It's the Patient's Fault

Stephen Brunton, Editor-in-Chief

When faced with the clinical challenge of a patient whose diabetes is not controlled, it is obvious with whom the blame lies. After all, we have had years of education directed at mastering disease management. We have brought this training to bear for the benefit of the patient to prevent suffering and forestall death. So, of course it is the patient's fault!

Throughout my years of working with medical residents, their frustration was palpable whenever they worked with patients who, despite their best advice, seemed to return for follow-up in worse shape than during the initial encounter. "She just won't lose weight," "He doesn't exercise," and "I doubt that he takes his meds" were frequent refrains. These were obviously patient responsibilities; if we told them to do something, it was incumbent on them to follow our erudite instructions.

When I was a residency director, I wanted to give new physicians an experience in patient education and, more importantly, a lesson in humility. I asked them to choose a behavior they might be willing to change for 1 month. It could be anything from not playing video games to avoiding potato chips. They were to observe and record the particular behavior for 7 days and, at the end of that week, develop a strategy for behavior change for the following month.

We did this for 5 years. Of the 40 residents who participated, only 2 were able to comply. One year, we published a letter about the exercise in a family medicine journal (1), which included a discussion about the factors that students identified as having an effect on their behavior-change efforts. In one amusing example of the role of "enablers," one resident said a friend had convinced him to rationalize that, although he had planned to avoid cookies for the month, perhaps a Fig Newton could be considered a fruit instead of a cookie.

If these young physicians were unable to make a simple lifestyle choice for just 1 month, why should they have expected patients to successfully make a multitude of lifestyle adaptations while grappling with the realities of their disease?

We ask so much of our patients. We should check in with them regularly regarding their understanding of diabetes and their willingness to make the necessary changes to improve their health. Behavior modification is a challenge in the best of circumstances, and our patients' agendas might be quite different from our own. Add to that the numerous cultural, family, and personal considerations that come to bear on all of our daily lives, and you'll discover that patients face a complex decision tree.

I have a slide that I use at some of my lectures that features a short comic strip with a physician sitting behind his desk "counseling" a patient. In the first frame, the doctor says, "Your lifestyle is killing

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you. You need to eat better, stop smoking, and get plenty of rest." The next frame shows the patient concerned. The doctor continues, "Start an exercise program, learn how to manage stress, and take your medicines." At this point, the patient stands up and thanks the caring physician. The thought bubble over his head as he is leaving says, "Man, I have got to find another doctor!" The point is that patients don't necessarily share with us their understanding of diabetes or their thoughts about what they are willing to address.

Perhaps it is not always the patient's fault. Perhaps we can take some responsibility when our patients are not reaching their goals. Did we really assess their willingness and ability to change? Were our recommendations realistic? Would trying to modify just one risk factor with the person to achieve some success be a better strategy? Can a change in diet be accomplished on a gradient, perhaps starting with just the single step of cutting down on sodas?

Validating even the smallest positive changes can give patients a win and propel them on to greater successes. The prospect of never eating ice cream again might lead many people to abandon their diet altogether. Therefore, I give patients permission to "cheat" one day per week. That way, a more spartan lifestyle may seem more bearable on the rest of the days.

We are all human, and, as providers, we are not perfect in our lifestyle choices either. We all rationalize why we ate that large dessert or didn't go to the gym. After all, there is fruit in a Fig Newton, right?

Duality of Interest

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

Reference

1. Brunton SA, Radecki SE. Behavior modification for family practice residents [Letter]. Fam Med 1994;26:274