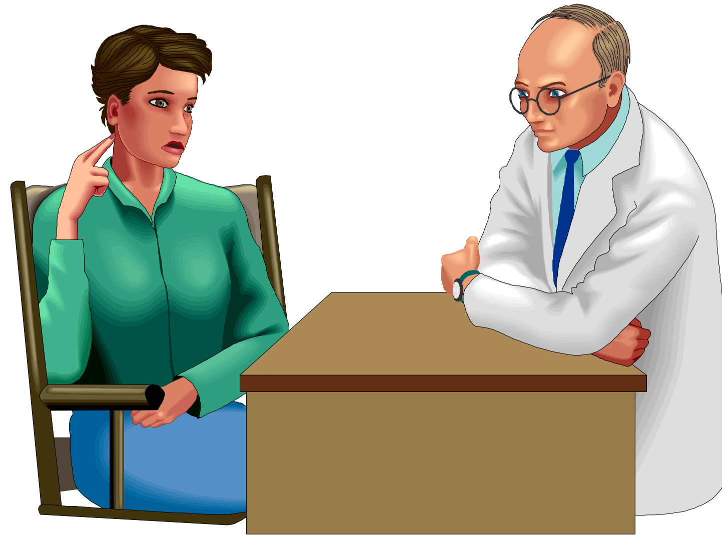

Changing health behavior through marketing methods:

Beyond the disease and the patient, get in touch with the person to sell your prescription and improve compliance

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Abstract:

In the first part of this paper, we will highlight the crucial importance of clinician-client communication in the complex issues surrounding compliance. We will see how affective models used in marketing can provide a useful complement to the cognitive models used until now, for the purpose of better predicting whether a prescription will be adopted or rejected, and of reorienting professional efforts.

In the second part, we will propose a new person-centered clinical approach. This approach arises out of an interdisciplinary process at the interface between marketing and advances in the clinician-client field over the last thirty years. It aims at restoring the person's (affective client's) dominant role in prescription compliance. We conclude with a summary of persuasive communication techniques that can be used in support of the approach and discuss its particularities.

Key words:

Health behavior, compliance, doctor-patient communication, counseling, marketing of health services

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FIRST PART:

Compliance: an emotionally mediated behavior

Introduction

Current health-care reform in Canada, as in other developed countries, plans to rely on primary care and prevention as the best means of improving public health while minimizing costs.[1,2] The success of this policy depends on the quantity and quality of interactions between **clinicians** (health professionals), their prospective **clients** (patients) and the **health-care and services organization** where they interact.

For an evidence-based therapeutic or preventive intervention to reach its target, five conditions must be met:

1) People who are sick or at risk must make use of available services (**consultation**)
2) Clinicians must identify the disease or risk in these people (**diagnosis**)
3) Clinicians must intervene sufficiently to control the situation (**prescription**)
4) Clients must follow the prescription or recommendations (**compliance**)
5) Convinced clients must have access to the prescribed products or services (**accessibility**)

Conditions 2 and 3 depend on diagnostic and therapeutic technologies made available through research, their dissemination through teaching and continuing education and their appropriation by clinicians. Conditions 1 and 5 depend on public and private policies that control access to health care and services. Condition 4 (compliance) is the most closely bound up with the clinical process, the **clinician-client relationship** playing a central role.

To explain and predict health-related behavior, such as compliance with a prescription, researchers have hitherto referred essentially to **cognitive models**. Although these models are recognized as having value in planning interventions for entire populations, they are complex and of limited use at the level of individual consultations. In fact, despite 14,000 listed publications on compliance, little progress seems to have been made in this field.[3]

We hypothesize that these models fail frequently because they don't take into account the **affective (emotional) component**, the client's main internal motivation. Marketing professionals have long played on their clients' emotions to induce them to buy all kinds of goods and services. For many reasons, health professionals feel uncomfortable in a salesman's role and are reluctant to play on their patients' feelings to persuade them to «buy into» their prescriptions.

However, health systems are putting increasing pressure on clinicians to achieve tangible outcomes at reduced costs, leading them to look for more effective and efficient ways to interact with their clients. The concept of *disease management :* « ...an ongoing process aiming to identify and supply to a selected group of patients the most efficient combination of resources for the treatment and prevention of disease» is a good example of this new trend.[4]

In the first part of this article, we will highlight the crucial importance of clinician-client communication in the complex issues surrounding compliance. We will see how affective models used in marketing can provide a useful complement to the cognitive models used hitherto, for the purpose of better predicting whether a prescription will be adopted or rejected, and of reorienting professional efforts.

In the second part, we will propose a new **person-centered clinical approach**. This approach arises out of an interdisciplinary process at the interface between marketing and advances in the clinician-client field over the last thirty years. It aims at restoring the person's (affective client's) dominant role in prescription compliance. We conclude with a summary of persuasive communication techniques that can be used in support of the approach and discuss its particularities.

Issues surrounding compliance

In 1979 Haynes defined compliance as «the extent to which the patient's behavior, in terms of taking medications, following diets or executing lifestyle changes, coincides with the clinical prescription».[5] Non-compliance seriously compromises the effectiveness of outpatient treatment. It causes considerable morbidity, numerous hospitalizations and deaths, wastes rare professional resources, and costs society astronomical sums of money.[6] Non-compliance affects all areas of care: patients refuse to commit to or remain in a treatment program, to take prescribed medication either wholly or in part, to renew their prescription, to adopt a lifestyle suited to their illness, to forgo behavior that puts them at risk, to attend appointments or to go to consultants to whom they are referred.[7]

As regards medication, if compliance is defined as taking at least 80% of the prescribed dosage at the right time, it is estimated that 50% of patients are non-compliant, and the figure might reach 70% in the case of preventive treatments. Out of 100 patients who receive a prescription, 7 never fill it, 4 order it from the pharmacists but never go to collect it, and 18 purchase it but do not touch it—giving over 25% total non-compliance. It is estimated that a further 25% of patients do not observe the prescribed dosage or duration of treatment (partial non-compliance). In addition, many patients use non-prescribed medication, either purchased over the counter or obtained from relatives and friends, in place of the prescribed medication. Physicians and pharmacists thus fail in over half of their «sales» of drug therapy. And yet, this poor performance remains unknown or is ignored, clinicians preferring either to imagine that failure is something that happens only to their colleagues, or to put the blame onto their clients. And if compliance with medication therapy for the most symptomatic diseases leads much to be desired, the situation is much worse regarding lifestyle recommendations (nutrition, physical activity, sexual activity, smoking), where the subjects are suffering no discomfort! Compliance with prescription, especially in the long term, is less than 10% in these cases.[8]

In this context, the health-care system's efforts to develop new diagnostic and therapeutic technologies at great cost are thwarted by the patients'oversight, neglect, conscious or unconscious refusal to comply with recommendations. Paradoxically, the solution to this problem lies not in technology, but largely in the quality of the dialogue between clinician and client.

Determining factors in compliance

At least 200 variables have been cited to explain what happens to a prescription.[7] Figure 1 (The Compliance Train) divides these determining factors into **9 interdependent functional components.**

***Client**-related* variables **(3)** have received the most study. Leaving aside age, which may increase compliance in some circumstances, and sensory-cognitive or psychopathological disabilities, which may reduce it, other individual determining factors such as sex, level of education, prior experience of the disease, knowledge, beliefs, attitudes, perception of the cost/benefit ratio, perceived self-efficacy and locus of control do not seem to have any constant relationship with compliance.[6]

*The client's **psychosocial environment*** **(4)**, made up of family, friends and peers, but also of community groups and the media, may have a significant impact on compliance, but clinicians show little inclination to get involved in order to mobilize this potential ally. Consolidating the client's natural social network, putting the client in contact with someone who has had a similar experience, creating self-help networks, identifying and supporting natural helpers and fostering individual and community empowerment are activities that generally go beyond the context of individual consultation, but the professional can play a pivotal role in their deployment.[9]

Little data has been published regarding the ***clinician**-related variables* **(1)** that affect compliance. One can assume that the professional's age, experience, qualifications and reputation may influence the confidence of his/her clientele. Interactions between people of the same sex and between those of opposite sexes are not equivalent: studies show that female physicians spend more time with their patients, are more willing to engage in discussions of a psychosocial nature dealing with feelings and emotions, and do more to facilitate the patient's participation and partnership.[10] Male patients' expectations of consultations and their way of expressing them are often different from those of female patients.[11] Some clinicians have a natural talent for communication, but this aptitude is not widespread and is generally not looked for as a criterion for admission in health-sciences faculties. However, communication skills are increasingly being considered as an «essential skill for the practice of medicine»,[12] «the main medium of care»[13] and even as a *sine qua non*: «If one is not relational, one is not practising care».[14] Moreover, it is considered that this skill can be learned, practiced and improved on the job.[15] As regards attitudes, the various authors believe that the following qualities in the clinician will increase compliance: approachability, cordiality and friendliness, respectfulness, and attentiveness to the patient's expectations and feelings. At a practical level, **knowing how to prescribe** involves: 1) providing brief, simple and well-structured information; 2) naming the disease, and specifying whether it is treatable or curable, and the goal of treatment; 3) describing the treatment, its benefits, side effects, and duration; 4) striving to simplify the taking of medication and to shorten its duration if possible; 5) enquiring about compliance problems that have been experienced in the past and seeking help from people close to the patient; 6) checking that the client has understood, replying to his/her questions, correcting mistaken ideas, and repeating as necessary; 7) reinforcing the message with written instructions; 8) monitoring compliance.[7]

Determining factors of compliance *related to* ***the organization of care*** **(2)** include accessibility of care (location, time), the efficiency with which appointments are managed, waiting time (for an appointment and in the office), quality of welcome, the commitment and dynamism of personnel, the personalization and continuity of care, the degree to which patients are supervised, and inter-care facility coordination. Excellent organization of care can compensate for various shortcomings in the client or in his/her environment, and can resolve a number of difficulties relating to the characteristics of the disease or the nature of the prescription.

Some *characteristics of the* ***disease*** **(8)** may help or hinder progress towards compliance. Acute or serious diseases, those that are apparent to others and those that are accompanied by unpleasant symptoms encourage compliance, whereas chronic diseases whose symptoms are absent or stable increase patient inertia.

Variables related to the ***prescription*** **(9)** that can hamper compliance are complex drug regimens (taking one medication sometimes makes it easier to introduce a second, but multiple drug regimens can be harmful), multiple doses and prolonged duration of therapy. The form of the medication and the way it is administered (tablets, liquids, injections), labels and containers, accompanying instructions, effectiveness perceived by the client, side effects and costs can also have an impact on results.[7]

However, all the authors agree that ***clinician-client communication*** **(5)** is the most important of the determining factors for compliance. A recent review of published studies[16] suggests that the duration of the interview has a lesser effect than the quality of the contact. **Quality communication** improves compliance through a better exchange of information, a reduction of divergent viewpoints, the patient's playing a more active role in decision-making, and greater consideration paid to his/her emotional life. Such communication also has a positive effect on other health results such as client satisfaction, pain and other physical symptoms, anxiety, functional capacity, and various physiological measures such as glycemia and blood pressure. From the clinician's point of view, better communication also pays dividends: the gathering of more complete and accurate diagnostic data, greater efficiency and satisfaction,[13] and a reduction in legal action for malpractice.

