictors of assistive technology abandonment. *Assistive Technology*. 1993;5(1):36.
9. Mathewson C, Adkins VK, Jones ML. Initial experiences with telerehabilitation and contingency management programs for the prevention and management of pressure ulceration in patients with spinal cord injuries. *Journal of Wound, Ostomy, and Continence Nursing*. 2000;27(5):269.
10. Coutts P. Pat Coutts answers a question on the effects of cultural background on patient communication and adherence to treatment. *Wound Care Canada*. 2005;3(2):42-44,48.
11. Jull AB, Mitchell N, Arroll J, Jones M, Waters J, Latta A, Walker N, Arroll B. Factors influencing concordance with compression stockings after venous leg ulcer healing. *Journal of Wound Care*. 2004;13(3):90.
12. Campbell R, Evans M, Tucker M, Quilty B, Dieppe P, Donovan JL. Why don't patients do their exercises? Understanding non-compliance with physiotherapy in patients with osteoarthritis of the knee. *Journal of Epidemiology and Community Health*. 2001;55(2):132.
13. Breuer UB. Diabetic patient's compliance with bespoke footwear after healing of neuropathic foot ulcers. *Diabetes Mellitus*. 1994;20(4):415.
14. Brooks J, Ersser SJ, Lloyd A, Ryan TJ. Nurse-led education sets out to improve patient concordance and prevent recurrence of leg ulcers. *Journal of Wound Care*. 2004;13(3):111.
15. Goettl K, Keast DH. Foot care for persons with type 2 diabetes: Can a teaching video improve compliance? *Wound Care Canada*. 2005;3(2):20-26.
16. Friedrich M, Gittler G, Arendasy M, Friedrich KM,. Long-term effect of a combined exercise and motivational program on the level of disability of patients with chronic low back pain. *Spine*. 2005;30(9):995.
17. Dubbert PM, Cooper KM, Kirchner KA, Meydrech EF, Bilbrew D. Effects of nurse counseling on walking for exercise in elderly primary care patients. *The Journals of Gerontology*. Series A, Biological Sciences and Medical Sciences. 2002;57(11):M733.
18. Tappen RM, Roach KE, Brooks-Applegate E, Stowell P. Effect of a combined walking and conversation intervention on functional mobility of nursing home residents with Alzheimer disease. *Alzheimer Disease and Associated Disorders*. 2000;14(4):196.
19. Ross, F M. Patient compliance—Whose responsibility? *Social Science Medicine*. 1991;32(1):89.
20. Sibbald RG. An appraisal of adult education principles and communication skills to improve patient care outcomes. Unpublished.
21. Keller VF, Carroll G. A new model for physician-patient communication. *Patient Education and Counseling*. 1994;23:131-140.