

The Experience of Family Medicine Interns Conducting McGill ILLNESS Narrative Interview with Non-Compliant Chronic Patients

A Experiência de Alunos do Internato em Medicina de Família e Comunidade na Condução de Entrevistas McGill MINI Narrativa de Adoecimento com Pacientes Crônicos com Dificuldades de Adesão ao Tratamento

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RESUMO

A formação médica no Brasil, apesar das várias políticas indutoras governamentais objetivando sua mudança é, ainda, predominantemente hospitalocêntrica, sendo o processo de aprendizagem centrado na doença. Em uma escola médica tradicional, realizamos uma pesquisa na qual o aluno do Internato conduziu uma entrevista voltada para experiência de adoecimento com pacientes crônicos com dificuldades de adesão ao tratamento de hipertensão e/ou diabetes na Atenção Primária. Quatorze Internos em Medicina de Família e Comunidade da Universidade Federal do Rio de Janeiro foram treinados a aplicar a Entrevista McGill MINI Narrativa de Adoecimento para identificar os modos de compreensão e atribuição de sentidos da experiência de adoecimento e tratamento. Antes e depois da realização do conjunto de 35 entrevistas McGill MINI, os alunos foram individualmente ouvidos quanto a sua compreensão do fenômeno adesão e à experiência com a entrevista McGill MINI. As 35 entrevistas realizadas pelos alunos foram analisadas quanto ao alcance dos objetivos de cada seção da entrevista McGill MINI, além do objetivo geral do entrevistador ser capaz de ofertar um lugar de expertise ao paciente no relato de sua experiência de adoecimento. Buscamos investigar a consistência da experiência do aluno com este roteiro para a obtenção da narrativa de adoecimento, utilizando para tal os temas conceituais desta entrevista – protótipos e modelos explicativos – e os temas emergentes identificados através da análise de conteúdo realizada conforme a técnica descrita por Bardin. Na análise das entrevistas realizadas pela pesquisadora com os Internos ao início e final do Internato, a análise temática foi feita a partir de dois grandes temas: compreensão e experiência clínica com o fenômeno da adesão, e apreciação da experiência de realização da entrevista McGill MINI no contexto da formação médica. Os alunos reconheceram a entrevista McGill MINI como útil para compreender e explorar a experiência de adoecimento e tratamento de um indivíduo no seu contexto socioeconômico e cultural. Ao reconhecerem esta importância da entrevista McGill MINI, os Internos frequentemente referiam as poucas oportunidades de aprendizagem na abordagem de pacientes em geral. Apesar de previamente reconhecerem a importância da escuta e do desenvolvimento do vínculo, desconheciam como isto poderia ser construído, e a experiência aumentou a autoconfiança no cuidado às pessoas no cotidiano médico. Os alunos perceberam que a não-adesão envolve múltiplos fatores, que normalmente não aparecem durante uma consulta médica habitual, e houve de fato uma ampliação na compreensão do fenômeno da adesão.

PALAVRAS-CHAVE

- Narração,
- Cooperação do Paciente,
- Internato,
- Medicina de Família e Comunidade
- Educação Médica

KEY-WORDS

- Narration,
- Patient Compliance,
- Internship,
- Family Practice,
- Medical Education

ABSTRACT

Despite several governmental policies with the purpose of changing medical training in Brazil, it is still predominantly hospital-centered, and the learning process is focused on diseases. We conducted a study in a traditional medical school, in which the students carried out an interview focused on the illness experience assessing chronic patients with compliance difficulties in the treatment of hypertension and/or diabetes in primary care. Fourteen medical students during the Family Medicine Internship at the Federal University of Rio de Janeiro were trained to carry out the McGill Illness Narrative Interview (MINI) and identify the modes of understanding and attribution of meaning to the illness and treatment experience. Before and after the completion of the set of 35 interviews, the students were listened to individually regarding their understanding of the compliance phenomenon and the experience with the MINI. The 35 interviews conducted by the students were analyzed with respect to the objectives of each section, in addition to interviewer's general objective of offering a position of expertise to the patient in their report of the case. We sought to investigate the consistency of the student's experience with this script to obtain the narrative of illness using conceptual topics – prototypes and explanatory models – and the emerging topics identified according to the technique described by Bardin for content analysis. In the analysis of the interviews conducted by the researcher with the interns at the beginning and the end of their internship, the content analysis consisted of two main themes: clinical understanding and experience with the non-compliance phenomenon, and the appreciation of performing the MINI in the context of medical training. The students considered the MINI a useful tool for understanding and exploring the individuals' illness and their treatment experiences in their socioeconomic and cultural context. By recognizing the importance of the MINI, the interns usually reported few learning opportunities while providing care for patients. Although the students had previously recognized the importance of listening and the development of bonds, they did not know how these issues could be built, and the experience increased their confidence in the healthcare provided to patients in their medical daily life. The students noticed that non-compliance involved multiple factors, which did not usually emerge during regular medical appointments. In fact, there was more understanding about the compliance phenomenon.

