

LETTER TO EDITOR

Ethical Reflections of Patient Adherence to Treatment Plans

Dr. Yusrita Zolkefli (Assistant Professor)

PAPRSB Institute of Health Sciences, Universiti Brunei Darussalam.

Email: yusrita.zolkefli@ubd.edu.bn

Dear Editor,

The emerging debate on patient adherence in the clinical literature and recent attempts in medical ethics to provide lists of patient obligations indicate dissatisfaction and an implicit desire to push the moral pendulum of the patient's responsibility back to the middle (1). Some ethicists (e.g. Hansson (2); Levy (3); Friesen (4)) believe that in healthcare, patient accountability means that patients have certain personal responsibilities, such as the obligation to comply with the treatment. Adherence is ethically important to make any plan of treatment work. When patients seek medical attention, they are making a commitment, both explicitly and implicitly. Patients have responsibilities within the healthcare system, and many of those duties can be explained by the principle of moral duty to others and to society in particular (5, 6). Moreover, if a patient accepts medical attention, he or she has a *prima facie* moral duty to adhere to the doctor's recommendations for treatment.

There are, however, several oppose this idea, arguing that not all patients are able to accept these personal obligations of treatment adherence and that those duties are not necessarily absolute (4,7). Consider the causes of non-adherence to medication, for example, where the reasons are multifaceted. This includes psychosocial (e.g. depression), structural (e.g. distance from health centre), health-system related barriers (e.g. poor user-experience with the system) (8). Studies have also reported that the beliefs of patients about medications and their understanding of their illness contribute to poor adherence (9).

Nonetheless, patients can also retain the right to decline care when adherence to treatment guidelines or medications is difficult or impractical. In this situation, the health professional must emphasise the patient's responsibility to notify them when they have opted not to follow treatment as directed. At the same time, if patients fail to follow treatment recommendations, this may make

them a significant threat to other people's health and safety, for example, when they are taking tuberculosis medicines as adherence to treatment is critical for cure of individual patients, controlling spread of infection and minimising the development of drug resistance (10); then, the health professional is morally justified in taking appropriate steps to reduce the threat patients pose to the public, including mandated medical treatment or denial of medicines.

It is important to keep in mind that any persuasive approaches for encouraging patient adherence need to be cautiously designed and implemented to avoid the possibility of a coercive or deceptive approach that might escalate to paternalism. The approaches should help the patient make active and responsible choices regarding health. In other words, our approaches in encouraging patient adherence to health should be handled prospectively rather than retrospectively as we delegate roles to the patients. Rather than criticism for past errors or decisions, we could strive for better future options and outcomes and direct responsible patient behaviour accordingly (1). We have a role as health professionals to protect and support our patients by reflecting on the ethical principles of beneficence (duty to promote good and act in the best interest of patient), nonmaleficence (the duty to do no harm to the patient), respect for patient autonomy (duty to protect and foster uncoerced choices) and justice (duty to ensure equal distribution of opportunities afforded by health care). Trying to blame them and being sceptical may not be the remedy to get them to embrace their treatments. Health professionals can support morally responsible decision-making by openly and honestly communicating with patients and their families about the impact of treatment options on others and the community in particular.

At this juncture, this is not the time for holding negative blaming attitudes (11). Effective

communication is critical to a strong patient-health professional relationship. At the same time, the duty and responsibility of patient adherence must be equally balanced and shared by health professionals and the patients, which means that the principle of solidarity negates collective action (7). Health professionals may have the medical and technical experts, however patients are also the expert themselves. It is therefore important that health professionals must first and foremost, promote patient understanding and be aware of any barriers to patient adherence to treatment plans. At the same time, they also make the patients realise and understand the 'technical' responsibility so that they are able to make informed decision of their treatment plans and continue to adhere the treatment plans.

REFERENCES

1. Kelley M. Limits on patient responsibility. *Journal of Medicine and Philosophy*. 2005; 30 (2):189-206. doi: 10.1080/03605310590926858
2. Hansson SO. The ethics of making patients responsible. *Cambridge Quarterly of Healthcare Ethics*. 2017; 27(1):87-92. doi: 10.1017/S0963180117000421.
3. Levy N. Responsibility as an obstacle to good policy: The case of lifestyle related disease. *Journal of Bioethical Inquiry*. 2018; 15(3):459-68. <https://doi.org/10.1007/s11673-018-9860-y>
4. Friesen P. Personal responsibility within health policy: unethical and ineffective. *Journal of Medical Ethics*. 2016; 44(1):53-8.
5. Gauthier C. The virtue of moral responsibility and the obligations of patients. *Journal of Medicine and Philosophy*. 2005; 30 (2):153-166. doi: 10.1080/03605310590926830.
6. Crisp J. Right or Duty: A Kantian argument for universal healthcare. *Online Journal of Health Ethics*. 2017; 13(1). doi: 10.18785/ojhe.1301.07
7. Davies B, Savulescu J. Solidarity and responsibility in health care. *Public Health Ethics*. 2019; 12(2):133-44. <https://doi.org/10.1093/phe/phz008>
8. Subbaraman R, Mondesert LD, Musiimenta A, Pai M, Mayer KH, Thomas BE, et al. Digital adherence technologies for the treatment of tuberculosis: landscape and research priorities. 2018; 11;3(5):e001018. doi: 10.1136/bmjgh-2018-001018.
9. Kumar K, Greenfield S, Raza K, Gill P, Stack R. Understanding adherence-related beliefs about medicine amongst patients of South Asian origin with diabetes and cardiovascular disease patients: a qualitative synthesis. *BMC Endocrine Disorders*. 2016; 16(1): 24. doi: 10.1186/s12902-016-0103-0.
10. World Health Organization. Guidelines for treatment of drug-susceptible tuberculosis and patient care. [Cited 2020 1st August]; Available from https://www.who.int/tb/publications/2017/dstb_guidance_2017/en/
11. Snelling PC. Who can blame who for what and how in responsibility for health? *Nursing Philosophy*. 2015; 16(1):3-18. doi: 10.1111/nup.12061. Epub 2014 May 29.