Improvements in the control of certain chronic diseases (e.g. diabetes, asthma) resulting from multidisciplinary teaching programs confirm the usefulness of improved communication.[17] In these programs, **health education** is not limited to a simple one-way transfer of information, but is defined as a two-way process involving variable sharing of power, responsibilities and risks regarding health results between teacher and learner.

However, in current conditions, more than 50% of clients say they are dissatisfied with the **information** received from the clinician, and this is the most frequent complaint.[13] Astonishingly, it is estimated that close to 50% of North-Americans are not sufficiently literate to obtain, understand and react to verbal or written information on their health provided by professionals.[18] Some scientific facts are difficult to explain in simple terms. The use of medical jargon—a language of its own comprising 40,000 words understood by a small circle of initiates—creates a barrier between health professionals and their patients. The information is too difficult to retain and the volume too large to get across in the small amount of time remaining at

the end of a consultation. It is admitted that in these circumstances clients retain only half the information given.[19] Clearly, therefore, information transfer in itself requires specific skills and better training of professionals is required. Showing patients how to communicate better with professionals could be a further promising avenue for improving compliance.[20]

But in the end, despite all efforts made to transfer information, it is found that knowledge of the disease or treatment is a **necessary but insufficient condition** for adoption or maintenance of the prescription.[3] As an example, when physicians or nurses neglect to follow the recommendations they give to their own patients regarding nutrition, substance abuse, physical activity and stress management, insufficient knowledge can hardly be advanced to explain their incongruous behavior. Such professionals will merely say that they «feel» better, falling back on arguments that are emotional in nature and do not stand up to scientific logic.

The compliance train could never get started and keep moving without the stimulus of ***technical expertise*** *in persuasive communication* **(6)**, which can be developed by any clinician (see Part II of this paper).

The train also requires a source of *renewable therapeutic or preventive* ***energy*** **(7)**. This energy arises out of the emotions aroused in the client by the disease (present or expected unpleasant experiences) or the prescription (experienced or expected benefits). These emotions, as we will see later, are the patient's main internal motivating factor, and often the only significant one. These unpleasant experiences and benefits also arouse emotions in people close to the patients, in the clinician and in other care providers, emotions which constitute an additional source of energy (external motivation) to keep the train rolling towards health.

Reason versus emotion in compliance

Cognitive models: reason in charge

Psychosocial factors leading to the adoption of a new behavior such as compliance with a prescription have been studied and organized in numerous theoretical models that are essentially cognitive, making it possible to explain and sometimes to predict coming changes. Each of these theories sheds a different light on the multiple facets of compliance. A summary of the main models is presented in Figure 2.

According to the **Health Belief Model**,[21] the adoption of a prescription depends on four beliefs: the patient 1) believes himself to be a carrier of or vulnerable to a disease; 2) believes that the disease will have a negative effect; 3) believes that the treatment will have a positive effect; 4) believes that the drawbacks of treatment are lesser than its benefits. Subjective assessment by the client of the benefits and risks involved in changing or not changing his/her behaviour seems to be the determining factor.[9] However, this model is sometimes criticized for not taking into account environmental factors that might influence the patient.[22]

In the **Reasoned Action Model**[23] and the **Planned Behavior Model**,[24] the immediate predictor of behavior is the intention to perform an action, which is in turn explained by the attitude and

subjective norms governing the situation. Attitude is determined by the beliefs regarding positive or negative consequences that could ensue from carrying out the behavior. For each belief, the individual assesses the probability that the consequence is related to the performance of the action and makes a subjective evaluation of the importance of this consequence. The subjective standard refers to perceived approval or disapproval from significant others in response to the performance of the actions, and to the motivation to comply with these opinions.

In the **Social Learning Theory**,[25,26] although the intention to change is present, the individual will only adopt a behavior if he/she has the feeling of being in control, able both to acquire the new behavior (personal efficacy) and to resist negative pressure from those around him/her (social skills). The **Interpersonal Behavior Model** [27] introduces three further principles: the moral standard, which corresponds to the individual's personal principles in relation to carrying out a behavior, habits already acquired, and external facilitating conditions.

Green and Kreuter [28] have described a model for planning educational interventions (***PRECEDE-PROCEED***) where predisposing factors (values, beliefs, attitudes and perceptions), facilitating factors (skills and resources) and reinforcing factors (gains or visible results, peer support) influence behavior. This model, widely used in public health, has been adapted to the context of prevention in clinical practice by Wash and McPhee.[29]

Another educational model proposed by Rochon[30] suggests a different method of tackling obstacles to behavior change according to whether they prevail in the sphere of knowledge, of will or of ability to change (*savoir, vouloir, pouvoir changer-**SVP** in french*). The question «does he/she know» refers to the patient's perspective (knowledge, beliefs, experiences, values, attitudes, interpretations) and on the clinician-client relationship (quality and quantity of information transmitted, quality of the relationship, type of educational relationship). The «does he/she want» refers to motivation (general attitude, hierarchy of needs, threat posed by the disease, locus of control, external influence).Lastly, the «can he/she» concerns the prescription's applicability (cost/benefit, complexity, resources).

To reframe the issues surrounding compliance from the client's point of view, Donovan assumes that after receiving the prescription, the patient carries out his/her own decision-making analysis (**Patient Decision Making**).[31] In this process, the patient is described as a rational being who bases decision-making on his/her own baggage of knowledge and belief. The patient analyses the cost/benefit ratio in light of personal criteria: perceived efficacy, side effects, fear of dependence and other beliefs, cost, and feasibility. From the patient's point of view, compliance is not a goal, but an option. Since prescription is not an exact science, the most it can do is to be «rational» (scientific), minimize cost and adapt itself to needs. The client has become a demanding consumer who insists on more information and who wants to participate in decisions. Non-compliance in this context may represent an attempt by the patient to regain control over his/her disease.[32]

Although these cognitive models are of some use in planning and assessing various interventions carried out at the community level, it is easy to see that their weightiness and complexity limits their usefulness in the instantaneous context of the clinician-client consultation. In addition, the

cognitive models ignore the major role played by the client's and the clinician's emotions in therapeutic concordance.

Affective models: emotion in charge

The above models present individual behavior as a logical process that can be modified by information and reasoning. Recent progress in psychology and neuroscience, however, calls into question the decisive influence traditionally attributed to the cerebral cortex, the seat of considered thinking, in human beings behavior. Research gives back their importance to more primitive structures in the brain, the seat of the emotions.[33] It is only over the course of the past 50,000 years that *Homo Sapiens* has undergone the startling development of the neocortex leading to his supremacy over other species. During the preceding million of years, survival was essentially guaranteed by olfactory structures in the brain such as the amygdaloid nucleus and the hippocampus,which have the capacity to learn from sensory experiences and to trigger immediate reactions, structures grouped under the label of **limbic system or «emotional brain»**. Because this system is so ancient, it has been able to develop neuronal circuits leading from an environmental stimulus to the individual's reaction to the stimulus that react to the environment much faster and more effectively than the modulating circuits in the cortex that are designed to inhibit or confirm the reaction. The limbic system is thus able to carry out occasional «emotional coups d'états», leading the individual to act against any cortical logic.

Clients and clinicians, like all human beings, obey a natural tendency to satisfy their emotional needs. As a result, the most important decisions of their lives (choice of a career, a spouse, a place to live, etc.) are often taken on impulse, an emotional choice which logic will attempt to rationalize in retrospect.[34]

In an affective model that we will call **Emotive-Rational Information Processing**, chance or circumstances bring a person into contact with a stimulus which may answer a need (sense organs). If the object or «product» does not arouse his/her emotional interest (limbic system), the person passes it by (switch «off»). If it arouses an affective need, the person decides to go further (switch «on») and proceeds with a rational analysis (cortex) of a possible «purchase» of the product. But before taking a definitive decision, the information is relayed by a second emotional switch (limbic system) which gives the action a green or a red light. Figure 3 illustrates an example of the processing that information undergoes from stimulus to action.

This model describes decision-making as a process in which emotions play a determining role and in which reasoning plays a much smaller part than expected. Knowledge of the person's emotional motivation thus becomes the key that will allow the sales clerk, or the clinician, to turn on the affective switches in order to set the sales process in motion and clinch the sale.
The **Emotional Balance of Decision** is a quick method for assessing the client's affective motivation, developed while testing persuasion techniques in the field of clinical prevention.[35] The clinician asks four questions with emotional content concerning behavior that he/she wishes to see adopted (e.g. breastfeeding) or abandoned (e.g. smoking). 1) What do you like about…(LIKE) 2) What do you dislike about ...(DISLIKE) 3) What holds you back in... or attracts you in…(IN) 4) What would make you decide to get out of ...or would make you give up…(OUT) The patient's answers are placed in the left and right pans of an imaginary scale.The

weight of the client's arguments usually tip the balance to one side or the other. The clinician can then estimate to what extent the client is ready to change and will know what more weighty arguments he/she can advance to initiate the change. In fact, the client's arguments are in general much more determining in initiating change than those of the clinician. For the patient, the decision of whether or not to change depends on this balance between pleasures and frustrations that he/she associates with the current situation or with the future situation. When the clinician wants to promote the adoption of a new desirable behavior, the good behavior has to be put into the balance. When he/she wishes to see an end to a current harmful behavior, it is the undesirable behavior that must be put into the balance.

This diagnostic technique, applicable to any decision to change, gets through to the client's emotions by using questions formulated to address the «heart», which, in Pascal's words, «has its reasons that reason does not know». For example, instead of asking a client who smokes «why» he/she smokes, which will bring forth a «presentable» rational answer from the professional's point of view, one asks him what he/she «likes» about smoking, which will bring forth more sincerely felt emotions.

Figure 4 shows the answers supplied by patients to the four questions asked, in the case of a healthy behavior which the clinician wants to see the patient adopt (breastfeeding) and in the case of an unhealthy behavior which the clinician wants to see the patient give up (smoking).

However, asking the questions well is not sufficient to get through to the client's emotions. One must show **empathy**, the capacity to sense the client's emotions and put oneself on the same wavelength. Over 90% of these emotions are expressed non-verbally, particularly by eye contact, body position or tone of voice,[36] without the parties always being aware of them. According to Gardner,[37] the ability to recognize one's own emotions and the ability to understand what others are feeling are closely linked in the concept of «personal» intelligence, as opposed to logical-mathematical and language intelligence that are usually measured by IQ testing. This emotional intelligence, which appears to be innate in some people but which can be developed in most, is a considerable asset in any kind of human relationship and is the key to the success of good salesmen—and of good clinicians!

Cessation of hostilities: reason and emotion reconciled

In the compliance train (Figure 1) we have made the emotions of all the players involved into the source of essential energy. Without our emotions, what would we be but paralyzed, aimless machines? On the other hand, the reign of blind emotion is incompatible with the lights of reason. In the parabola of the blind man and the cripple who discover they can help each other, the blind man supplies movement and the cripple direction. In our view, it is only with awareness of these two inseparable elements of a person that clinician-client communication can develop.

How the target moves and what arrow to use: the transtheoretical model

Having realized that two interdependent systems of behavior change exist in his/her client, cognitive and affective, the clinician must now determine whether his/her patient is ready for change with regard to a given clinical problem. The answer to this question is rarely clear-cut.