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INTRODUCTION

The sociocultural changes that have occurred in recent decades have acutely transformed the social roles of patients and healthcare professionals, with clear implications for their development and professional practices¹.

With the challenge of training professionals who are able to work with quality and offer resolutions in the SUS (the Brazilian Unified Health System), the Ministries of Health and Education, in a two-decade partnership, have developed several governmental policies, aiming at the realignment of professional education, towards a more holistic approach to the health-illness process^{2,3}.

The drive to achieve comprehensive care, establish bonds that enable committed alliances and the mutual responsibility between professionals and patients show new directions for healthcare⁴. In order to achieve better resolution with patient

participation in their health treatment^{5,6}, the professional must know how to explore the patient's perspective, especially their experience of illness and its meanings^{7,8}. It is necessary to listen, understand, and then answer the demands and needs of individuals, groups and communities⁹.

The experience of illness is culturally molded, determining the way in which it is perceived and the paths for its recovery. There is an abyss between what medical knowledge calls disease and what the person actually suffers when they are ill. This differentiation was classically studied by Kleinman *et al*⁷ in the following way: *disease* refers to the abnormalities in the structure and function of the organs and systems in the biomedical perspective, and *illness* is the experience of distress or discomfort suffered by the person when they face a health issue^{7,8}. The construction of the medical history, exclusively guided towards clarifying the symptoms or the disease,

usually fails to prioritise the narrative of illness experience. This may cause a distance in the physician-patient relationship generating significant implications for the therapy and the patient's participation¹⁰.

Investigation into the illness experience has afforded particular focus on chronic patients, which has contributed toward improving their healthcare¹¹⁻¹³. Some studies clearly point out the need to improve the relational competence to be built in professional education¹⁴. The illness narratives are obtained and analyzed through different theoretical-methodological references in qualitative health surveys.

Patient-oriented narratives of illnesses in medical student qualification have rarely been the object of investigation in the field of medical training. In general, such narratives are associated with medical humanities, especially in the teaching of narrative medicine¹⁵, aiming at the development of empathy, narrative competence^{15,16}, affective competence¹⁷, and communication competences¹⁸. Of the few studies in Brazil, we can highlight the innovative pedagogical experiences carried out with 1st to 3rd year students of the Medical School of Health Sciences in Brasilia^{17,19}, as well as the Medical School of Botucatu – UNESP¹⁶; and the interprofessional education program in health at the Campus Baixada Santista – UNIFESP²⁰. These studies address the possibility the student has to improve their knowledge about the patient and their illness, and also about themselves, through structured practices of narrative medicine, and especially the writing of such narratives, with or without scripts, engaging patients in different scenarios, from basic care^{16,20} to tertiary hospitals¹⁷; using the regular discussion of oral narratives of clinical cases, following the biopsychosocial model^{18,21}; and performing anamnesis with questions on the patient's perspective on their illness¹⁹. In all these studies, as well as the research for this paper, the main issue is patient-centered care, the commitment to comprehensive and humanized care, and research into the qualification of healthcare education, especially physicians.

As stated by Eliana Cyrino, "*entering this field of narratives, as researchers, students, professors and healthcare professionals, means investing in the expansion of the view on care, qualifying health care that values the relationships between human beings*"¹⁶ (p.13).

We considered the scenario of this research to be a traditional medical school without innovative pedagogical practices similar to the ones described above. The investigation focused on an experience involving the students from the mandatory internship in Family Medicine (MFC, in Portuguese), since, besides a holistic work training for 8 weeks, the MFC practices are guided, among other principles, by comprehen-

sive and longitudinal care, thus exposing the student to problems in the continuous healthcare of people, families and communities. These students were introduced to the ethnographic interview called the *McGill Illness Narrative Interview* (MINI)²², whose semi-structured script was translated and transculturally validated into Portuguese²³, a theoretically driven interview that aims at the methods of understanding and attributing meaning to the illness experience. Its semi-structured script is made up of five sections: a narrative about the initial illness experience; a prototypes narrative; the explanatory models narrative; help seeking and service utilization and impact of illness on life. This interview was used in studies focused on the narrative of people in several clinical situations²⁴⁻²⁶, but in none of them was the interviewer a medical student.

