I Have Never Liked the Term "Compliance"

Stephen Brunton, Editor-in-Chief

Although the past decade has brought steady improvement in the achievement of recommended A1C, blood pressure, and cholesterol targets among people with diabetes, 33–49% of our patients still do not meet these goals. In many cases, this is due in part to patients' difficulties in following lifestyle recommendations and medication and self-monitoring regimens (1).

Perhaps one reason we have such a problem with patients not following their management plans is our attitude, as reflected in our lexicon. Medicine has a history of paternalistic and top-down approaches to patient care; patients had to follow our instructions, and if they did not, we labeled them "noncompliant." (How dare they ignore our erudite advice?) More recently, as we have become more enlightened in our recognition that input from our patients needs to at least be considered, we began using a term many of us thought of as more politically correct: "adherence." However, this term also suggests a power differential, and although we may believe it to be less offensive, it, too, misses the mark. We have simply slapped a new label ("nonadherent") over the old "noncompliant" label, but we are still blaming and shaming our patients.

The British have what I believe to be a much more acceptable term: "concordance." This term recognizes that health care providers serve as consultants to their patients (or "clients," as our psychology colleagues call them). Concordance implies a more equal relationship, in which the health care provider offers input, the patient offers input, and together they discuss, negotiate, and reach agreement on the most appropriate management plan for the patient.

There is no doubt that we have a problem. Most patients with chronic diseases are unable to follow their prescribed treatment. Frequently, prescriptions are not even filled, and up to half of our patients stop their therapy within 6 months (2). A 2015 study by Buysman et al. (3) found that 1-year persistence with glucagon-like peptide 1 receptor agonist therapy was even lower, with only 34% of patients continuing therapy.

There are a number of potential reasons why people with diabetes may not take their medications, and many of these reasons are not identified or addressed during office visits. It may not be that patients simply forget to take their medication. Instead, there may be a number of other issues involved, including, but not limited to, patients' preconceptions of the disease, denial, poor understanding of the reason for the treatment, or fear of adverse events; complexity of the treatment regimen; and prohibitive expense of the medication.

As we have endeavored to develop a framework for effective communication, concepts such as motivational interviewing and shared decision-making have become more popular. The use of these strategies recognizes that it is the patient who

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has the disease and that, without effective communication, patients will make decisions based on considerations we may not be aware of and may not have addressed with them.

When I work with residents, I suggest that effective communication is an essential element in achieving a desired patient outcome. I suggest that they ask questions such as, "What has been the most challenging problem in managing your diabetes?" instead of the more social, but also more general, "How are you doing?" The first, more specific, question is likely to elicit more information than the second. Similarly, I suggest giving patients "permission" to be honest by prefacing an inquiry about medication use with a statement about it being a common problem, such as, "Many of my patients have trouble taking their medications regularly. Approximately how many times a week would you say you forget to take your medicines?" If the answer is once or twice, it is likely that the real number is ~50% of the time; if the answer is more than that, the likelihood is that the drugs are being taken intermittently at best.

In 2003, the World Health Organization observed that "increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments" (4). If we are to make a difference in our patients' lives, we must take the time to understand their concerns and to work with them to address the barriers to their treatment. Partnering with our patients will yield greater satisfaction for both them and us and will also help us make significant inroads into the effective management of this ever-increasing pandemic.

The *Clinical Diabetes* editorial team is seeking manuscript submissions for a special-topic issue on Patient-Centered Diabetes Care, scheduled for publication in mid-December 2017. We welcome submissions on a wide range of topics under the umbrella of "patient-centered care." Submissions may be research reports, descriptions of innovative programs or initiatives, review articles, or commentaries on topics such as treatment adherence, patient empowerment, advocacy, or patient-provider collaboration. The deadline for submissions is 15 June 2017. Full details and instructions can be found in the announcement on p. 75 of this issue.

Duality of Interest

No potential conflicts of interest relevant to this article were reported.

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