The clinical target lies somewhere on a continuum where it can be reached or remain out of reach. In the **transtheoretical model** of Prochaska, Norcross and DiClemente,[38] behavior change is described as a spiral passing through successive stages (pre-contemplation, contemplation, preparation, action, maintenance, termination) during the course of which individuals encounter obstacles which require specific interventions. As in the development of a child, who begins by crawling and then stands and finally walks, the stages follow an inevitable logical order: none can be skipped without failing and regressing. There are particularly effective clinical tactics for each stage that will bring the client to cross over to the next stage.

At the pre-contemplation stage, the person denies or is unaware of the problem. At the contemplation stage, his/her convictions are shaken, he/she recognizes the problem, but does not see an immediate solution. At the preparation stage, the individual has decided to change and is actively looking for ways to do so successfully. At the action stage, the person makes the change with all the difficulties that it brings. At the maintenance stage, he/she attempts to consolidate his/her decision, but remains liable to lapses. Finally, if ever he/she reaches the stage of termination, he/she will have definitively adopted the new behaviour.

Stage diagnosis is often difficult, but it enables clinical resources to be used more judiciously. Clients who are truly ready to move to action (preparation stage) are few, but they deserve maximum investment, because they are the only prospects in position to conclude the transaction. At the other stages, the clinician must initiate or maintain a movement along the continuum, while showing him/herself to be realistic and patient. The time required for psychological and educational change is not dead time, but a necessary maturation time.[17] A constructive aspect of the transtheoretical model is to consider a lapse as an expected and «recyclable» episode in change rather than as a failure.[13]

Conclusion

The clinician now holds in hands the many strings of his/her client's compliance behavior, the most powerful being emotional. He/she has still to discover the delicate secrets of their handling, which has to be done in the client's respect, by sealing with him/her a long term confidence relationship. It is the aim of the second part of this paper.

SECOND PART:

Convincing the client to buy the prescription—and come back!

Introduction

In the first part of this article, we ascertained that clinicians today not only have the mandate to improve public health by making diagnoses and issuing prescriptions, but must also ensure that prescriptions attain their therapeutic or preventive goals effectively. This calls for improved communication with the client, which leads to an increase in compliance. We demonstrated the importance of the affective component in patients' decisions to change their behaviour, and showed that this component, coupled with cognition, is what brings a client, step by step, towards favourable behaviour regarding his/her health.

In this second part, we will see that the new demands placed upon clinicians call for a redefinition of their role and of their skills. Marketing skills such as negotiation and sales techniques can provide a valid solution to the types of problems that are regularly encountered with clients, as long as certain ethical guidelines are respected. Our reflections on this matter have led us to put forward a **new person-centered clinical approach** that focuses on the client's emotions and combines advances made in recent decades in the realm of clinician-client communication with techniques of persuasion borrowed from marketing to be used in the context of a relatively brief consultation. This article will examine the characteristics of this model.

The new roles and skills of the clinician

The past thirty years have seen a considerable change in the nature of the clinician-client relationship. The old health-care model, which focused on acute illnesses and had the hospital as its sanctuary, now accounts for only 10% of medical interventions. The current model, which consists in dealing with chronic illnesses—increasingly on an outpatient or an extra-hospital basis—has to cope with 90% of the demand. This second model obliges health professionals to prescribe treatment without having any real control over its application, and to educate their patients, share authority with them, manage asymptomatic illnesses or risk factors, handle emergencies, deal with late complications, and offer patients psychological and social support.[17]

In this new paradigm, clinicians must climb down from the paternalistic pedestal from which they used to control their passive patients (clinician-centered relationship) and abandon their position as scientific and technical experts handing out an opinion that is not open to question to a dependent client (disease-centered relationship). New types of more egalitarian relationships—based on cooperation, partnership and the facilitation of autonomy—are emerging.[39] An example of this is the patient-centered relationship, where the clinician strives to understand the client's perspective and to come to an understanding with him/her.

At the other extreme of the spectrum, there is the "informer-consumer" (consumerism) model, which tends to reduce the health professional to a simple "health values broker" whose role is to inform the patient of the options available on the market. From there on, it is the client who

decides what he/she prefers, based on his or her own values. In this model, where it is the client alone who makes the decisions, the clinician no longer has any convincing to do.[40]

The skills required to put these new relationship models to work—models where the centre of gravity moves towards the client—are less at the level of knowledge than of skills (knowing what to do) and attitudes (knowing how to be), particularly with regard to communication. Helping clients to express themselves, face up to their emotions, negotiate shared decisions and come to conclusions are skills that health professionals must now seek to master.[41] In this sense, they have much to learn from the world of marketing, where these skills have been put to use since time immemorial.

Making clinicians into better salespersons

A striking necessity

In a telephone survey,[42] Quebec doctors identified non-compliance as the main difficulty encountered in their practice. They deplored their inability to share their understanding of the problem with patients and to reconcile diverging expectations, and bemoaned the energy as a result. Doctors typically overestimate both the quantity and the quality of their educational interventions, which according to them only too rarely lead to changes in their patients' behaviour.[13] The fact that more than half of prescriptions fail, as outlined in the first part of this article, clearly demonstrates the need to find more efficient methods for transmitting health messages to clients.

Moreover, health professionals are not trained in communication skills or in the attitudes they need to manage their patients' health decisions effectively. They have always been taught to keep at an emotional distance from their clients, maintaining a degree of "scientific" objectivity. It is therefore easy to understand how they may perceive their role as being limited to that of presenting options, rather than influencing their patients' decisions. In addition, faced with their overcrowded waiting rooms, some hesitate to embark upon the task of persuading patients—a task perceived as being long and not very profitable.

An ethical dilemma

Clinicians who advocate a prudent, neutral approach will most likely face disappointment, since it seems impossible to open one's mouth without revealing one's presuppositions about people.[43] Furthermore, one cannot *not* communicate, and every act of communication is irreversible[44] and constitutes an attempt to influence the other person by words or by actions.[45] The result of clinician-client communication is therefore determined by the collision between two subjective perspectives—each of which attempts to influence the other.

Health professionals have to face up to the differences between their own values and those of their clients, and also those of the psychosocial and cultural environment from which the client comes. The market economy, which has become more and more aggressive in its use of the many and varied arms of marketing, incites consumers to adopt life habits that pose risks to health: fast-food and overeating, passive leisure activities, powerful vehicles, extreme sports, unrestrained

and unprotected sexual activities, and substance abuse. All being fair in love and war, does it not make sense for clinicians also to use powerful weapons against these threats to public health?

In accomplishing their mandate, members of the health profession may ethically make use of all diagnostic and therapeutic methods appropriate to the situation, within reason and according to the rules of their art. According to the principle of beneficence, a treatment must produce benefits that exceed any negative effects, with the exception of those that cannot be foreseen. At the very least, it must not harm the patient (*primum non nocere* or "First, do no harm"). A favourable risk/benefit ratio can justify a persuasive attitude in favour of intervention. On the other hand, the principle of autonomy limits this attitude by virtue of the value placed by the patient, who is free to think, feel and act as he/she wishes, on that particular aspect of his/her health. Consent must therefore come freely, without undue pressure, and taking vulnerability due to the illness into consideration. Consent must also be given in light of all the information necessary for making the decision. The patient must have the basic factual information to understand the situation, the possible alternatives and their consequences, and to interpret them in terms of their physical and psychosocial advantages and disadvantages. Written or audio-visual aids can be helpful, but are no substitute for dialogue. In order to better serve patients' interests, it is important to be aware of the rational and emotional reasoning behind their actions, and to negotiate realistic and mutually acceptable solutions with them.[46]

Sales: the art of influence

The tools of the trade

To be a salesperson is to take on the role of a **leader** in the relationship, that is, to persuade someone to do something they would not have done otherwise. This leadership depends on the leader's authority, which is determined by his/her expertise and the sense of dependence or indebtedness felt by the client, but also occasionally by his/her ability to make the client feel either threatened or charmed. However, the most important characteristic of an effective leader is his/her ability to listen and to negotiate.[47]

Charm uses smiles, a cheerful attitude and a good dose of **humour**—the most effective tool for breaking the ice. Through his/her ease and relaxed attitude, and by knowing what to say and when to say it, the salesperson earns the client's trust.[45] The salesperson's thoughtful, easy-going and **positive attitude** is described well in Dale Carnegie's principles[48]: "Smile. Remember the name of the person you are speaking to and call him by his name. Always begin in a friendly way. Get the other person saying, 'yes, yes' immediately. Become genuinely interested in your client. Encourage your client to talk about himself and talk in terms of his interests. Make the client feel important and respected by offering honest and sincere praise. Let the other person do a great deal of the talking. Let the other person feel that the idea is his. Show that you are able to see things from the other person's point of view. If you are wrong, admit it quickly and emphatically. Show respect for the other person's opinion. Never say, 'you're wrong.' Don't criticize or condemn. Call attention to people's mistakes indirectly. Let the other person save face."

The sales process

To influence the client successfully, the salesperson must first reconstruct the unconscious and implicit universe of the client's cognitive objects through **empathy**. Next, the salesperson finds the words to redefine an idea, situation or phenomenon and manipulates these cognitive objects in order to give them the desired meaning.[45]

At the outset, the client (referred to in sales as the "prospect") has a **problem** of some kind, a dissatisfaction that can be alleviated by a product or service. The problem only becomes a **need** if the client expresses a **desire** to resolve it. A need cannot be created; it must already exist in either the client's conscious or unconscious mind. By asking open-ended questions, followed by closed questions, the salesperson seeks to identify and define the need. A supporting intervention, or **demonstration**, links the identified need with the product or service. The sale is **closed** when a question asked leads the client to a commitment. This happens once the client has indicated, either verbally or non-verbally, a desire to buy the product or service, and all his/her **objections** have been dealt with satisfactorily. Rather than avoiding objections, the salesperson should seek them out and help the client to express them, then respond to them specifically. The failure to close a sale is often due to the client's doubts regarding the information received (scepticism) or because he/she does not feel the need identified by the salesperson (indifference). If the closing is a success, it remains to negotiate the details and outcomes of the transaction, offer product support (after-sales service) and, finally, ensure follow-up in order to verify the client's satisfaction and consolidate the business relationship.[47, 49, 50]

High-pressure sales techniques (push)

The public's negative perception of salespersons stems largely from irritating experiences with high-pressure sales tactics. In this process, the relationship between the salesperson and the buyer is tainted by reciprocal distrust, asymmetrical (the buyer having the upper hand), anonymous, ephemeral, and centred on the product and the need. [45] The buyer may make the purchase mainly to get rid of the manipulative salesperson, but will not come back a second time.

Letting the client buy (pull)

In the PRO/BAC marketing model, (Person, Role, Object / Benefits, Advantages, Characteristics) the salesperson is interested in the buyer above all as a **person** and as someone with a specific **role** in society, who in both capacities would probably benefit from the product (**object**). The proposed product either has objective and inherent characteristics that provide a solution to the client's problem, or it does not (*Characteristics /Discharacteristics: what it is / is not).* These characteristics either do or do not translate into a certain number of rational **advantages**, according to the "so what" formula: that is, what the product does or does not accomplish for the buyer in terms of his/her role in society (*Advantages / Disadvantages*: *what it does / does not do*). According to the same "so what" formula, these advantages in turn either do or do not translate into emotional **benefits** for the potential buyer—they either have or do not have something to offer (*Benefit / Disbenefit: what it means / does not mean for you*). The client buys the product in order to reap the tangible advantages directly (e.g. a car for carrying out his/her work) and the often-intangible benefits indirectly (e.g. the social prestige derived from owning the car).