This paper has the purpose of analyzing the potential of the MINI in medical education, providing a better understanding of the illness experience of chronic patients with difficulties in complying with treatment in Primary Care. The choice of patients with compliance difficulties is justifiable because it is a prevalent and relevant problem identified by Primary Care professionals.

METHODS

This is a qualitative, exploratory study. The study was carried out in the years 2013 and 2014, in the municipality of Pirai, in Rio de Janeiro state, due to the connection with the Internship in Family Medicine (MFC, in Portuguese) with the UFRJ (Federal University of Rio de Janeiro) Medical School, and the fact that the coverage offered by the Family Health Strategy (ESF) is entirely controlled by this municipality. Besides 13 units spread across the rural and urban areas, Pirai reported good indicators: a low level of child mortality, vaccination of all children, and records of all patients with hypertension and diabetes and their access to free medication²⁷.

Participants

The subjects of this survey were 14 UFRJ Medical School students enrolled on the MFC Internship who agreed to take part in the study and conduct the MINI interviews with 35 chronic, diabetes and hypertensive patients, who found difficulties in complying with their medical prescriptions for at least 3 months. They were selected by the healthcare team. All students and patients signed the Informed Consent Form.

Procedures

At the start of each eight-week round, a new class of about 40 students entered the MFC Internship and took part in a whole day of welcoming activities, to which we were invited to talk

about the topic: "The Narrative of Illness Experience". Next, the interns from Pirai-RJ were invited to participate in a training session on the McGill Illness Narrative Interview (MINI), which was part of the presentation about its script with focus on the different and potentially complementary characteristics, in relation to clinical anamnesis, the main concepts of this interview and the goals of each of the five sections. Afterwards, we performed a simulation, where the interns play the role of the physician who conducts the MINI or the patient being interviewed. To conclude, we discuss this experience through an interview which was filmed for this purpose, with the authorization of both participants.

Four groups from the UFRJ MFC Internship in the municipality of Pirai-RJ took part in this training on the MINI, from a total of 48 students. Of those, 14 agreed to being part of this study, conducting at least two interviews, out of at least four MINI interviews in which they partook, since they always conducted the interviews in pairs. All these interviews by the students were observed by the researcher who paid weekly visits to the healthcare units where the students and patients selected by the ESF team met. Most of the MINI were carried out at the patients' homes. Upon their arrival, the health community agent (ACS, in Portuguese) would introduce the students and researcher, who would explain the purpose of the study. If the patient accepted the participation, the student would give them the consent form to sign.

Following the training, the students who chose to participate in the study were interviewed individually by the researcher about their previous experience and knowledge of the non-compliance phenomenon. The semi-structured script was aimed at investigating what the student knew about this phenomenon, the approach to patients and the resources already obtained through their medical qualification to deal with such patients. After the weekly application of the MINI with the patients, at the end of their Internship, the students were interviewed individually again by the researcher. In this final interview, besides repeating the questions from the initial interview, the semi-structured script included other questions to find out if the students appreciated the experience with the MINI. The researcher aimed at understanding whether, in the student's opinion, the MINI was useful in its approach of patients with compliance difficulties; whether the student had difficulties in conducting the interview; whether they would suggest this interview for the healthcare of other patients; and, lastly, whether the experience with the MINI had any consequences on their approach to patients in general. The responses of each student on the non-compliance phenomenon provided in the initial and final interviews were compared.

Two sets of interviews were carried out: 35 MINI interviews with patients conducted by the students, and 28 final and initial interviews with the 14 students, conducted by the researcher. All the interviews were recorded, transcribed and analyzed, according to the thematic content analysis technique²⁸. The thematic content analysis of the two sets of interviews configures the triangulation through the analysis of multiple sources of data, which increases the validity of the survey²⁹. The students (A) were identified by numbers 1 to 14 and patients (P), by numbers 1 to 35, followed by a diagnosis: diabetes (D), hypertension (H), or diabetes and hypertension (DH).

