

Patient–Clinician Relationships and Adherence to Antiretroviral Therapy in HIV/AIDS

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Only 25 years ago, contracting HIV was regarded as a death sentence. In 1996-1997, the life expectancy at age 20 for an individual infected with HIV was 19.1 years compared to 63.4 years for an HIV-uninfected person.¹ Now, HIV is considered a treatable chronic illness.² Patients in North America that are fully on antiretroviral therapy (ART) have life expectancies comparable to that of the general population.¹ Though HIV/AIDS treatment shares many common components of chronic disease care models with other chronic illnesses, people living with HIV/AIDS (PLHA) face unique and complex challenges in longitudinal care.²

One major challenge is ART adherence. Patient adherence to ART in British Columbia and worldwide has improved over the past decades, due to simplification of drug regimens, combination pills, and decreased toxicity and side effects of drugs. A study by the B.C. Centre for Excellence in HIV/AIDS (CFE) scored patients on their ART compliance between 2000 and 2009 using six indicators, showing that the percentage of patients with perfect compliance scores increased from <5% of those starting ART therapy in 2000, to >40% in 2009.³ Despite the substantial progress, suboptimal adherence amongst patients is still quite common in British Columbia, with only approximately 40% of patients scoring perfect compliance scores in 2018.⁴

Research consistently shows that adherence alone is associated with slower progression to AIDS-related illness, fewer complications, lower mortality, and lower risk of HIV transmission.⁵ The 2012 B.C. CFE study showed that those with poor compliance scores had mortality rates up to 22 times higher than those with perfect compliance scores.³ As such, the issue of adherence remains a healthcare priority. However, this issue is quite complex since it relies not only on independent patient, clinician, and treatment factors, but also on the interaction between clinician and patient. This article aims to investigate the role of patient–clinician rapport in ART adherence and provide a summary of further suggestions for research and clinical practice.

Impact of Patient–Clinician Relationships on ART Adherence

Patient–clinician interactions play a key role in the management of chronic illness; strong patient–clinician rapport has been shown to improve patient treatment adherence and lead to better clinical outcomes.^{6,7,8} Though the patient–clinician relationship, by its subjective nature, is difficult to study in a standardized manner, research repeatedly demonstrates a positive association between good rapport and improved adherence. A study from the United Kingdom in 2007 showed that perceived respect for patients, the clinician's ability to initiate dialogue with the patient, and feelings of trust were all positively correlated with patients' self-reported adherence. Interestingly, patients' feelings of trust with the nurse showed

statistically significant correlation to adherence, whereas trust with the physician did not, likely due to more time and direct care provided by the nursing staff.⁹ Another study by Schneider et al. dissected treatment adherence into six components and showed that quality of communication, trust, HIV-specific education, dialogue focused on adherence, and the patient's overall satisfaction with the clinician all independently increased self-reported adherence.¹⁰ Other studies based in the United States support these findings.^{11,12} These studies are often limited by their cross-sectional analysis and convenience sampling, as well as the subjective nature of questionnaires and self-reporting. However, they consistently suggest that trust, education, and two-way communication are important factors in ART adherence.

Challenges in Patient–Clinician Relationships in HIV/AIDS

PLHA often face or anticipate discrimination while seeking care. They can experience stigma for contagion, sexual identity, mental illness, and substance abuse.⁷ Even without direct signs of rejection, PLHA often face difficulty developing trust and rapport with their clinicians due to shame or expectation of discrimination.¹³ Patients feel less encouraged to seek care if their clinicians do not foster empathetic, non-judgmental, and open discussions, especially due to the sensitive nature of sexual health, substance use, or sociocultural discussions often involved in care.¹⁴ As HIV/AIDS can often coexist with lower education attainment, substance use, or mental health concerns, HIV-specific education and conversations of medication adherence can suffer if these areas are not addressed.¹⁴ Physicians can also face their own challenges when caring for PLHA. They face a burden in not only keeping up with the ever-expanding body of HIV/AIDS research and guidelines, but also learning enough about their patients' lives within a 15-20 minute appointment to best guide them through the treatment. In addition, physicians may experience compassion burnout while managing low adherence rates, comorbidities, side effects of medications, and often insidious yet life-threatening complications of HIV/AIDS.^{15,16}

Further Suggestions for Research and Clinical Practice

Despite the efficacy of novel ART regimens and expanding knowledge on HIV/AIDS, patient adherence to treatment still remains a barrier to achieving desired clinical outcomes. Existing preliminary studies demonstrate a positive impact of strong clinician–patient relationships on treatment adherence. As such, further population-based, longitudinal studies with standardized questionnaires for measuring adherence and clinician rapport are needed. Furthermore, clinicians and clinicians-in-training, whether specialized in treatment of PLHA or not, would benefit from the following recommendations compiled from existing research and educational guidelines:¹⁶⁻¹⁸

1. Be aware of one's own attitudes towards HIV/AIDS, sociocultural differences, differences in sexuality, mental health, and drug use;
2. Provide appropriate reassurance and compassion towards dealing with a chronic illness and its implications on quality of life;

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3. Encourage questions and facilitate a discussion-based, rather than didactic, education, recognizing that education is an important part of treatment adherence;
4. Ask patients for their goals and preferences in treatment to develop a collaborative care plan and optimize treatment adherence; and
5. Take opportunities to learn and improve communication skills.

In summary, while HIV/AIDS treatment becomes more efficacious and accessible, patient-physician relationships remain a cornerstone in promoting better adherence so that every patient can benefit from the advances made in ART. Thus, physicians should employ evidence-based strategies to improve adherence for a historically challenging disease.

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