HEALING ARTS

Materia Medica

Resident Non-adherence: A Case Study

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At the end of our ambulatory group-practice experience called the long-block¹, I meet the residents to review their year. I usually know what to expect, but sometimes, surprises happen.

“How did it go this year? Did you learn anything?” I asked a resident.

“Well,” he said without pausing, “something happened in clinic this morning. A guy came in and started complaining about back pain and fatigue. He kept going on and on. Then a little voice inside my head said, ‘he’s going to ask for disability—he’s going to pull out the forms.’ And I was like...wait for it... wait for it... and then, after a million complaints, he pulled out the papers! I was so right.”

He smiled as if he had discovered an essential truth.

I was horrified. Of all the stories he could have related, of all the lessons he had learned, he chose this one. He seemed to have missed the point of the entire year. During the long-block we train in self-management techniques and motivational interviewing. We favor the term non-adherence over non-compliance. We imagine ourselves in another’s shoes and even go so far as to inject ourselves with saline and check our finger stick blood sugars four times a day just to see what it is like (no one can ever do it correctly). We expend a good deal of energy being patient-centered.

And yet...it doesn’t always work. At the end of the year, when I take stock of the residents, most of them have bought into our philosophy, some are indifferent, and a few are radically opposed to it. This resident was one of the few. Residents like this cause me to have the exact same emotional response I get from patients who ‘don’t get it.’ It’s a funny little echo. I want something for them more than they want it themselves.

I used to try rhetoric with patients like this. I asked them to switch roles with me and pretend they were the doctor, and I had the smoker’s cough or the high hemoglobin A_{1c}.

“Pretend I’m your patient,” I told them, “and pretend I’m deaf. You see me walking down the middle of the street with a big truck barreling down behind me unable to stop. What do you do?”

Every patient said they would figure out a way to let me know the truck was coming and get me out of the way.

“That’s exactly how I feel about you!” I would say. “The cigarettes and diabetes are about to run you over. I’m telling you to get out of the way!”

As a young physician I thought this was a brilliant way to help people gain insight. Except, it rarely worked. People have to believe that a truck is coming. Many don’t. It’s easy to be discouraged by people who appear to be making the wrong choice. If I’ve gained any wisdom over the years it’s to get past the what (the bad decision) and get to the why. No reasonable patient would choose to go blind, get a foot ulcer, and go on dialysis. And no reasonable resident would choose to let a disability claim define a person, or an entire year’s worth of education. Right?

Echoes.

I fell back on *my* training.

“Why did you choose to share that particular encounter?” I asked the resident.

“These patients can do it,” he said. “They can work. They can take their meds. They just don’t want to. I’m more optimistic for them than they are for themselves.” Then he looked at me, primary care doctor to the underserved. “I don’t know how you do it all day,” he said. “I’m an optimist. These people let you down. It makes me unhappy.”

I laughed unexpectedly. I didn’t of think of myself as a pessimist!

“Look,” I said, “a few years ago I was on the verge of burnout. I redefined my job description, and it saved me. I believe in the compliance/adherence rubric we’ve been teaching you. Compliance connotes a kind of moral failing—as if the patients could do what we ask them, they just choose not to. I believe many patients *can’t* do what we ask given the set of circumstances life has handed them. My job is to understand these circumstances and help patients overcome them so they can take better care of themselves.”

He didn’t think that was his job. After this, our discussion shifted to society as a whole, the current divide in American politics, and then to a locus of control argument.² People with an internal locus of control believe that their own behavior is guided by personal decisions and efforts. People with an external locus control believe that their behavior is guided by fate, luck, or other external circumstances. Was I hard-wired to be an *internal*, thinking that my actions could affect those of my patients, and was he hard-wired to be an *external*, thinking that his patient’s actions were essentially independent of his? Can these attributes be taught and learned?

In the end, of course, we did not agree.

Interestingly, a good majority of the residents who ‘don’t get it’ every year, go into critical care. This resident was no exception. Maybe some people are just not able to thrive in the ambulatory setting. In the ICU he will be in control. Running a ventilator requires very little shared decision making or motivational interviewing. Still, I worry about all the family meetings and end-of-life care decisions that will require a sense of the other. I wonder how many ethics consults he will call that will be less ethical dilemma and more failure to communicate.

So next year, ever the *internal*, I will try again. I will not wait until the end of long-block to find out who my non-adherent residents are. I will identify those who don't believe their actions really matter and attempt to find out why. I will try to help these *externists* look at patients like *internists*. And I will worry for them if they do not.

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