Analysis

The thematic analysis²⁸ of the interviews performed by the students with the patients was based on one major topic: knowing the narrative of illness through the MINI. We tried to investigate how consistent the student experience was with this script to obtain the illness narrative. The interviews performed by the students were analyzed regarding the goals achieved in each section of the MINI, besides the interviewer's main goal: to be able to offer expertise to the patient regarding their account about the illness experience^{22,23}.

In the interview analysis carried out by the researcher with the Interns at the beginning and end of the Internship, the thematic content analysis²⁸ was performed on two major topics: clinical understanding and experience with the non-compliance phenomenon and the appreciation of the experience with the MINI in the context of medical qualification.

The research ethics review board of the Municipal Health Department of Rio de Janeiro, RJ approved the research protocol and consent forms (CAAE. 1944.0.000.314-11).

RESULTS AND DISCUSSION

The 14 students who accepted taking part in the research interviewed 21 women and 14 men, almost none of them had finished elementary school, and their ages varied from 45 to 74 years old. Of the 35 patients interviewed, 12 of them had been diagnosed with both hypertension and diabetes, 19 of them had only hypertension, and four of them had only diabetes. Therefore, all the patients' illness experiences were related to a chronic disease.

Getting to the know the illness narrative through the McGill Illness Narrative Interview (MINI)

Learning to recognize the patient's expertise

The MINI starts with the negotiation of the term "health problem", which remains the focus throughout the entire interview,

and this was the student's first challenge with the instrument. Groleau *et al.*²² affirm that this is a key point related to the interviewer's recognition of the patient's expertise on their illness experience, and it must be negotiated with the interviewee. In this case, the students already knew about the interviewee's diagnoses, however, when they started the interview, they were supposed to ask them what their "health problem" was. Half of the patients declared they had "no health problem". Some students had difficulties and mentioned their diagnosis as their health problem to be discussed. Other students had to use certain skills to search for an answer about the health problem to be explored. We observed that, when the "health problem" chosen is negotiated and respected, communication between the interviewer and the interviewee occurred in a clearer manner.

The objective of the first section is to collect the illness narrative, allowing the interviewee to tell their story as freely as possible^{22,23}. Initially, the students demonstrated difficulties in using an instrument that does not fit the traditional model of medical appointments; the expertise traditionally comes from the physician, whereas, in the MINI interview, the expertise comes from the patient. This difficulty demonstrates a knowledge/power relationship imposed in medical practice and reproduced in medical education, where students must learn how to edit what the patient says in order to build their clinical case¹⁰. As the students performed the interviews, they were able to gain a better understanding of the instrument, and were capable of exploring the facts associated to the illness, appreciating the patient's narrative on their illness process.

From the first section, the compliance difficulties appeared to be related to the fact that the patient says they "do not feel anything", because patients who do not feel sick often avoid taking any medications, as pointed out in the literature^{6,30,31}. In her study with type 2 diabetes patients, Cyrino¹² identifies this behavior pattern, recognizing that difficulty in accepting or denying the disease is considered one of the main barriers that prevents self-care¹². Drug compliance difficulties associated with asymptomatic disease, appeared as information that was known and revealed by many students and patients.

The popular belief that "if you keep taking medicine, you'll get sicker" or "if you take too many drugs, the disease gets used to it" was mentioned a few times by patients. When Manfroi *et al.*³⁰ evaluated the factors involved in compliance difficulties reported by patients in anti-hypertension treatment, these authors also identified dissatisfaction in having to use medication, since they said they felt nothing. Patients also reported that it was the fact that they had to use medication that caused them to feel ill³⁰.

Bury's concept of rupture and biographic reconstruction³² can help us understand resistance to modifications in identity, relationships, structure of meanings and the concrete organization of life imposed by chronic disease. Several factors can hamper anyone's efforts to follow the treatment, generally changes to one's life style require dedication and persistence, and, some drugs may have adverse side effects, or impose specific schedules for daily intake, or incur high costs, etc.^{6,30,34}.

Abusive alcohol consumption was also frequently associated with difficulties in treatment compliance by hypertensive patients, because they believe that they should not take any medication when they have consumed alcohol on the same day. Excessive intake of alcoholic beverages was narrated as a habit of social life with friends. The difficulty in reducing the intake of alcoholic beverages is already recognized in literature as a harmful practice for the control of chronic diseases^{12,33,34}.

