Some considerations about the importance of alliance between patients and dermatologists in psoriasis

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Summary

Therapeutic alliance between the patient and the physician plays a primary role in the patient-doctor relationship and has significant repercussions on the quality of care and health outcomes. This is even more important in chronic diseases in which frustration and distress are commonly complained by patients and that require continuous motivation and support. Psoriasis is particularly associated with widespread treatment dissatisfaction, high “doctor shopping” and suboptimal adherence to treatment. Such aspects may be improved by promoting patient education and implementing the patient-physician relationship. The role of therapeutic alliance in psoriasis will be briefly analyzed in this article, reviewing the most relevant and recent studies on this topic, and in particular those concerning patient-physician relationship, patient’s perception and involvement in decision-making process. Particular emphasis will be placed on the Italian experiences in this context.

KEY WORDS: psoriasis; therapeutic alliance; patient-doctor relationship; empathy; patient’s education; treatment decision making.

Background

Therapeutic alliance between the patient and the physician has a primary role in their relationship and offers the premises for multiple favorable consequences. In effect, it is crucially important for the patients to feel that they and their problems are taken seriously and that they have an ally with whom they can join the forces in the battle against their disease (1). This is even more important in the case of chronic diseases in which this struggle is particularly long and exhausting. In fact, a chronic disease needs support and motivation to be repeatedly provided in the long-term in order to face and control the frustration, disappointment, and distress of patients (2).

Patient education and an adequate doctor-patient relationship are fundamental bases required to build a therapeutic alliance and to achieve an optimal care and successful health outcomes. Relevant dimensions of an effective patient-physician relationship include time, interest, information and teaching, as well as open-mindedness, enthusiasm and understanding, hope, candidness, and discussion of treatment options (3). One of the words that encompasses most of such dimensions is the term “empathy”, that is certainly an essential tool to establish an alliance with patients in their struggle against the disease. Empathy consists of 3 components: a cognitive focus (exploring the patient’s perspective), an affective focus (experiencing surrogate feelings), and an action focus (with explicit acknowledgement of emotions, giving the patient an opportunity to modulate the physician’s understanding) (2). Empathic perception means understanding the patients’ experience but without losing the “as if” nature (4).

Dermatologists handle peculiar situations, as they commonly have to manage complex psychosocial issues associated with disfiguring chronic skin diseases within the limited time period allotted to each visit. A routine office consultation may not be adequate to provide proper information and sufficient support to patients with chronic diseases (2).

Psoriasis is associated with widespread treatment dissatisfaction, high “doctor shopping” and suboptimal adherence to treatment. Education of patients about medication use and communication regarding their psychosocial needs seem to be particularly poor in psoriasis (5-8). Some studies demonstrated that both patient confidence with their treatment and patient satisfaction may be significant predictors of adherence. In turn, patient satisfaction was shown to have positive associations not only with satisfaction with treatment and quality of care, but also with the dermatologist-patient rela-
Patient-physician relationship, patient’s perception and decision making in psoriasis

Clear information, empathic communication and respect for patients’ beliefs and concerns could lead to better knowledge among psoriasis patients thus increasing the likelihood of being actively involved in decision-making process. Patients could have more ‘ownership’ of clinical decisions, entering a therapeutic alliance with physicians (12).

A study carried out in psoriasis patients who attended a large dermatological hospital in Italy revealed that, in routine clinical practice, 68% of patients wanted to be involved in decision making, while 28% wanted to leave decisions entirely to the doctor, and only 4% preferred making decisions alone (13).

Another Italian study assessed the importance of patient-physician relationship in psoriasis patients administering a specific questionnaire to few dermatologists and to 120 outpatients receiving systemic treatments for psoriasis (14). Attention paid to the disease/patient and improvement on well-being after treatment were significantly overestimated by dermatologists. Among patients, 81.7% rated the attention paid by the dermatologist regarding their disease as favorable, and 77.5% were satisfied with the treatment received. The influence of safety on treatment choice was perceived differently by dermatologists and patients. In fact, the former stated that the therapeutic choice was conditioned by side effects in most cases (83.3%), while 45.8% of patients reported that side effects did not represent a significant obstacle to continue the systemic therapies.