The salesperson's job is to discover the needs (internal motivations) of the client through active listening, and to make the client realize the extent to which his/her needs are still unfulfilled (the feeling of a void) but could be satisfied if he/she were to accept the proposed product. In this way, the client is "pulled" towards the product in an irresistible way, in order to fill the void and reduce this rather uncomfortable **cognitive dissonance**. Once the client's possible objections have been explored and answered, the salesperson can close the sale and obtain a commitment from the buyer by presenting the product as a rare commodity reserved for privileged, deserving clients. Only then do negotiations concerning the terms of purchase take place. The client does not feel as if he/she had been obliged to buy the product, but as if he/she has received a special favour, and will not hesitate to return if the product truly satisfies his/her needs.[47, 50]

The evolution of clinical approaches

The person, the patient and the sick individual

Before becoming a sick individual or even a patient, the potential client of the health-care system is first and foremost a **person** in tune with his/her environment, believing that he/she is healthy and preferring to ignore illness (Figure 6). This person has joys and sorrows, dreams and an ideal way in which he/she would like to live. It is this person—very real, yet often ignored by the medical world—who will ultimately have to follow the prescribed treatment or recommendations and who will necessarily have the last word. It is this person who will decide to take or not to take the medicines prescribed, who will continue to smoke or who will adopt a more active lifestyle—not necessarily based on logic or reason, but because it "feels better" to act in that way.

When the person begins to feel physical discomfort or begins to worry (due to the presence of a particular symptom or clinical sign, following an anomaly in a screening test, or because of an illness in someone else in his/her surroundings), he/she begins to feel a sense of concern, and eventually becomes a **patient**. This subjective feeling of *illness* may or may not be diagnosed as an actual *disease* by a health professional, but the patient eventually consults a clinician in order to obtain responses to his/her concerns or relief from the discomfort and a return to his/her normal life.

Following the process of diagnosis, the patient may either be declared to be sick or not. If he/she is **sick** (as confirmed by the clinician based on the pathological significance of risk factors, symptoms, signs and abnormal test results), a remedy will be prescribed and possibly followed. If it is successful, the sick individual returns to the healthy person of before, until the next episode.However, if the patient does not fully recover, a vicious circle of *chronic disease*, or *CD* (prescription, failure to heal, new prescription, etc.), may begin.

If the patient is clearly not sick, counselling will be attempted to reassure him/her. If this is successful, the patient goes back to being the same person as before. However, if the clinician fails to convince him/her, the dissatisfied patient may enter a different type of vicious circle—that of the "chronic patient," or *CP,* who continues to consult indefinitely (consultation, healthy diagnosis, patient not reassured, new consultation, etc.).

These three representations of the client—the sick individual, the rational patient and the person with his/her emotions—are at the core of three clinical approaches. The approach that focuses on the **disease** has been taught since the beginning of the 19th century, when the scientific "clinico-pathological" method was developed. The **patient**-centered approach, developed over the course of the past thirty years, stems from clinicians' desire to enter the patient's world in order to see the disease through his/her eyes.[51] The **person**-centered approach complements these other two approaches in that it recognizes the central role played by the client's emotions in his/her decision to comply or not to comply with the prescription. Far from contradicting one another, these three models are on the same continuum; they complement one another and fit together like Russian dolls.

The disease-centered clinical approach

In this approach, which is still taught widely in faculties of medicine throughout the world (Figure 7), the client is seen as an essentially passive subject of scientific observation. The patient is a "case," or a specimen of a potential disease to be appropriated and studied. Doctors may make such inappropriate and trivializing statements as, "I put your lung cancer case on the stretcher," or "Come have a look at my hemorrhoids here before I operate." The clinician's task is to discover clinical and paraclinical evidence which, through hypotheses and deductions, will lead to a plausible diagnosis. This process is followed by the logical prescription of the best available treatment for this condition according to scientific evidence, the verdict being beyond challenge. The expert's opinion has been handed down with little concern for that of the "case". Thereafter, it is as if the clinician had spent all the available time and energy for the consultation on making the diagnosis and choosing the appropriate action to be taken, with no time left for discussing the prescription. Any ensuing lack of compliance is the client's fault. The clinician has shown him/herself to be rational, clear and objective; he/she knows what is best for the client and must decide for the client.[31] There is no effort to ensure follow-up or to establish a long-term relation with the client. Instead, the baton is quickly passed to other health-care professionals. "Next!"…

The patient-centered clinical approach

The development of family medicine, which advocates a holistic, sustained, personalized approach, contributed to the evolution of a **patient-centered** method (Figure 8), in which the client is considered to be as much an expert as the clinician, and where the two must cooperate.[52] The patient offers "cues" to the clinician regarding his/her experience both of the disease and of the feeling of illness. The clinician then seeks to clarify the symptoms and the clinical and paraclinical signs of the disease, as well as the "effect on function"— the effect of the disease on the patient's life—and the patient's ideas and feelings about the disease or the treatment, as well as what he/she expects to gain from the consultation. These elements become part of a broader analysis of the problem, which includes the patient's family and social context, thus allowing for a more exhaustive diagnosis.[53]

The success of the patient-centred method is dependent upon the ability of the clinician and the client to find common ground. The **negotiated approach**, which increases the quality of

participation—the empowerment and satisfaction of both parties in the transaction—makes it possible to reconcile any differences of perception between the clinician and the client. What is negotiated is the definition of the problem, the choice of objectives, the methods and conditions of treatment and follow-up, and the application of these agreements.[39] Finally, the clinician verifies that the prescription decided upon with the client meets the client's expectations, and seeks confirmation that he/she is satisfied.

In this method, the clinician is encouraged to empathize with the feelings conveyed by the client and to better understand the client's life context or his/her suffering, but this precious information is used primarily to help the patient ventilate his/her emotions and does not directly lead to a mobilization of the patient towards a solution to the problem.

The person-centered clinical approach

The **person-centered approach**, which takes its inspiration from the PRO/BAC model (Figure 9), helps to discover, beyond the mask of the disease, the patient's rational complaint and the emotional suffering of the person, deprived of his/her sources of pleasure and increasingly frustrated by the clinical problem. The clinician cannot make a complete diagnosis that will be useful in determining the prescription unless he/she asks **questions** not only about the **disease** and the **patient**, but also about the **person** who yearns to regain the lost sense of equilibrium, well-being and security. The clinician must **validate** his/her impressions regarding these three aspects of the client before making a **prescription,** and the appropriateness of the prescription itself must also then be evaluated—particularly by the person. The clinician must actively seek out the client's possible **objections** and respond to them before **closing** the sale. Then, to conclude, there is a summary of the consultation, a clear message is given, and the clinician offers support and follow-up to the client.

This approach responds well to the concerns of researchers, who indicate that significant results are observed when: 1) the client is encouraged to ask questions about the diagnosis or treatment and receives answers to these questions (objection management); 2) the clinician gives clear information, offers effective emotional support and agrees to share the decision-making process; 3) the clinician and client must come to an agreement regarding the nature of the problem and the intervention plan (negotiation).

Persuasive communication techniques

The person-centred clinical approach cannot function without a set of communication techniques. The effectiveness and quality of communication are improved by the interviewing methods developed in recent years in the clinical field [8, 43, 53-55] which converge with those used in marketing. These techniques focus on contact with the client, active listening, formulating key questions, seeking confirmation of information supplied, the prescription, objection management, the closing of the sale, and discussion about the terms of the agreement, support and follow-up (Table 1).

The magic of words

The spoken word is the most important diagnostic and therapeutic tool in medicine, but clinicians do not always know what to say or how to find the right words.[56] In addition, the way in which a question is phrased (the container) can have a radical influence on the response, regardless of the intended message (content). For this reason the use of certain key phrases that serve as a type of "magical formula" during the consultation can bring to light hidden information or help to lead the client closer to the desired objective. Table 1 provides numerous examples of this.

Discussion

The person-centered clinical approach constitutes a kind of new prescription for clinicians. This prescription comprises some characteristics and rational advantages, but it is perhaps the anticipated short-term emotional benefits that will incite clinicians to adopt it.

Characteristics of the person-centered approach

- Complements existing methods with techniques borrowed from marketing;
- Recognizes the critical role played by emotions in changes of behaviour;
- Listens actively to the sick individual, the patient and the person;
- Has the clinician and client negotiate as equals.

Rational advantages of the method for the clinician as a professional

- Offers a solution to the difficulties most often encountered in practice;
- Lets the clinician get to know and understand his/her clients better;
- Can be applied to any health problem, just as sales techniques can be adapted to any product or service;
- Can be used in relatively short consultations;
- Calls for learning and practice;.
- Requires an initial investment of time with the client. However, this is recovered in the follow-up, and the information gathered can be useful for future sales;
- Brings about a certain triage of patients, resulting in less time wasted with those who are not ready to modify their behaviour and more time spent with those who are;
- Lets clinicians use their time more effectively, the number of unnecessary consultations resulting from poor communication being reduced.

Emotional benefits of the approach for the clinician as a person

- Makes the clinician feel the quality of his/her practice has improved and is more holistic, consistent and personalized;
- Helps develop communication and leadership skills that can prove useful not only with patients, but also with colleagues, family and friends;
- Adheres to the highest professional standards;
- May reduce the risk of malpractice suits, which are most often the result of communication problems;

- Gives the satisfaction of mastering a new diagnostic and therapeutic technique (an element of pleasure);
- Eliminates the displeasure of delivering useless moralizing sermons;
- Improves health results, including the achievement of common objectives and the patients' satisfaction and gratitude. "The salesperson's greatest reward is the client's satisfaction, which leads to an indescribable feeling of self-worth. Conversely, nothing hurts more than a blunt refusal that reduces all his efforts to nothing" [50]

Clinicians' objections [56]

"It takes too much time."
It takes less than a minute to form a useful picture of the person, and this will develop and expand throughout the relationship.

"Patients want to get right to the point."
On the contrary, patients want their doctors to interact more with them as individuals and are pleasantly surprised when they are asked to talk about their favourite person—themselves!

"Becoming too close compromises professional objectivity."
It is important to remember that clinicians must have an emotional contact with their patients in order for their therapeutic methods to be successful.

Closing the sale

And now for the closing question: "If we were to propose to you an approach whose characteristics would allow you to better resolve clinical problems, provide you with proven professional advantages and, above all, offer you the personal benefits that you most desire, would you be interested in giving it a try?"

Conclusion

This article rethinks compliance with clinical recommendations and its main determining factor—clinician-client communication—placing it in an interdisciplinary perspective at the boundary of marketing and medicine and highlighting the importance of the role of emotions in the behaviour changes. The result is a person-centered clinical approach, which is both a progression from and an enrichment of the efforts made over the past thirty years to increase the effectiveness and quality of health care. The development of new negotiation and sales skills by health-care professionals can only reinforce the objectives that were at the heart of health-care reforms introduced at the dawn of the century, by optimizing the interface between health-care workers and patients.

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Table 1: CONDUCTING A PERSON-CENTERED INTERVIEW: STRUCTURE, CONTENT AND USE OF KEY PHRASES

<table>
<tr><td colspan="2">PROBLEM SECTION</td></tr>
<tr><td>Interview stages</td><td>Key phrases</td></tr>
<tr><td>Making contact (small-talk phase)

• Having carefully set up a favourable environment for the interview, the clinician begins to observe the patient. He/she introduces himself/herself and greets the patient warmly.