I don't take my medication on Saturdays and Sundays because I drink. (P14;H)

When asked about the events related to the beginning of their illness, the patients reported, above all, losses: like the death of a family member, retirement or a separation. When asked about how they felt in relation to their health problem, especially when they first learning of their diagnosis, practically all of them said they felt "sad" or "upset", and almost half of them said they felt "depressed". Feeling angry and depressed appear frequently in the narratives of patients with hypertension and diabetes, in relation to both the causality and the way in which they face the disease^{24,26}.

Investigating prototypes and explanatory models

The second section uses the narrative to clarify models or prototypes related to the current health problem, investigating previous experiences of the interviewee, their family members and friends, evidence in the media, and popular representations that would serve as a model for the meaning of their illness experience^{22,23}. The family prototype was the most familiar one, but the interviewees considered their experience of being ill different to that of the family member they mentioned. The social prototype was pointed out by patients who remembered acquaintances who also faced the same health problem and, once again, considered that their compliance experiences were different in most cases. The most frequently mentioned media was television, identified as an introduction to people with similar experiences to the patients'. (Table 1).

TABLE 1
Conceptual topics of the MINI: Prototypes and explanatory models

Conceptual themes	Illustrative excerpts of the narratives
Prototypes	<p><i>Oh.... My mom's blood pressure is way higher than mine. And she says she doesn't seek treatment because she doesn't feel anything. But my dad and I chose to take the medications properly, even if we don't feel a thing. (P13;H).</i></p> <p><i>It's different! My dad never took care of himself, he didn't take the medications and drank a lot. He ended up having his toe amputated. I take care of myself, but I can't change my eating habits. But I take the medication every day. I'm afraid, but he was not. (P33;D).</i></p> <p><i>I was just like my sister, I wasn't as careful as I am today. Today, I'm different. I like to take care of myself. And she continues to not take care of herself at all. (P15;H).</i></p>
Explanatory Model	<p><i>I can't think about anything that could have caused it. I guess it's normal for me to have diabetes, my whole family has it. (P8;D). I retired, I stopped being active and useful. Then, the disease came and paralyzed me even more. I just stay home every day, not doing anything.</i></p> <p><i>My blood pressure is not high, it only goes up when I'm upset. And I get nervous all the time since my son died. Lots of worries that increase stress and blood pressure. (P19;H).</i></p> <p><i>I'm highly strung. So much so that it goes to my head when my blood pressure is high. I get so tense and nervous that it makes me want to tear myself apart because I get so angry. (P1;DH).</i></p>

In the third section, the interviewer collects the patient's narrative, investigating the explanatory model to their health problem, clarifying the causes, popular names related to the problem, if necessary, and expectations related to the treatment's evolution and results^{22,23}. Almost all of the interviewees diagnosed with only hypertension pointed out nervousness, annoyance or stress as the primary responsible factors for the appearance of their illness. O nervosismo foi narrado como um dos responsáveis pela pressão alta por vários autores^{11,33,34}. Canesqui¹¹ carried out a qualitative study on narratives and meanings for "high blood pressure", having also discovered disbelief in the medical diagnosis and refusal to take medications as prescribed, associated to the personal and unique experience of the illness inserted in a wider sociocultural context. The author shows how the communication of the medical diagnosis is insufficient for the patient to recognize and accept their illness, since their life circumstances influence their representations of health and illness.

Most patients who reported their health problem as diabetes, responded that sadness and discouragement associated to feelings of loss, like the death of a family member, their retirement or the end of their marriage, were the causes of their illness. Several studies found in the literature associate diabetes to depression. Cyrino¹² also found narratives where the term "depression" expressed symptoms of sadness in situations like loss or adversity and was considered the cause of the emergence of the disease. The rest of the interviewees considered other factors for the cause of their illnesses, such as: difficulties in maintaining healthy eating habits, regular physical exercises or genetic predisposition. (Table 1).

Experience with treatment

The fourth section addresses the experience of the healthcare service user and the response to treatments, including difficulty or lack of difficulty in following recommendations, and the paths taken to attain the current care^{22,23}. The interviewees only sought medical treatment, and stated that physicians had provided them with information, explaining their health problem "properly". Only three of the interviewees said they followed the treatment, and those same three patients failed to take their medications from Thursday through Sunday, so that they could consume alcoholic beverages. They described the way the physicians had assisted them: most of them narrated good experiences, but there were also some conflicts in clinical assistance. When they talked about the negative experiences, some patients pointed out how the physicians had contributed to their non-compliance with the current treatment.