Another experience from Italy analyzed the perception of psoriasis and doctor-patient relationship using a questionnaire, based on the information gathered at preliminary focus group meetings and completed by 300 patients with moderate to severe psoriasis who were enrolled in 17 Dermatology clinics (15). Nearly 38% of patients presented features suggestive of alexithymia, as they declare their inability to describe an emotive reaction to psoriasis. Patients who suffered from psoriasis for more than 10 years were however more prone to report an emotional response to the disease. Most patients (83%) believed that others (including the physician) were quite unable to understand and share their experience. Satisfaction with the treatment received was regarded as fair by 54.7% of patients and high by 32%. Half of the patients had learned at first diagnosis that psoriasis cannot be cured definitively, and had received some information on therapeutic options. Thirty-five per cent of patients felt they needed more information on psoriasis, whereas 30% did not want to know more, expressing resignation. Moreover, 54.6% of patients had been previously visited by at least 3 dermatologists, and the main reason for changing physician was a lack of satisfaction with treatments prescribed (70%). When asked about the characteristics of ‘the ideal dermatologist’, the most desirable qualities corresponded to the ability to use simple/everyday language (29.7% of patients), and the propensity to pay attention to patients’ words (25.7%). Among the aspects of dermatologists’ knowledge that patients believed could be potentiated in order to improve the physician-patient relationship, patient psychology was the most reported (50.3%), followed by interpersonal communication techniques (27%), and non-pharmacology therapy (21.7%).

An Australian survey was carried out in patients with acne, psoriasis or atopic eczema to explore the relationships with their treating doctors (16). Reports of negative experiences with doctors were common. Both general practitioners and dermatologists were described as having poor comprehension of the psychological implications of skin diseases, being insensitive to patients’ emotional suffering, and trivializing patients’ disease. Survey participants recognized however that time considerations and other pressures might at least in part justify the apparent deficiencies. Some participants perceived their doctors as medical technicians who were concentrated on treatment for their physical skin problem, and not for its emotional or social aspects.

A qualitative study among psoriasis patients in the USA indicated that patients desired more verbal and written information on the condition (17). Both physicians and patients reported the necessity for realistic expectations to be initially established in order to avoid frustration and non-compliance, but patients also wished to have reassurance about the drugs prescribed and greater confidence in treatments. Patients desired to see greater recognition of the social impact of the disease and to hear more compassionate and empathetic comments.

In an online survey among Canadian dermatologists, 18% indicated that psoriasis patients had difficulty making decisions about treatment all of the time and 61% had difficulty some of the time (18). The same group performed an online survey in 248 psoriasis patients (19). They reported that the most recent treatment decision was either made by patients alone (42%) or physicians alone (28%) or was shared (29%). More patients who had their decision made by or in conjunction with their physician felt confident compared to those who decided solely. In the interpretation of these results, it should be borne in mind that 70% of patients in the survey had mild psoriasis treated with topical drugs. In treatment decisions for psoriasis, general factors considered most important by dermatologists and patients were: having access to the physician for discussion, having information about treatment benefits and risks, and being clear about what is important (18). Among treatment-specific factors capable of influencing
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treatment decisions, those regarded as the most significant by dermatologists were side effect profile (87%), cost (80%) and route of administration (68%), whereas patients gave the greatest importance to efficacy (78%), followed by availability (55%), convenience (52%) and side-effect profile (52%). Patients believed that their physicians had insufficient time to keep abreast of medical information (47%) or to provide counseling (41%), and these aspects were recognized as the most responsible for hindrance to treatment decision making (18).

Educational programmes

Education and motivational support may increase compliance and improve the patient-physician interaction. The sharing of feelings among people with the same problem may help to attenuate negative emotions. Patients with a good understanding of their disease are more likely to achieve emotional distance from it and become more self-motivated (20).

Education programmes had been successfully applied in various fields of medicine and also in atopic dermatitis, resulting in clinical and psychological advantages (21-24). These programmes can consist in meetings or in teledermatology tools, such as mobile phone-based interventions, aimed at motivating and educating patients. Some studies have investigated the role of educational intervention in psoriasis patients, showing significant benefits. Important limitations of these approaches are represented by the need of multiple sessions and collaboration with psychologists, nurses or social workers, and the application to only a few patients (24-26).