• The clinician may begin with a non-medical subject of interest to the client in order to find common ground for conversation. Using active listening, he/she shows genuine interest in the person and his/her activities, without judging and avoiding any kind of confrontation. To listen actively, one must concentrate, summarize and classify information, seize the gist and retain key words. The professional will also attempt to penetrate the client's private "bubble", to discover his or her specifics, the anchor points that may enable him/her to close the sale.

• Continuing to listen to the emotions revealed by the person, the professional attempts to find the correct distance, both literally and figuratively. This distance is as close as remains comfortable for both client and clinician. In verbal communication he/she strives for the level of language appropriate to the client's social and cultural background and uses the client's expressions and figures of speech. He/she introduces only one idea at a time and obtains agreement about this idea before introducing the next.

• In non-verbal communication, he/she pays</td><td>• Good morning/afternoon, Mr. or Ms. X, I'm Y (smile). Is this your first visit here?...

• How did you manage to get here in this awful weather? ...
• That's an unusual flower in your buttonhole. What does it stand for?...
• Is this your daughter? What's her name?...
• (New client) Before we get down to what has brought you here, I'd like you to tell me a little about yourself...
• (Known client) So, what's new with you?

Examples of body language that show the</td></tr>
</table>

attention to eye contact, to body position and movement—to body language. He/she observes the client's reactions with each statement—continuing in the same direction if they are positive, but taking a new tack if they are negative.	patient one is listening to what he/she is saying: eye contact, nodding, leaning towards them, expressions of approval: *ah-hah, OK. Yes, I see, I understand...*

Questionnaire	
• The questionnaire covers three sphere—sickness, patient, person. It must not be conducted in the manner of a checklist, but in a natural conversational manner. The clinician retains control over the interview by jumping from one sphere to another with questions, while making clear links between the questions. Keeping his/her agenda in mind, the clinician must above all make the client talk and *pick up on all the cues* that the client gives him/her. If he/she feels that the client is taking him too far off track, he/she can interrupt and steer the discussion in another direction, until a diagnosis can be made in the three spheres. The clinician avoids providing explanations at this stage of data collection.	
• Reasons for the consultation: ask an open-ended question and *let the patient talk* for at least a minute, interrupting as little as possible except to ask him/her to explain or reformulate if necessary. A study has shown that American doctors interrupt their patients on average after 23 seconds.[55] This is clearly insufficient either to allow the client to "get things off his/her chest" or to allow the clinician to form a clear picture of the client's concerns. This haste shown by clinicians actually tends to prolong the consultation or to lead to other, unnecessary visits.	• *What brings you to see me, what can I do for you?*
• Help the patient to express all his/her	• *Is there anything else worrying you, that you want to tell me? What else?*

concerns in order to avoid his/her waiting until the end of the interview before unveiling the primary reason for the consultation (*the door-handle syndrome*). • *Negotiate objectives and the conduct of the consultation*: agree with the client on the problem(s) to be discussed on this particular day. If the list of problems is too long for the time available, agree on what should be dealt with as the main priority. Then, propose a sequence comprising a more detailed questionnaire, a physical exam, tests, a diagnostic impression, and an investigation or treatment plan, etc.	• *I'm afraid that we may not have time to tackle all these problems today. What is your biggest concern? What would you like to deal with today?* • *If you like, we could ...*
Disease questionnaire: Ask, in relation to the reason for the consultation, all questions relevant to the client's *medical history* (personal and family), *lifestyle* and *environment*, as well as *symptoms*, clinical signs and test results.	• *Have you ever been hospitalized, operated or treated for...* • *Do you smoke? How many alcoholic drinks do you take each week? ...* • *Is there dust, stress at your work....* • *Do you cough? Has anyone told you that you seemed out of breath? Have you taken respiratory function tests? ...*

Patient questionnaire (the client's rational side): Ask, in relation to the reason for the consultation, all questions relevant to the client's reasonable *expectations*, to *changes* in function the problem has caused in his/her professional, family and social role, and to his/her *ideas* about his/her health concerns and their treatment.	• *Now that we have defined the problem more clearly, what exactly are you expecting from me today? What would you like me to do to help you? What things would you like to change, to improve, that I might be able to help you with? If I were a magician rather than a physician and I could grant one of your wishes, what would it be?* • *How does the problem trouble you? What*

	has it changed in your life, in your functioning, in your relations with others, in how you see yourself? What did you do before that you can't do any more? Why did you consult me today rather than three months ago? What has changed? • *What do you know about your condition? What do you think you have? What do you think is causing your symptoms? Do you see a connection between... and ... If you were to do... to stop doing... do you think you would have the same symptoms? What might help, in your view?*
Person questionnaire (the client's emotional side): Ask, in relation to the reason for the consultation, all questions relevant to the client's sources of *pleasure* and *frustration*, and to his/her *feelings* about the disease and treatment. • To discover the person's emotions, show *empathy* for his/her concerns, worries, anxieties, depression, anger, frustrations, suffering... but also his/her sources of pleasure. Allowing the client to express his/her emotions is in itself therapeutic, but more importantly will mobilize the client's energies in favour of change.	 • *What do you love best in life, what inspires you, fires you up? What would make you get up at 5am when you don't have to? What do you do when you want some pleasure? What would you not want to be deprived of, what would life not be worth living without?* • *What don't you like in your life? What frustrates you, displeases you, enrages you? What is the worst thing that could happen in your life?* • *What do you feel about being diagnosed with... or having to be treated for...?* • *It must be hard to... How do you feel when... What does...do to you? It must be nice to...*

<table>
<tr><td>Validation

This stage allows the clinician to check back with the client that the correct diagnosis has been reached of the disease, the patient (client's rational side) and the person (client's emotional side). It is essential if one wants to move on safely from the PROBLEM section, without risk of returning to it, and to embark firmly on the interview's SOLUTION section.</td><td>• If I understand correctly, what you have come for today, what you would like, is for me to do something (treatment, explanations, advice...) that would...(eliminate or reduce the discomfort of the disease), that would allow you to... (once again, as a rational patient, fulfil your professional, family or social role) and to... (as an emotional person, return to your sources of pleasure or avoid frustrations). Am I right?</td></tr>
<tr><td colspan="2" align="center">SOLUTION SECTION</td></tr>
<tr><td>Prescription
• The clinician has in his/her hands the three diagnostic keys that can open the door to a prescription that suits the client's needs. He/she must create in the patient a cognitive dissonance between the objectives pursued in the three spheres and the current situation. The gap between the two represents an uncomfortable void that only the prescription can fill. To make the client desire the prescription, the clinician makes it into a rare, precious commodity that he/she has to deserve.

• Silence is a powerful lever for change. It allows the client to reflect on what is being proposed. It steps up the intensity of the question asked and hence is difficult for the patient to tolerate for more than a few seconds. For the clinician, it is also difficult to bear, because he/she is itching to give the answer to the question. However, he/she must hold fast, because the first party to break the silence will be in a position of inferiority in the negotiation. When the patient speaks first, it is often to put forward the solution to the problem him/herself.</td><td>• Are you looking for a temporary solution, or a definitive solution to your problem?

• I can see a definitive solution, but it's not an easy one… and I'm not sure you're ready for it ... that you are a good candidate...

• ...SILENCE ...</td></tr>
</table>

• The clinician must now face possible *objections*, or raise them him/herself. They may be true, false or hidden. Objections can reveal a decisive argument. To uncover them, the clinician can use the emotional scales of decision (see part one), especially with pre-contemplators and contemplators. By asking additional questions, the clinician may discover what is bothering the patient. He/she can then attempt to answer the objection and end with the question:	• *What do you like about this solution?* • *What don't you like about it?* • *What is making you hesitate, what's stopping you from...?* • *What would it take for you to decide...* • *Does that answer your question?*
• With preparers, the clinician can remind the client of common objections in order to test the decision's solidity. If the client has strategies for dealing with the difficulties, he/she is ready for change.	• *But if you make this change, aren't you afraid that you'll...* • *If you choose this option, you have to know that... Is that an obstacle? That doesn't pose a problem? Would you like to discuss other options?*
Conclusion	
• The clinician is now ready to close the sale. He/she begins by summarizing the elements of the problem (diagnosis) and the solution (prescription) on which clinician and client have agreed. He/she then asks the closing question:	• *If I had a proposal to make to you that would...*(meet your needs)*, without causing you too much...*(objection) *would it interest you? Would you be prepared for us to give it a try?*
• Whether the offer is accepted or rejected, the clinician will deliver a clear message appropriate to the stage of change, one that is emotionally supportive.	• *I don't need to tell you that…You already know that...* • *As your attending (health professional), it is my job to advise you on your health, and obviously I strongly recommend that you…*
• Lastly, the clinician negotiates the specific terms of support for the prescription and subsequent follow-up.	• *If you agree, I would like to suggest …* (documentation, appointment, follow-up phone call…), *to support you in your decision and prevent a relapse. What do you say?*