These doctors are all like that, they usually don't even look at you and want you to do everything they say. You study all this medical stuff, but let me tell you something, there are lots of ignorant and rude doctors out there. (P11;DH)

Impact on life

In the fifth and last section of the interview, the interviewer collects reports on the impact that the health problem had on the life of the individual, including how they believe this condition affected or not their identity, their life style, their relationship with themselves and with others^{22,23}. Most of the interviewees recognized changes in their lives caused by their illness process, feeling their identity affected, as pointed out by Bury³², especially in chronic illnesses. However, some be-

lieve that very little or nothing had changed, and that their relationships with themselves and with others were not affected by their health problem.

The only thing that has changed is that now the doctor says I have this disease. Apart from that, everything is still the same. (P30;H)

Some of the patients pointed out the way they themselves and their family members perceived the growing limitations on their independence, identified as the main consequence imposed by the health problem. When they narrated what had changed as regards their independence and productivity, some even said they were “reduced to almost nothing”.

It changes everything! Today I feel more stupid, I can't do anything alone. (P5;D)

I have to make the most of my family's care and take better care of myself. My children are all worried about me. They keep on bugging me about it! (P35;D)

The literature points out the need to develop strategies that favor the development of bonds, enabling patients to analyze their health status and generating more autonomy while they care for their own health³⁵.

Narratives of the Interns before and after the experience with the MINI on the non-compliance phenomenon

The students noticed that non-compliance involves multiple factors, which do not appear during a usual medical appointment, and there was, in fact, a better understanding of this non-compliance phenomenon. However, some ideas remained the same after the experience conducting the MINI, especially the association between non-compliance and lack of appropriate information, even after seeing that their patients are aware the consequences yet decide not to follow the treatment.

Table 2 shows the categories that appeared in the initial and final interviews carried out with the students, related to understanding the non-compliance phenomenon, besides the context units represented in their speech. Before the experience, the students would relate compliance to the transmission of information, obedience, acceptance of the illness and the physician-patient bonds. At the end of the experience, the following topics appeared: self-care, contextual understanding, listening to the patients, and student and patient empowerment, showing a significant change to the understanding of the non-compliance phenomenon, because they reported that, besides informing, physicians should try to “explore why non-compliance occurs” (A9).

Now, with the application of the questionnaire, we have more skills to try to intervene (A4).

TABLE 2
Understanding of the non-compliance phenomenon before and after the experience with the MINI

Emergent themes		Student	Illustrative excerpts of the narratives	
Before the experience	After the experience		Before the experience	After the experience
Transmission of information	Self-care	A1	<i>Compliance happens when the physician gives the information and the patient is able to understand it.</i>	<i>In order to maintain compliance, the patient has to want to take care of him or herself in the first place.</i>
	Contextual understanding	A4	<i>We need to explain in a better way, so the patient can comply with the treatment.</i>	<i>We have to ask the patient why they don't follow the treatment.</i>
Obedience	Self-care	A8	<i>Compliance is about the patient being able to follow the treatment that the physician prescribed.</i>	<i>It starts with their [the patient's] responsibility for their own health.</i>
Acceptance of the illness	Patient empowerment	A9	<i>For the patient to comply, they have to believe they are sick and take care of themselves.</i>	<i>We have to try to understand why the patient does not comply. Talking about their participation in this treatment.</i>
Physician-patient “bond”	“Listening” to the patient in a better way	A13	<i>Compliance depends on the physician-patient bond.</i>	<i>For the patient to comply with what I'm saying, I need to listen to what he says in a better way.</i>
	Student empowerment	A14	<i>Patient's trust in the physician.</i>	<i>I feel a lot more skilled to explore the patient's compliance difficulties. Before, I felt angry, but now I talk to them.</i>

The students were able to discover multiple reasons implied in the non-compliance phenomenon to the extent that they were capable of conducting the interview and listening to the patients. The execution of the MINI allowed the student to get to know the patient in their own setting, discovering the reasons for the non-compliance and engaging with relevant aspects in the world of the chronic patient, as described in the literature.

