What Can Be Learned From Nonadherent Patients to Promote the Health of Populations?

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There is an element of paternalism inherent in the work of health and health promotion that is ubiquitous yet often unstated. Through years of education, clinicians (physicians, nurses, and other health care professionals) learn what factors influence health and disease. This knowledge puts them in a position to determine what patients should do to stay healthy, or if already sick, what will likely return them to health. Implicit in this exchange is that the clinician knows more than the patient—a reasonable assumption given the years of training of the former—and that the patient is well served by following the clinician’s recommendations, be it taking medication, changing lifestyle, or any number of other interventions. This is similarly the case in public health, where the goal of public health professionals is to create and preserve the health of the population.

This transaction in which expert professionals provide evidence-based health recommendations to patients and populations underlies the work of health. Bedeviling this exchange has always been the problem of nonadherence. When patients do not follow recommendations from health professional, historically these patients have been labeled as not being compliant with the implication (bred of the aforementioned paternalism) that they do not know what is best for them and are causing themselves harm. A similar paradigm underlies the work of promoting health in populations. Public health advice is often ignored, presumably at the peril of the population.

Even though patient nonadherence to advice has been the subject of some very good thinking in the medical literature, less has been written about the behavior of populations in failing to follow the edicts of public health. In the aftermath of a global pandemic response that was hampered by discussion about how populations were abiding by public health recommendations, and also about what those recommendations should be, it is important to consider the notion of population nonadherence systematically, and to ask what can be learned about population nonadherence with health advice by drawing on the patient literature.

Building on prior writings about patient behavior, I suggest that there are 4 main categories of reasons that underpin nonadherence to medical advice, and that each holds lessons that could inform population health practice.

First, common sense suggests that rational actors (be it patients or a population) should want to follow health advice from experts because doing so is in their best interests. The central challenge to such behavior is that the calculus that underpins expert medical advice may be quite different for the patient, who may weigh the pros and cons of adherence differently than the expert does. This creates the stage for rational nonadherence, in which the patient or population aims to listen to expert advice, but reaches their own different conclusions. An example is the extent to which a patient chooses to tolerate a particular antibiotic because of bothersome adverse effects. The adverse effects may seem trivial to a clinician, but may be substantially challenging to a patient’s quality of life, enough so that the patient stops taking the medication. Patients must weigh the risks of stopping a prescribed treatment (probably a small risk once an active infection has clearly subsided) with the harms of continuing a treatment that is impairing daily function.

Such rational nonadherence similarly challenges the goals of population health. For example, public health guidance to avoid visiting elderly relatives during an infectious disease outbreak implicitly assumes that the risk of transmitting disease to a vulnerable population outweighs the
emotional costs of isolation for both parties. This type of risk-benefit consideration can be quite rationally evaluated by individuals who simply disagree that the former outweighs the latter.

Second, an assumption underlying treatment adherence is that the patient, or the population, understands why it is important to comply. There is abundant evidence that the level of communication by health experts is often not at the desired effectiveness level, and limited understanding of why patients want to adhere to the recommended treatment often underpins the breakdown of action following expert health advice. To return to the antibiotic example, have the risks of not completing the course of antibiotics been convincingly explained so that the patient may weigh the risks with any other harms experienced by continuing treatment? Populations similarly need to understand the risks that may be incurred not only to themselves, but also to entire communities. Large-scale risks are too often poorly explained to populations; public health communication is challenging, particularly during emergencies. If the total health risks are not made clear, populations will find it difficult to understand, follow, and embrace public health advice.

Third, a perhaps less discussed barrier to following expert health guidance is that sometimes factors outside their control limit the capacity of a patient to adhere to health advice even if they want to. One obvious example is the cost of some medications. There is ample evidence of the financial barriers patients experience in obtaining medication and similar evidence that clinicians may not be aware of costs when prescribing medications. At the population level, the financial and reputational costs of adhering to health recommendations can range from stigma in communities to occupational limitations. For example, it is difficult for some populations to stay home during a pandemic if their work cannot be performed at home. Similarly, community norms about wearing masks can be powerful barriers to following public health advice.

Fourth, following expert health advice rests on the notion that the experts and the patients are operating from a shared understanding of the medical condition in question, the importance of treatment, and health more generally. For health experts—be they physicians or public health professionals—health is often seen as the ultimate goal. But for individuals, health is a means to an end, with living fully being the ultimate goal. This notion challenges the assumptions that underlie risk-benefit considerations that inform treatment- or population-level recommendations that ultimately elevate health above nearly all other considerations. But few people want to be healthy and indefinitely confined, and many would accept some element of risk (perhaps more than clinicians would consider reasonable) to skydive or ride motorcycles, for example.

It is worth noting that nonadherence embeds a set of assumptions about unidirectionality and paternalism underlying the work of health, whereby experts tell patients and populations what to do and the latter then follows those orders. A forward-looking agenda for health for both individuals and populations can be built on understanding the limits of expertise, and that decisions to promote health are choices that must be made jointly if they are to succeed. An understanding of why patients and populations may choose not to follow the advice of experts can be an important step in that direction.

ARTICLE INFORMATION
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REFERENCES