Two different approaches were evaluated in a pilot study in 123 patients with mild-to-severe psoriasis attending Comano Spa, who were assigned to an educational group (group E) or a psychoeducational intervention (group PE) (20). Group E received a 2-hour educational training by a dermatologist and group PE a 2-hour educational training by a dermatologist (the same as in the E group) in the presence of a psychologist who participated in the discussion to manage negative emotions and offer coping strategies. The patients were asked to complete the same questionnaire before and after the session, and received a phone interview after 6 months. Both the interventions induced an equally marked improvement in all disease knowledge and emotional items. Patient satisfaction with the programme was generally high. In particular, the subjects who attended the PE session were more likely to go to this meeting again in the future. The patients who attended the PE session were more significantly inclined to undergo a systemic treatment. After 6 months, the patients retained the information regarding the disease and manifested a higher propensity to initiate systemic therapy. The results obtained by the authors underlined that single-session educational intervention is effective in increasing knowledge about psoriasis, providing opportunities for patients to share their feelings and experiences, to help them cope with psoriasis, and to provide psychological relief and a better attitude towards therapy and physicians (20).

The feasibility and effectiveness of an educational teledermatology intervention were investigated by a randomized, controlled, investigator-blinded prospective pilot study in 40 adult patients with psoriasis (27). Eligibility criteria were the ownership of a mobile phone capable of receiving text messages (TM) and the ability to use it properly. Patients were allocated in a 1:1 ratio to TM group or control group. The patients in the TM group received 1 TM per day for 12 weeks (reminders 3 times per week, educational tools 4 times weekly). TM were created using simple language, considering frequently asked questions about psoriatic drugs (e.g. administration, adverse effects) and general recommendations to take care of overall health. The cumulative results at 12 weeks showed a significant increase of patient treatment adherence in the TM group, with consequent achievement of better health outcomes in terms of both objective improvement of skin lesions and impact on quality of life. The patient-physician relationship improved in the TM group, while it remained unchanged in the control group. High levels of satisfaction were registered, and 85% of patients found TM useful.

Conclusions

Patient experience is increasingly recognized as one pillar of healthcare quality. An interesting systematic review has critically analyzed the evidence on the links between patient experience and clinical safety and effectiveness (12). Consistent positive associations were detected between patient experience and self-rated and objectively measured health outcomes, adherence to recommended clinical practice and medication, preventive care, and resource use. Overall, it was more common to find positive associations between patient experience and patient safety and effectiveness than no associations.

A patient-centered approach should be implemented in psoriasis clinical practice, exploring and understanding the patient’s disease experience, enhancing the doctor-patient relationship, while maintaining realistic expectations. The engagement of two-way communication and education promotion can favor the active role of patients in treatment decision making. It is not possible to nurse a chronic disease without the informed and responsible participation of the patient (28). In such a context, the therapeutic choice should not be viewed just as a simple medical prescription, but is the natural consequence of a contract between doctor and patients, that implies preliminary steps apt to examine the subject and the disease and to provide accurate explanations and information, leading to final negotiations (28). Actually, this contract is between two parties, the physician and the patient, who have however different point of view and level of knowledge and competence, and an unequal position. Therapeutic alliance is aimed at reaching the same objectives, giving the patient the opportunity of acquiring and sharing knowledge. The nature of this covenant is interposed between paternalism and contractualism, which are characterized by the minimization and the ab-
solutization of the patients’ role in clinical decision-making process, respectively. In the 4th century B.C., Plato, in his Laws, already depicted the physician-patient relationships, setting the figure of a slave doctor, who simply gives a prescription without questioning or giving information, against a free doctor who interacts with free patients, instructing them about their disease and prescribing a treatment only with the patient’s consent. Figure 1 summarizes the most relevant aspects that can contribute to achievement of the therapeutic alliance between patients and dermatologists. Finally, we should remember that, among the ethical standards listed in the updated version of the Hippocratic Oath, there is the promotion of therapeutic alliance with the patient, based on trust and reciprocal information, respecting and sharing the guiding principles of the art of Medicine.

References