During the initial interview, the students considered the users who were not complying with their treatment plans due to lack of information about their own health, emphasizing that the need for the transmission of information. Strategies such as “scaring the patients to see if they understand”, “explaining in the most accessible way possible for them to understand” or “having to be bossy with them [the patient] so they obey”, are related to the emerging topics of transmission of information and obedience. Thus, the care would be related to a work process focused on the prescriptive act, with the students understanding the users as consumers of guidance, which takes us back to what Merhy³⁶ called “dead work”.

In the final interview, what the students said indicated a significant change, because only one of them mentioned that the best course of conduct would be only to provide information to the patient. Thirteen students reported that, besides providing information, they would try to “explore the reasons for non-compliance” (A7). They said they felt more confidence to investigate the patient’s difficulty in compliance: “Now, with the application of the questionnaire, we already have better skills to try to intervene” (A4). Most of the students showed another way to provide health services, valuing the establishment of a bond, in a more solidary relationship towards the creation of a commitment to care, as pointed out by Merhy³⁶.

After the experience, the students began to emphasize understanding together with the patient the reason for non-compliance, that is, the difficulties they experience. They considered that, when they investigate the reasons for non-compliance, it is necessary to recognize when a patient is lying or omitting aspects of their treatment, and also how they need to deal with their own limitations when the patient does not want to take care of themselves: “Their blood pressure will always remain high and you will not understand the reason, since they say they are actively exercising, following a diet and taking the medications” (A7).

Two students confessed they felt angry with their patients with compliance difficulties:

Before the interview, I struggled and felt upset with the patient because it seemed like my work was futile. Today, after this experience, I was able to understand that they were not refusing to comply just for the sake of it, they have a problem and a reason for not complying. (A7)

The students added that they had not received, as part of their academic education to date, the resources to transmit information or communicate with patients who display compliance difficulties. They also underlined the lack of examples of professionals who deal with such patients.

We don't usually have much to work with when dealing with patients with compliance difficulties, it is more about intuition (A9).

Appreciating the experience with the MINI

The students considered that the MINI would be very useful for their education, allowing their performance to be observed and assessed regarding their approach to patients with any disease, not only with difficulties related to treatment compliance. All 14 students recognized the usefulness of the interview in their medical training and pointed out some difficulties found when they conducted it. (Table 3).

The students showed understanding and appreciation of the clinical narrative, this was also identified by Greenhalgh *et al.*³⁷ when they considered the subject building their stories of the illness process, their demands, their forms of understanding and their responses. The student had the chance to incorporate the role of listener who wishes to capture and perceive the elements that emerge from the illness experience.

The students admitted that they encountered difficulties in applying the interview, but they reported that such difficulties diminished as they continued to conduct the interviews, since they understood that the semi-structured script can be used as a guide, allowing for adaptations to be made for each individual interviewee as required.

When they recognized the importance of the MINI as a resource to better understand and explore the patient’s experience of illness and treatment, the interns talked about the limited learning opportunities related to how patients should be approached in general.

Throughout our medical training we learn through a teaching style that identifies a problem, states the solution: I give you the solution and you are treated, and that's it. It does not focus on trying to see the whole picture and trying to adapt the best conduct for the individual. Usually, there is a flowchart that shows that this disease is treated with this medication, so prescribe and the disease will show improvement. We don't think a lot about costs, or if it's easy for the person to have access to that medication, we just think about flowcharts. (A7)

TABLE 3
Appreciation of the experience with the MINI in the context of medical training