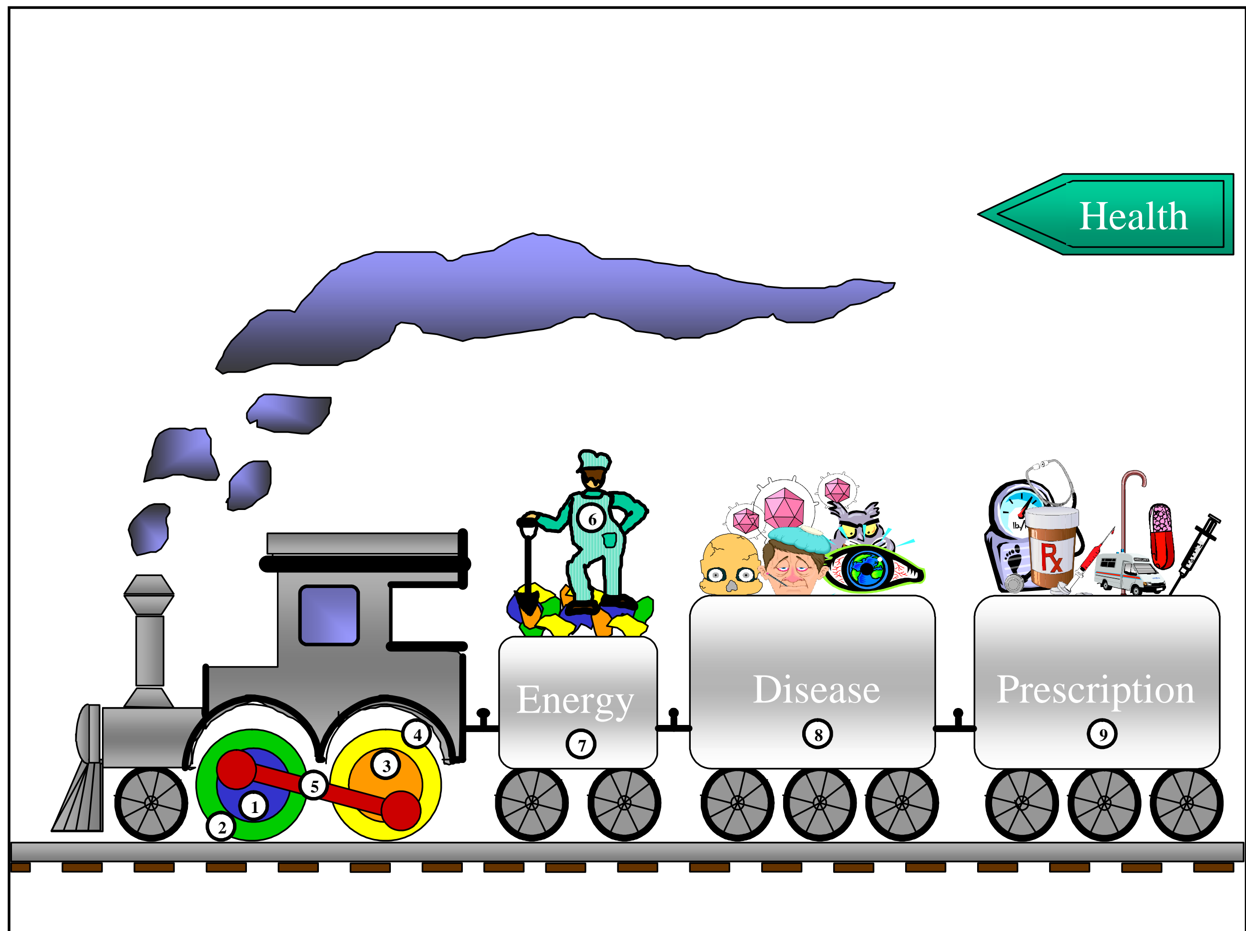

Figure 1: THE COMPLIANCE TRAIN
The locomotive is driven by two wheels: that of the clinician (1), surrounded by the health-care organization where he/she works (2) and that of the client (3), with his/her psychosocial environment (4). These wheels are connected by a vital component : clinician-client communication (5). Getting the train moving requires technical expertise (6) and a source of renewable energy (7), provided in varying proportions by the clinician and his/her organization, and by the client and his/her environment. The load to be pulled is made up of two main cars which represent varying amounts of inertia depending on circumstances: the disease car (8) and the prescription car (9) (see text for more details).

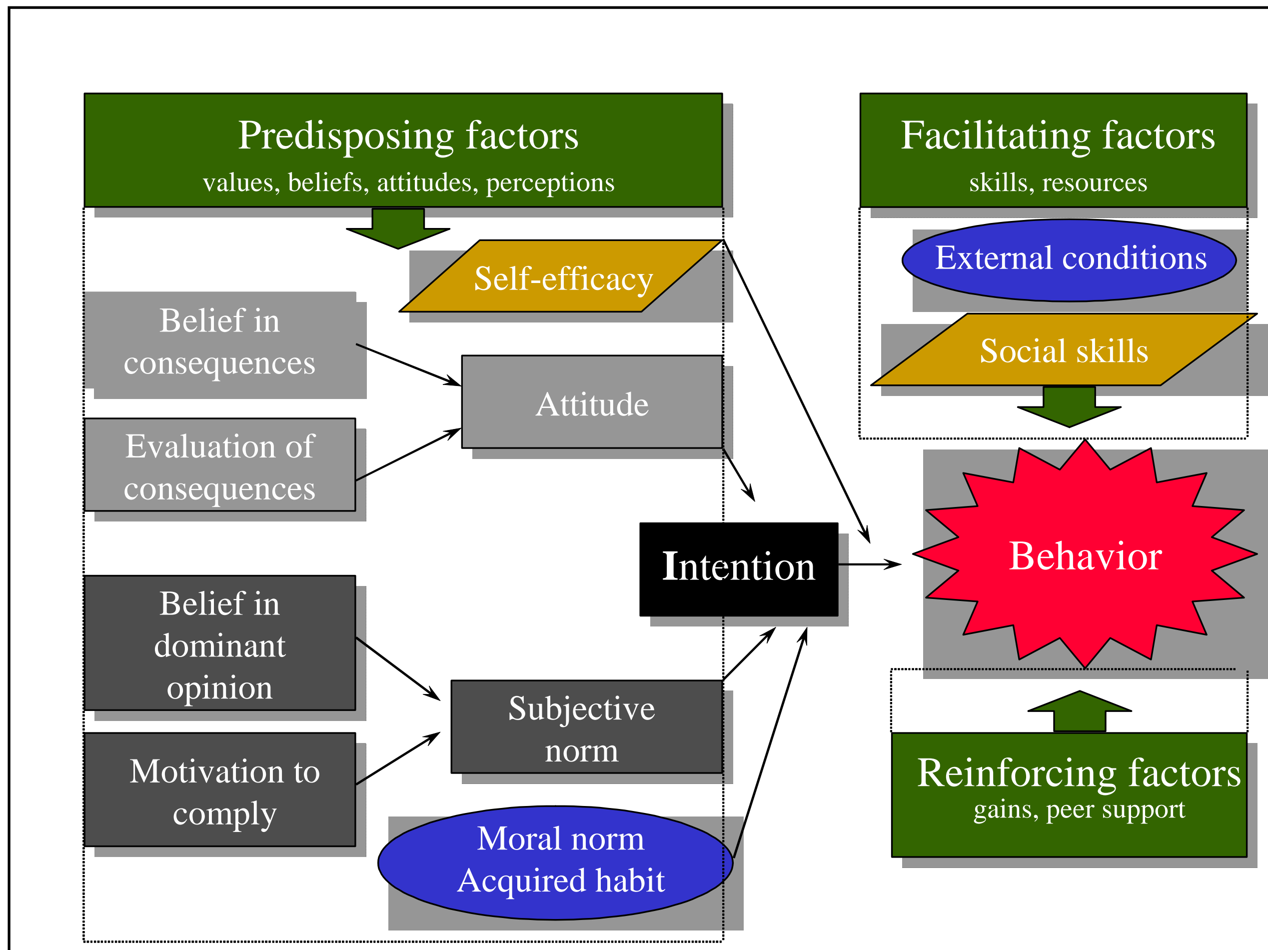

Figure 2: ***SUMMARY OF SOME COGNITIVE MODELS***
Predisposing, facilitating and reinforcing factors (green rectangles) in Green's model place determining factors into three categories using the dotted lines. The models of Fishbein and Ajzen are represented by the grey and black rectangles, Bandura's model by the brown parallelograms and Triandis' model by the blue ovals (see the text for further details).

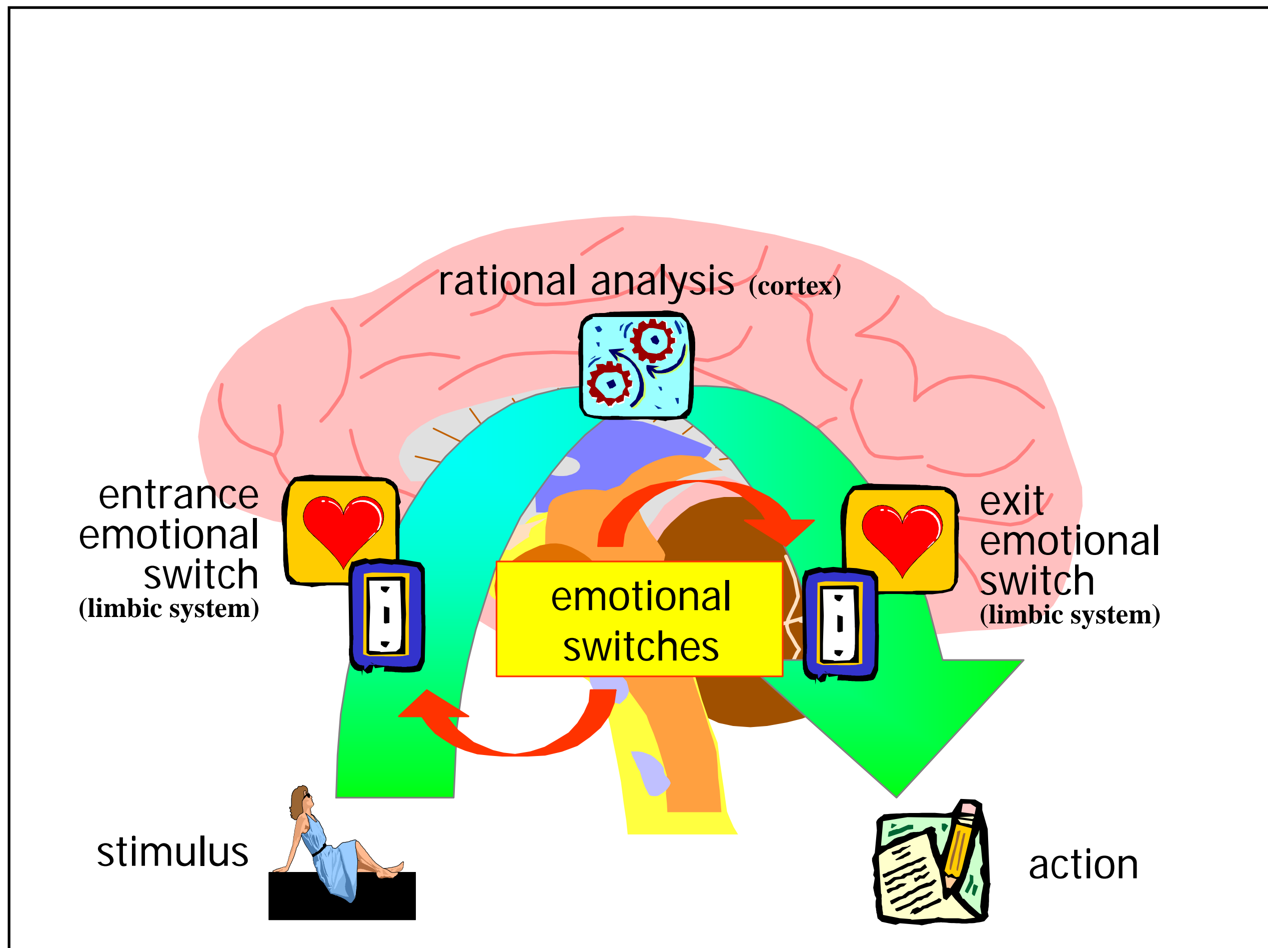

Figure 3: EMOTIVE-RATIONAL INFORMATION PROCESSING

Yolande and Nancy, two health professionals working at the same hospital, each go window-shopping in town. Yolande loves blue, and Nancy hates it, because of prior pleasant and unpleasant respective emotional experiences. By chance they both walk past the same store window in which a blue dress is displayed. Nancy goes on her way, since the emotional switch (limbic system) is turned off: the next day, she will not even remember having seen this dress. Yolande, on the contrary, is immediately attracted by the colour (limbic switch turned on). She goes into the store and decides to move onto rational analysis of the proposition (cortex): Do they have my size? Does the dress suit me? Is the length right? Is it machine-washable? How much does it cost? Can I afford it? Etc. The data analysis is favourable from every point of view, except for the price which is prohibitive. However, the emotional switch is fully turned on because Yolande is thinking of a party at which she might cause a sensation and which Charles will attend. The prospect of pleasure wins out over financial prudence. Yolande signs the contract and retrospectively justifies her purchase by telling herself «I won't get a chance like this again» or «I needed a dress for that party anyway».

