programs. Combining these insights can help explain key findings, illuminate unanticipated effects, and clarify self-reported outcomes such as quality of life.

Many new Section 1115 waiver policies are controversial, which raises the stakes for postapproval evaluations. Waiver policies are also diffusing rapidly; as states exchange ideas, their evaluations should establish a knowledge base for Medicaid policy choices. Section 1115 waivers rely on experimentalism, and the model of states as laboratories can best fulfill this commitment by producing meaningful evidence of the effects of experimental programs. For untested waiver policies, we believe that CMS and states should take "experimentalism" literally and harness the rigor of randomized, controlled trials.

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Doctor Sahib

Saurabh Jha, M.B., B.S.

Many of my father's patients, Pakistanis who migrated to Britain to save dying manufacturing industries (which were starved for laborers), did not take their medications. His most memorable patient was Mr. Khan, a good-natured Pathan (Pashtun) who hailed from the border zone between Pakistan and Afghanistan. Mr. Khan feared no one except Allah, doctors, and his wife. That he feared my father struck me as endearingly comical, since he towered nearly a foot above him.

Mr. Khan, with hypertension, diabetes, and a lipid profile suggestive of a silent uprising — a sort of Metabolic Spring against a tyranny of red meat — would play hooky from his medications. On one occasion, my father recalls, Mr. Khan's wife accompanied him to a consultation. She begged my father to reproach her husband for failing to bring his medications on a recent visit to Pakistan. Mr. Khan said, cheekily, that the weight limit for checked baggage had been exceeded, so he'd had to leave the medications behind.

Neither Mr. Khan nor his wife spoke a word of English, but my father understood them not just because he was fluent in Urdu: as a migrant himself, he understood that most people from the Indian subcontinent — Muslims, Hindus, and Sikhs alike — don't see doctors unless they're ill and don't take their medications unless they have symptoms. Mr. Khan's blood pressure was climbing perilously high, and my father's challenge was getting him to take his medication. So my father indulged in a subcontinent variant of shared decision making, a variant not taught in medical school.

My father: "*Khan Sahib, aapko dawaii lai nee paregi*." (You must take your medication.)

Mr. Khan: "*Doctor Sahib, agar nahi, to kya hoga*?" (What will happen if I don't?)

My father: "*Tab aapka haath or pare nahi chalega*." (You will become paralyzed.)

Mr. Khan: "*Tab kya hoga, doctor sahib*?" (What will happen next?)

My father: "*Tab aapka beta aapka zyadaad lega aura aapko ghar se nikaal dega*." (Then your son will take your property and throw you out of the house.)

Mr. Khan (laughing): "*Tab to mujhe dawaii lainee paregi*." (Then I must take my medication.)

My father never asked Mr. Khan what his values and preferences were — he knew such an approach would be pointless, because Mr. Khan saw the job of the doctor as telling him what to do, not asking what outcomes he wanted. If my father used decision aids to explain the trade-offs between various anticoagulants in order to arrive at a shared decision, Mr. Khan would probably have been befuddled.

Mr. Khan wasn't illiterate — he was a connoisseur of Urdu poetry. He had just never bothered learning English. He never questioned my father, second-guessed his quality, or checked that he was following evidence-based medicine. He trusted my father, not just because of their common language and heritage — both hailed from a region that had once been united. He trusted him because he believed my father genuinely cared about him.

My father was seldom nonjudgmental with Mr. Khan. His tone was mildly authoritarian and to someone like me, raised with the Western concept of the physician–patient relationship in which the patient makes the decision and the physician merely inveigles, my father's tone sometimes seemed patronizing. But not to Mr. Khan or his wife, who sensed in my father's occasional irritation with Mr. Khan's lackadaisical attitude toward medication a deep affection, which they reciprocated with their own affection toward not just my father but our whole family.

Slowly, Mr. Khan became a friend of the family. His wife would make us tasty kebabs during Eid. Every time Mr. and Mrs. Khan would visit, the conversation would start and end with his famed noncompliance with medication. Mrs. Khan promised to be my father's spy, to keep a check on Mr. Khan's recidivism.

The angiotensin-converting–enzyme inhibitor would have been useless without Mrs. Khan. Pharmacology submits to culture, and in Mr. Khan's culture, his wife was the cox of his health care. Mrs. Khan needed my father for credibility, and my father needed Mrs. Khan for coordination. It doesn't take a village to treat hypertension, but you do need more than just a scribble on a doctor's prescription pad.

Mr. Khan would openly discuss his medical issues with my father in front of me and my mother. At times I would offer to leave to give him privacy, but privacy was the least of Mr. Khan's concerns — he would have gladly discussed his health with anyone who feigned interest. Once I became a physician, Mr. Khan often asked my father to run his care by me, to see what I, the *Chhota* doctor sahib (junior doctor), the British-trained medic, thought. He wasn't seeking a second opinion; he was merely indulging me.

I didn't always agree with my father. Once, my father told me in front of Mr. Khan that he wasn't going to check his prostate-specific antigen level, because a positive result could set a freight train in motion and complicate things for Mr. Khan, who was already in the throes of polypharmacy. This decision was too much for my Western sensibilities. I realized that screening for prostate cancer wasn't an unalloyed good, but I believed that the decision should be Mr. Khan's, not my father's. We argued first in English, then in Urdu. Mr. Khan seemed bemused and a tad flattered at father and son arguing about his medical care. Agreeing with my father, he said "*Inshallah. Jo Allah ki marzi*" (God willing — it's all in Allah's hands), bringing our argument to a diplomatic end.

My father practiced medicine beyond duty hours. He became a physician, at least in an advisory capacity, to Mr. Khan's relatives visiting from Pakistan. Once, he received a call at 3 in the morning from Mr. Khan, who was in Pakistan and had forgotten to take his malaria prophylaxis and now had a fever and rigors. He did not trust the doctors in Pakistan. Indeed, he didn't trust any doctor but my father because he knew my father so well.

Though Mr. Khan had a right to health care, he felt he never thanked my father enough. He never said "Thank you." Gratitude in Mr. Khan's culture is expressed in deeds, not words. As an all-purpose handyman, he realized that my father wasn't terribly useful around the house. He offered to revamp our double glazing, which looked like a shoddy, amateurish job, fix our pipes when they burst, and landscape our garden. The more my father declined his kind offers to work for free, the more Mr. Khan felt compelled to do something, anything, for our family.

In the end, he did not live long enough to have a stroke. He died from colorectal cancer 6 months after his wife died of a heart attack. Compliance remained Mr. Khan's Achilles' heel. Without his wife, his sentinel, he was overwhelmed by his daunting chemotherapeutic regimen. The sheer number of required pills broke his resistance. He died from cancer after falling victim to polypharmacy.

At his death, my father wept once for his patient and twice for his friend. If my father was the ideal doctor for Mr. Khan, Mr. Khan was his ideal patient; it was a match made in heaven. My father loved Mr. Khan not despite his noncompliance but because of it. It was by caring for Mr. Khan that my father had become the physician he'd always wanted to be: a doctor sahib.

The patient's name has been changed to protect his privacy.

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