ISSN NO: 2770-2936
Date of Publication:22-09-2023

Problems of Long-Term Therapy of Chronic Diseases: Compliance – Refusal of Therapy – Motivation for Treatment

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Abstract. The article discusses the problem of compliance in terms of treatment of patients with chronic diseases. Lack of adherence to therapy (non-compliance) significantly reduces the effectiveness of treatment, and often negates all the efforts of doctors.

Keywords: compliance, patient, chronic diseases, non-compliance, treatment, doctor.

Introduction

The problem of compliance is currently attracting great attention both in general somatic medicine and in psychiatry. This is due to the need for long-term therapy for most somatic (diabetes, hypertension, etc.), as well as mental diseases, primarily in order to prevent possible exacerbations and relapses. The prevalence of non-compliance is extremely high. Thus, for chronic somatic diseases it is 30–60% [1], and for mental diseases it reaches 70–80% [2, 3].

Materials And Methods

In a study by K.A. Cerkoney and L.K. Hart [4] showed that only 7% of patients with insulin-dependent diabetes complete all steps necessary to control the disease. It is no coincidence that non-compliance in severe somatic diseases is regarded as passive suicide (reducing the dose of the drug or changing the regimen) or active incomplete suicide (complete refusal of treatment).

Results And Discussion

Thus, loss of trust in the doctor or iatrogenic behavior can change compliance to non-compliance in one day, which indicates the subjective significance of a certain factor at a certain point in therapy. Conceptual models of compliance are no less controversial, reflecting the variety of research approaches to studying this problem: 1) biomedical model focusing on such aspects as treatment regimen and side effects; 2) behaviorist model with an emphasis on environmental influences and the development of behavioral skills; 3) an educational model centered on improving the patient-doctor relationship; 4) a model of popular ideas about health in society, based primarily on a rational assessment of utility, as well as barriers to treatment; 5) a model of self-regulating systems, within the framework of which cognitive and emotional reactions to the threat of disease are analyzed. Analysis of these compliance models shows that some of them are based on belief in recovery, others on alternative adaptation, others on cognitive functions, etc. The lack of any comparability between them, as well as a unified theory of compliance development, causes justified criticism from opponents of both these models themselves and the results obtained from their use.

If we talk about factors contributing to non-compliance, then out of their almost endless variety, only a few are clearly negative. With more or less reservations, most clinicians consider discomfort caused by various undesirable manifestations of a medical nature to be the reasons for disagreement with treatment; high cost of treatment; judgments of patients based on individual, religious or cultural values regarding the advantages and disadvantages of the proposed treatment; adaptation difficulties caused by personal characteristics (for example, denial of the disease), etc. Factors such as full informing patients about the possible side effects of drugs prescribed by a doctor, the one-time use of them, or, for example, the use of intramuscular injections in different patients can contribute to both compliance and non-compliance.

Most patients tend to give preference to the outpatient form of therapeutic care, categorically refusing inpatient treatment. At the same time, patients, as a rule, are concerned not so much about the unsatisfactory,

ISSN NO: 2770-2936
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in their opinion, living conditions of the proposed hospital, but about the alleged restrictions on the freedom to make their own decisions and behavior associated with excessive control on the part of the medical staff. on the contrary, preference for inpatient mental health care is more often given by older patients, especially those experiencing fear of death or loss of self-care.

Patients who have comprehensive information about their disease, the main effect of drugs and their adverse effects, obtained from various sources, are less likely to interrupt therapy when side effects occur than those who are not informed [3]. However, the results of a survey of inpatient patients conducted by J.L. Geller, showed that only 8% of them could correctly reproduce the name of at least one drug they were taking, its dosage and intended effect, and approximately 54% of patients knew practically nothing about the drug therapy they were taking. Special surveys conducted among doctors and their patients revealed significant differences in respondents' views on the need to provide information about drug therapy, as well as the factors determining consent or refusal. Almost three quarters of the patients surveyed stated that they would agree to receive treatment if they were confident in advance that the drug was both effective and safe, thereby confirming the thesis that patients agree to take the drug only when, regardless of the amount of information they receive, they firmly believe that he can help them and not harm them.

Conclusion

However, there is still no consensus among the researchers themselves on the question of the extent to which informed consent insures against the patient's subsequent refusal of therapy and, in general, in what form and, most importantly, volume of information is desirable or necessary for patients to make a positive decision about the treatment recommended to them.

Refusal of treatment is the clearest goal for compliance therapy [4], and more precisely, motivational therapy, which is a specific psychotherapeutic technique aimed primarily at increasing and maintaining a high level of compliance in patients throughout the course of treatment. Currently, two methods of compliance therapy are used. In our country, the destructive strategy of "intimidation" and "intimidation" is widely used, which consists of informing the patient as much as possible about the risks associated with his possible refusal of treatment and providing him with the most concise information about the side effects of the drugs used.

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