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Commentary: Clinician Behavior and Patient Compliance -- Is there a Bridge?

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When a patient walks into your office, it's fairly safe for you to assume three things. The first is a 3-part assumption: a) The patient is uncomfortable. He's coughing; or his knee hurts or he has a suspicious lump; b) He wants relief and to feel comfortable again; c) He wants you to solve his problem.

The second assumption that you can make is that he has some degree of pre-conceived notion that you are capable of solving his problem. He might have learned that from a phone book listing, a call to the local city or county medical board, a recommendation from a friend or relative that he trusts, or an insurance listing. But somehow your name was suggested along with some reference about your skill level.

The third assumption is that he is willing to share (or possibly completely turn over) control over his care to you.

If all three assumptions are met, it is likely that you have a cooperative patient entering your office. However, to ensure as much compliance as possible, there are behaviors that you can engage in that will give you the best possible shot at getting the patient's cooperation. After all, a patient has a problem and the chances are that you have the skills to resolve it (the history, problem analysis, differential diagnosis, proper data gathering, appropriate treatment or referral to another health care professional). But the bridge between the patient's problem and your resolving it is the establishing the patient's trust, credibility, and faith in you. If the patient cannot find any of these qualities in you, the chances are that your treatment skills with this patient won't matter.

So when that patient walks into your office, there are some steps you can take to immediately start building those intangibles that become the basis for the patient's belief in you and thus increase patient compliance to complement your skills and your management of his health.

To begin with, one must understand the difference between appearance and intent. Appearance doesn't necessarily equate with intent. When the patient first sees you, what first impresses that patient is what he sees and not necessarily what he thinks you are thinking. If and when the first eye-to-eye contact is made, the patient feels that the clinician is interacting with him. If, at that initial contact, the clinician is looking elsewhere, the patient feels that the clinician is interacting with him. Especially in today's "visual media oriented" society, we are conditioned to react to first impressions. What would we think when standing at the head of the class giving a lecture, and the student in the fourth row is sitting and has his head buried in the computer screen?

Having eye-to-eye contact, exhibiting a facial expression that suggests an upbeat display of hope as opposed to an expression that suggests a negative demeanor or despair, and devoting physical attention towards the patient and not towards some inanimate device in the room (including the computer) are steps that can show an immediate interest in the patient. An initial dialogue such as "it's good to see you," if the patient has been there before, or if the patient hasn't

been there before, a personal comment such as “welcome”, it’s a pleasure to meet you” as opposed to an initial comment such as “what’s troubling you today?” is more apt to give the patient a feeling of personal attention. Feelings of personal attention are more apt to equate with cooperation and a sense of credibility and trust.

Try to avoid being judgmental or accusatory and suggesting negative signs of futility. Try to avoid institutionalizing the patient (“Mrs. Smith I’ve treated hundreds of cases like this before”) and thus taking a feeling of individuality away from the patient, as opposed to “Mrs. Smith I think I know what is happening here and I am sure we can do such and such to give you relief.” And don’t overlook that when seeing a young patient, teenager or younger, not only is the initial personal attention important for the relationship to develop, but with a youngster, that initial interaction can have an influence over the youngster’s general attitude towards medical practitioners and medical care in the future.

It seems as if we are going through some sort of communication renaissance. There seems to be an explosion of words. Cultural mixing is stimulating increased mixing of languages. The traditional considerations of vulgarity is changing. Witness the modern acceptances of what once was taboo in contemporary literature, drama, and comedy. While technology is broadening exposure to information, it is tending to foster isolation and dependency on viewing screens, be they on the wrist, the pocket phone, the desk, or at room size. The point is that initial face-to-face communication and body posturing may play an increasingly critical role in setting the stage for the personal contact that takes place initially when the patient walks into the clinician’s office. Indeed, the stage may have been primed by interactions in the reception area.

However, once the patient leaves your office, you have less influence over whether or not the patient will take the medications properly, will seriously consider your surgical advice, will continue with your treatment protocol, or even want to return to you. This is why it is so important that early in your relationship with the patient, you should be sensitive to your own behavior above and beyond the technical skills that help define you as a clinician. In that first encounter, your appearance may trump your intent.

Your behavior goes a long way to building a bridge to your patient’s compliance.