Emergent themes	Illustrative excerpts from the narratives
The interview as a learning tool for clinical practice	<p><i>It would be great to have this experience throughout college. There could be a practice for students, who are starting with a patient, with a professor observing. So they could leave with the experience of learning to listen, asking deeper questions, searching for causes in the family or personal problems. This search is what I find important and what I learned to do with this experience (A2).</i></p> <p><i>In the fourth term, we get used to asking questions, such as: when the symptom started, how long it lasted, and, at the end of the whole list, we say we are approaching the patient in a holistic way. When I saw this interview carried out in such a different way, I think there are lots of things missing to assist the patient in a comprehensive manner (A6).</i></p> <p><i>We end up including a few questions we learned in the interview for our own appointments. I noticed that, in fact, I did not ask that before and now I'm asking it, without even having to think about it.</i></p> <p><i>The experience with the interview eliminated the prejudice that I had about non-compliance. Without even noticing it, I incorporated a few questions into my anamnesis. The interview helped prepare us better to do that (A13).</i></p>
The interview contributing to the approach of patients with difficulties in compliance	<p><i>The interview was worth it. It showed me how important it is to have this conversation and let the patient talk, starting with the question: "So, how did this happen?" Let the patient tell it in their own way, because even in their own way, they will describe their experiences, and explain why they are following the treatment or not (A3).</i></p> <p><i>Before, when the patient said they did not take the medicine during the week, I would skip the question and move on to the next one, now I ask if something happened that week, how their family and their lives are doing. This experience changed me. It was very good, because it showed me I must listen (A12).</i></p> <p><i>It was very good, because it showed me I should listen more and keep a better relationship with the patient. I must keep a good relationship because not maintaining a good physician-patient relationship is what causes non-compliance (A6).</i></p>
Difficulties in accomplishing the interview	<p><i>In the first two interviews, I felt blocked. I did not understand when to interrupt the person and ask another question, but then it became easier and I began to understand when I should let the patient speak and when I could speak without cutting off their answer (A5).</i></p> <p><i>The interview has many questions, I found it repetitive. But after applying it a few times and talking to you [the researcher] after the interviews, I understood it. The questions are repeated to try and extract new information that hasn't been previously mentioned (A7).</i></p> <p><i>I found the interview very long, and it was difficult to ask everything. But I was able to talk to the patients about topics that I wouldn't usually investigate (A10).</i></p> <p><i>Yes, it was very hard for me. It was a very different kind of approach. The interview makes you ask more from the patient, which wasn't something I was used to doing (A11).</i></p>

Many aspects described by the students in relation to skills that were lacking in their medical training to deal with the patient's compliance difficulties have already been recognized, including by Janaudis *et al.*³⁸ who relate these problems to a fragmented learning process, that hampers the development of a comprehensive view of the patients and better knowledge of how the healthcare system functions.

I think this capacity to engage the patient in their treatment makes them understand that treatment is not only a passive issue, it is an active issue that they have to be involved in. There was a lack of this in my academic education. (A3)

The way students responded to how the interview changed their approach to patients suggested that the experience made them feel more secure in dealing with, not only the patient's compliance difficulties, but also other difficulties that they might encounter in their future clinical practice. The students emphasized that they have lost their fear of investigating potential problems and they have learned how they

can start a conversation and approach the necessary treatment issues (Table 3).

The critical reflection expressed by the students regarding the reach of their therapeutic actions is a competence highlighted by Leite *et al.*³⁹, who point out how important it is that healthcare professionals are able to stimulate the users to become social subjects, able to stand up for their own interests.

The interview facilitated a new learning process for the student, providing the perception of different ways to establish bonds with the patient. The Ministry of Health, through its policies aimed at qualifying professionals to work in the SUS, emphasizes the creation of these bonds, since they interfere in the subject's commitment to their own health, the perception of how much that person affects them and the fact that recognizing the bond is therapeutic and may contribute to accomplishing growing levels of autonomy. Balduino *et al.*¹⁹ corroborate this aspect, indicating the student's lack of preparation to effectively form empathic bonds with patients.

CONCLUSIONS

The importance of listening to the experience of illness and treatment as a necessary aspect of the care, taken hand-in-hand with biomedical knowledge, proved to be both useful and desired by the students. Although it may not have transformed conceptions acquired in their learning process over the course of several years in the hegemonic model of education, it allowed them to recognize the need to better understand and get to know the patient, learning not to focus almost exclusively on the technical aspects of disease characterization and treatment.

The development of a critical capacity in relation to the achievement of therapeutic actions is imperative, especially in Primary Care, which must, therefore, value the use of an instrument such as the MINI, allowing us to get to know the subject beyond their body.

The experience with the McGill Illness Narrative Interview (MINI) triggered in the students a feeling of greater skills to approach patients with compliance problems. Our results suggest that the MINI can contribute to a dialogic relationship, that integrates attitudes of innovation and renovation in the relationship between the physician and the patient. The students recognized the MINI as a useful tool to understand an individual's experience of illness and treatment in their socioeconomic and cultural context, in line with the objectives described for this interview in the literature.

The increased number of studies about patient experiences, distress, the way they understand and face their illness – including the stigmas derived from it – have contributed to the management of compliance difficulties and other clinical problems. This is already part of the research field in medical practice and must be included in the field of medical training as well.

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CONFLITO DE INTERESSES

Os autores declaram ausência de conflito de interesse.

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