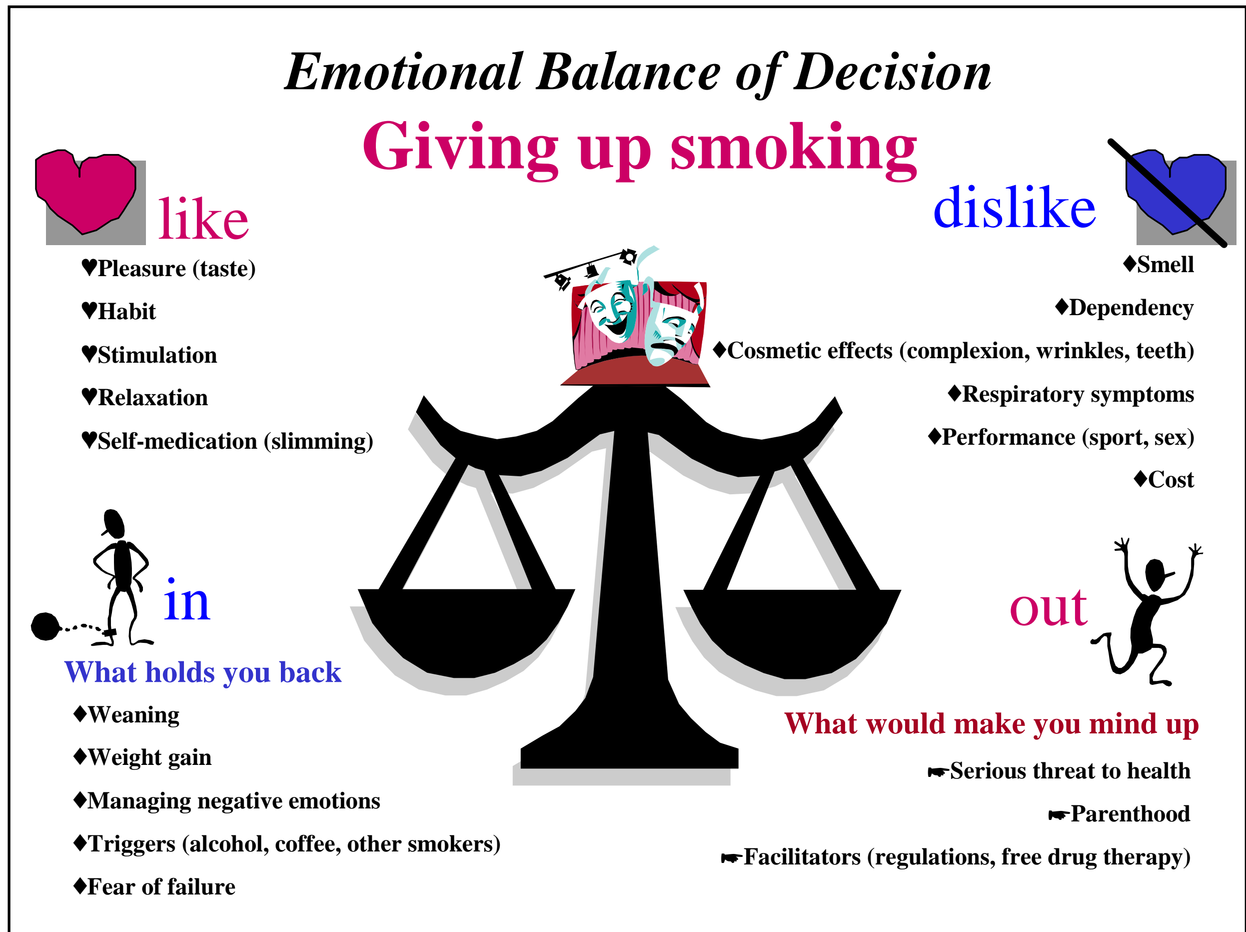

Figure 4 A: THE EMOTIONAL BALANCE OF DECISION: THE EXAMPLE OF GIVING UP SMOKING

The arguments put forward by the client in response to four emotionaly formulated questions concerning a harmful behaviour (smoking) and a desirable behaviour (breastfeeding) are placed in the pans of a scale, reflecting the whole spectrum of his/her internal motivations. The movement of the scale highlights the decisive arguments from the patient's point of view and his/her preparedness for change.

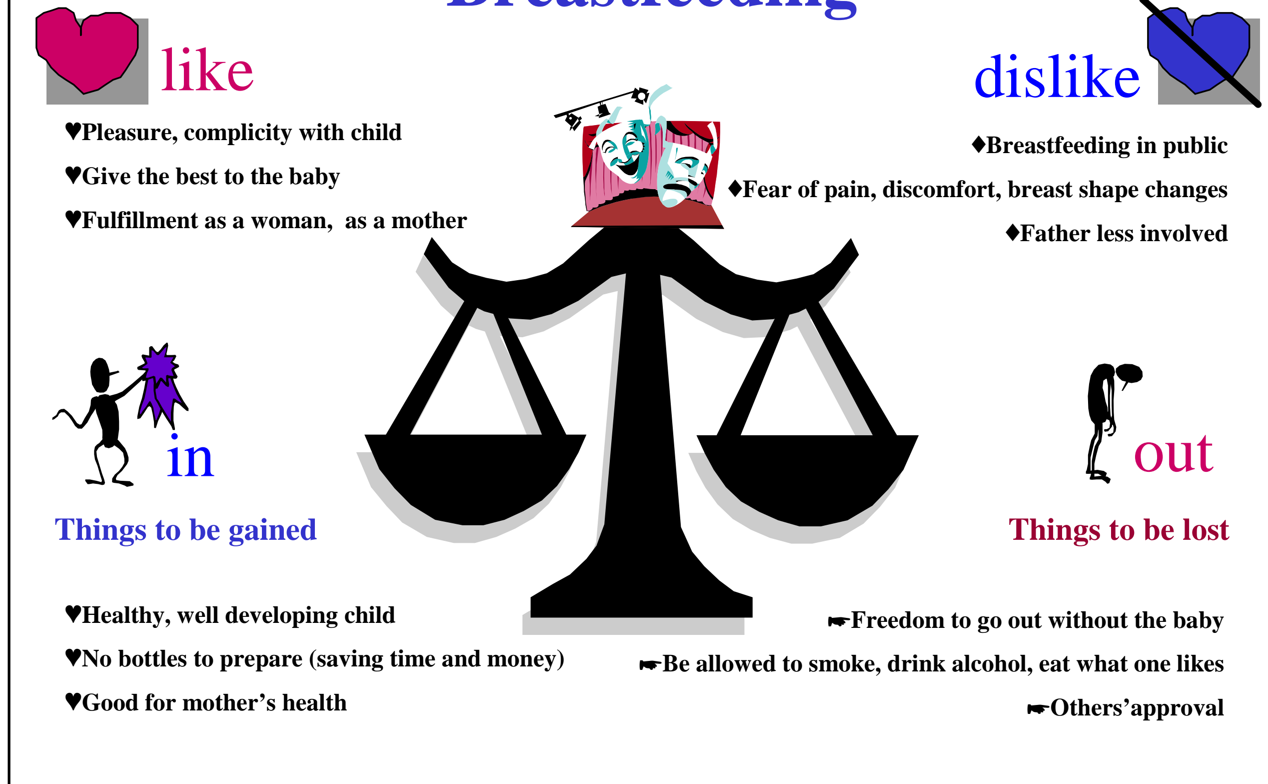

Figure 4 B: THE EMOTIONAL BALANCE OF DECISION: THE EXAMPLE OF BREASTFEEDING

The arguments put forward by the client in response to four emotionaly formulated questions concerning a harmful behaviour (smoking) and a desirable behaviour (breastfeeding) are placed in the pans of a scale, reflecting the whole spectrum of his/her internal motivations. The movement of the scale highlights the decisive arguments from the patient's point of view and his/her preparedness for change.

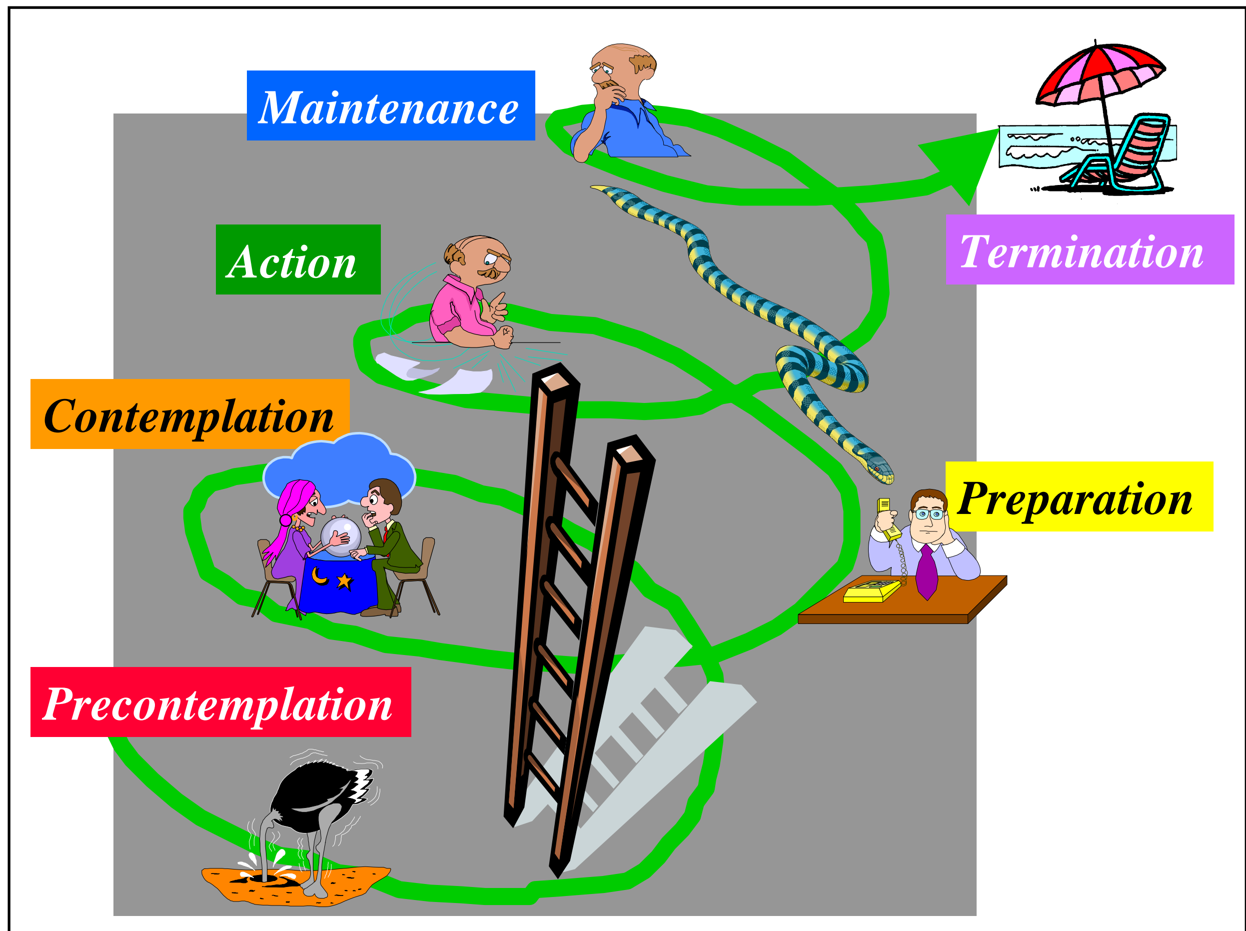

Figure 5: ***THE TRANSTHEORETICAL MODEL***
A person in a change process goes through six inevitable stages in a spiralling continuum. At each stage there are obstacles that can be resolved by specific interventions. If the person takes a shortcut (ladder) in order to skip a stage, he/she may well experience a lapse or fall (snake).

