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Opinion

Shifting Language in Medical Diagnosis to Improve Patient Care

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Abstract

Introduction: The term "medication non-adherence" alone is widely used in the medical community to describe the medication taking behavior of patients. This term alone ignores the underlying social barriers many patients face in marginalized communities such as housing, food, and employment insecurity.

Discussion: Social barriers were further magnified and exacerbated by the COVID-19 pandemic for Black and Brown communities and continue to prevent many patients from being able to afford medication or access the healthcare system. In this paper, we utilize patient stories to highlight the above facts and urge the medical community to consider adding the root cause of medication non-adherence in their diagnosis.

Conclusion: Highlighting the root cause will shift focus to the social problem at hand and help create solutions to aid patients in overcoming these barriers so that they can become adherent to their medication and reduce poor health outcomes.

Keywords: Non-adherence; Socioeconomic; Health Disparities; Social Barriers

Introduction

Medication adherence is a term widely used in the medical community to describe the medication taking behavior exhibited by patients [1]. Using the term non-adherent alone when referring to the medication taking behavior of patients results in unconscious bias and contributes to substandard care and poor health outcomes. It ignores the underlying barriers many patients face in taking their medication as prescribed. As medical students rotating in Internal Medicine at the Detroit Medical Center (DMC) Sinai Grace Hospital, we unfortunately witnessed the acute and chronic impact of medication non-adherence due to socioeconomic disparities. We will highlight the story of two patients we encountered who were non-adherent to their medication regimen due to socioeconomic barriers.

Discussion

Patient A was a 56-year-old male who presented to the emergency department in diabetic ketoacidosis (DKA) due to medication non-adherence. He revealed that he recently lost his job, home, and medical insurance. He was temporarily staying at a motel for shelter and could not afford food in the week prior to his admission. The week prior to his admission, he had rationed his already limited supply of insulin because he could not afford

additional insulin and believed he did not have to take the prescribed amount since he was unable to eat full meals. Inevitably, he developed DKA and was brought to the emergency department by emergency medical services.

Had our patient not faced these social barriers, he may not have become non-adherent to his medication regimen and developed a potentially life-threatening condition. Due to the rising costs of insulin, it is estimated that about one in four individuals with diabetes in the U.S. ration their insulin which leads to devastating complications and hospitalizations [2]. Overall, one in twelve adults do not take their medications as prescribed due to their inability to afford them [3]. Inability to afford medications is a public health issue that needs to be addressed.

In cities such as Detroit, MI, where the non-White population is 89.5% [4], the effects of racial and socioeconomic disparities are magnified. The median household income in Detroit from 2015 to 2019 was $30,894 making Detroit one of the lowest income cities in the United States with 35% of the population living in poverty [5], 40% of Detroit households relied on the Supplemental Nutrition Assistance Program (SNAP) benefits in 2019 and 39% of households were food insecure. In 2019 more than 10,000 residents experienced homelessness in Detroit, of which 2,326 were identified as chronically homeless. Furthermore, the unemployment rate was 11% in 2019 and has since increased [6].

It is important to note the disproportionate impact of the COVID-19 pandemic on people of low socioeconomic status, as well as Black, Latino, and Indigenous people [7]. As a result of the pandemic, levels of unemployment rose, and housing and food insecurity were exacerbated in vulnerable communities [8]. These social disparities intersect with health disparities and create insurmountable barriers to achieving medication adherence for many patients.

We urge the medical community to reconsider using the term "medication non-adherence" alone when describing medication taking behavior to focus on the root cause of medication non-adherence. Ignoring the socioeconomic barriers that disproportionately plague marginalized communities, especially Black and Brown communities [9], dehumanizes our patients by ignoring their lived experiences. It inevitably leads to an increase in readmissions for preventable illnesses and an increase in hospital costs [10, 11]. Identifying reasons for medication non-adherence provides opportunities for care teams to address barriers and prevent adverse events and poor health outcomes.

Additionally, we recognize the availability of programs to medically aid elderly and low-income individuals and families such as Medicare and Medicaid, but the lack of comprehensive coverage and accessibility to healthcare services remains troublesome [12]. Patient B, a 71-year-old male presented to the emergency department due to an acute exacerbation of chronic obstructive pulmonary disease secondary to medication non-adherence. He disclosed that he had not taken his medication because he could not afford the price of it, nor did he have transportation to the pharmacy to pick up his medication. Though he did have Medicare, prescription coverage was not included in his Medicare plan.

Medicare provides health care coverage to those over the age of 65, those with a disability, end-stage renal disease, and amyotrophic lateral sclerosis. Medicare is broken into 4 main parts: Part A, Part B, Part C, and Part D which provide various coverage and premium plans depending on income. Most beneficiaries will qualify for premium-free Medicare Part A which includes hospital and related facility costs but will have to pay a premium for Part B, Part C, and Part D which includes outpatient care and supplies, added private services, and prescription medication aid, respectively [13]. It can be challenging for many patients to navigate the Medicare and Medicaid systems and understand which plans they qualify for without guidance.

Conclusion

The term "medication non-adherence" alone ignores the multifactorial causes of non-adherence which should be addressed to provide optimal and inclusive patient care. We, as health care providers, should critically reconsider labeling patients simply as non-adherent and be intentional in our approach to understand why patients are unable to take their medications so that we can provide better care for those in need of additional support. Reframing language for medication non-adherence to highlight socioeconomic barriers for vulnerable populations may help healthcare providers focus on addressing barriers and ultimately reduce hospital admission rates and poor health outcomes for these populations.

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Conflict of Interest

The authors have no financial interest to disclose.

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