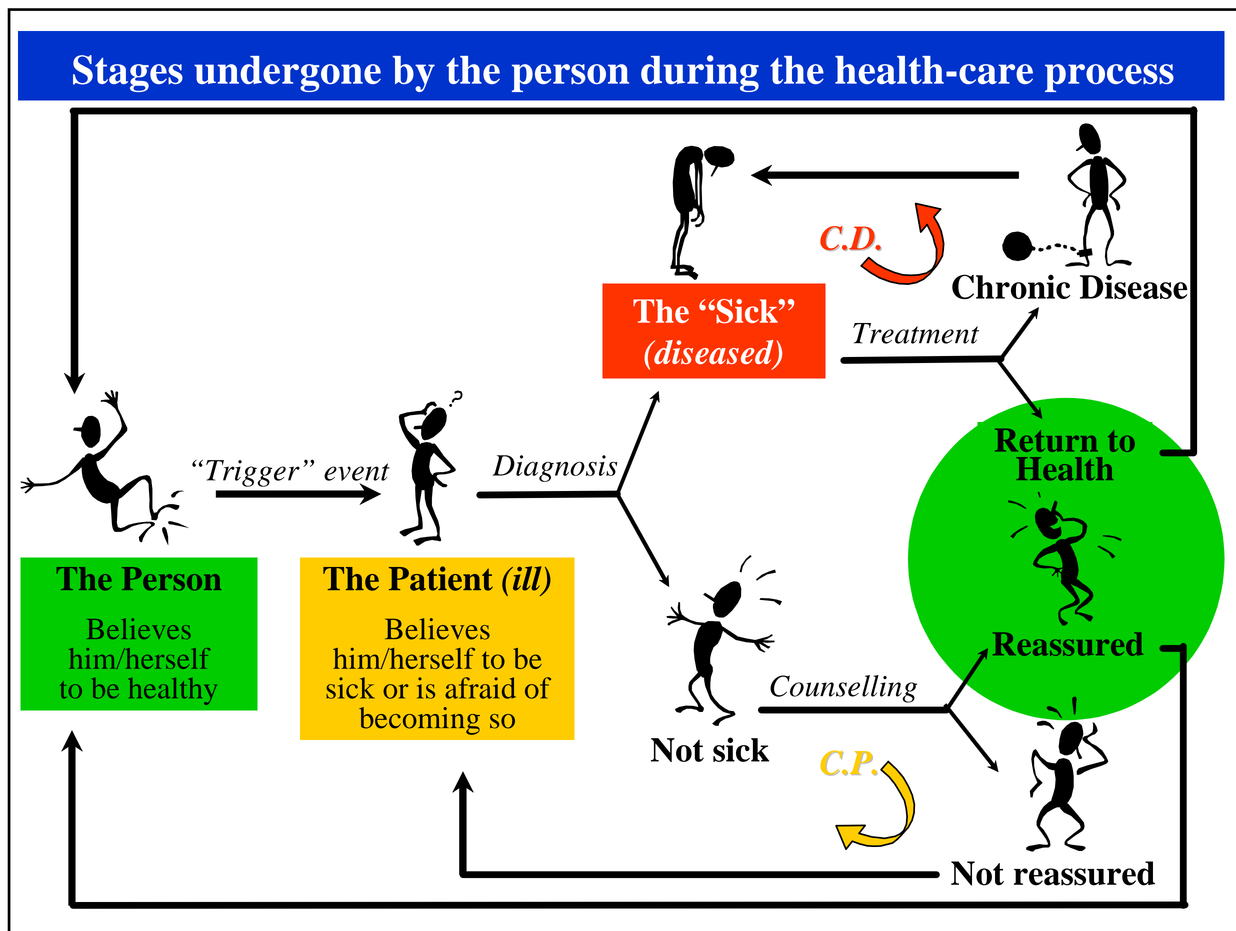

Figure 6: ***THE PERSON, THE PATIENT AND THE SICK INDIVIDUAL***
During the care process, the person undergoes a series of transformations, becoming successively a patient and then a sick individual, triggering the diagnostic and therapeutic process, which ends in a prescription (see the text for more details). Vicious circles: CD = chronic disease; CP = chronic patient.

Disease-Centered Clinical Approach

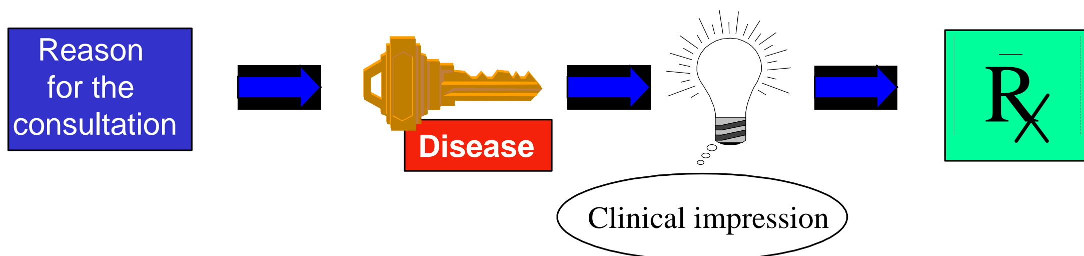

Figure 7: THE DISEASE-CENTERED CLINICAL APPROACH
The client, who presents abnormal symptoms, clinical signs or test results, is considered as an object of scientific observation. Following the diagnostic process, a clinical impression emerges, for which the expert recommends a specific intervention (see text for more details).

Patient-Centered Clinical Approach

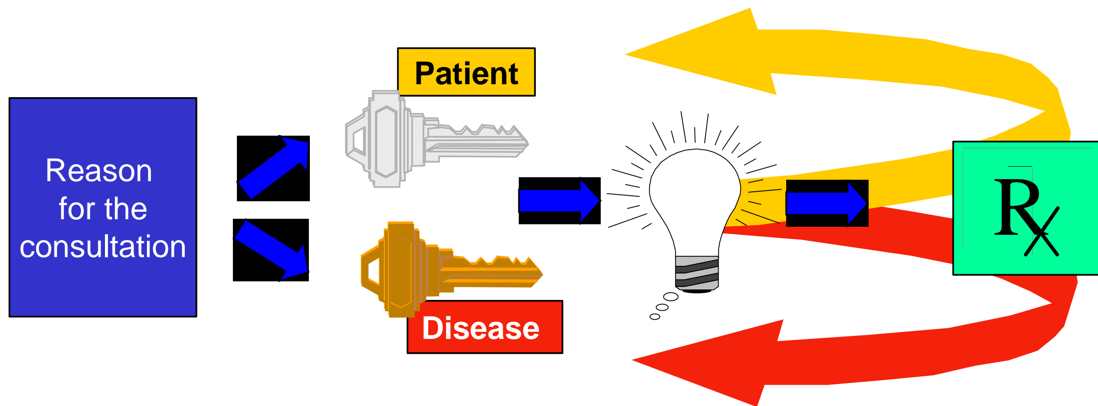

Figure 8: ***THE PATIENT-CENTERED CLINICAL APPROACH***
The client presents with his/her double experience of the disease and of illness (the state of being unwell), which the clinician has to integrate in order to arrive at a broader diagnosis. The clinician validates the information and attempts to find common ground regarding the problem and the proposed intervention (see text for more details).

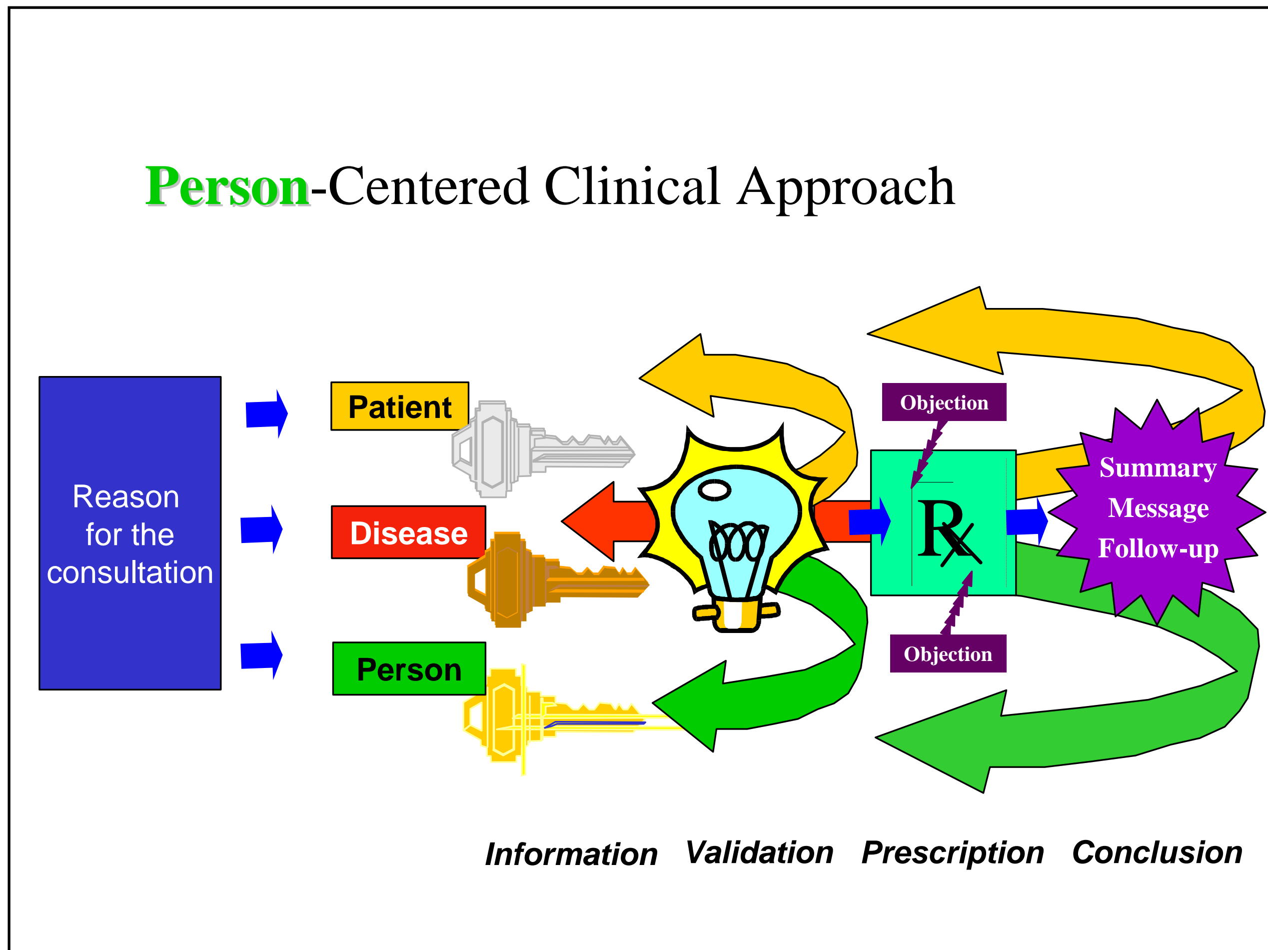

***Figure 9:* THE PERSON-CENTERED CLINICAL APPROACH**
The client presents with a triple identity as an emotional person, a rational patient, and a sick individual. The clinician arrives at a diagnosis that encompasses these three dynamic aspects, validates the information, proposes a prescription, manages objections and concludes the sale (see text for more details).