Health Understanding and its Effect on Health Outcome

Anthony F. Cole, MRCGP, Thord Theodorsson, MCIF(Swe),
Department of Family & Community Health, College of Medicine, Sultan Qaboos University, Oman.

INTRODUCTION

In their seminal book "The Task of Medicine, Dialogue at Wickenburg", Kerr White and colleagues discussed the importance of broadening both the information base for understanding our patients' problems and the framework for interpreting what we learn. The forum for that exchange is the doctor-patient encounter, the consultation.

All consultations have effects or 'outcomes': Pendleton states that they may be immediate, such as patient satisfaction; intermediate, for instance patient compliance; or long-term, such as any change in the patient's health - the health outcome.

Pendleton has also stated that patients come to a doctor with an understanding of their problems which may be incomplete, rudimentary, and inaccurate, or it may be elaborate and entirely in agreement with current medical opinion. However, the patient has a theory and it is influencing his behavior. This last sentence forms a theory which embodies the patient's health understanding.

Correspondence to:
Dr. Anthony F. Cole, College of Medicine, Sultan Qaboos University P.O. Box 35, At Khod 123, Sultanate of Oman
In their article on the consultation and health outcome, Horder and Moore\(^3\) have stated that there is a growing body of investigations into the effectiveness of doctor-patient communication. These studies relate specific aspects of communication between doctor and patient to evidence about their effectiveness in improving outcomes.

In this article, our discussion focuses on the importance of addressing and developing the patient's health understanding in order to enhance the effectiveness of the medical intervention and improve the long-term health outcome.

**HEALTH OUTCOME**

What are the indicators of effective doctor-patient Communication? In their studies, Sherrie H. Kaplan and colleagues\(^4\) have shown that patient satisfaction and compliance are necessary but limited as indicators. They have shown that optimal health outcomes depend not only on patient compliance (participation) but upon the extent of behavioral change. By making patients more active in the consultation they succeeded in changing the behaviour of the doctor as well as that of the patient. Furthermore, they assert that 'generic measures' of patients' health (subjective health status), in addition to available physiological measurements (objective health status) are the logical outcomes against which to assess effective doctor-patient communication.

**HEALTH UNDERSTANDING**

The consultation's processes are dependent upon the entire context of the doctor-patient relationship, including the cultural belief systems within which that encounter occurs, as well as the personal belief systems of the two individuals concerned.

In their book on the experience of illness, Fitzpatrick and his co-authors\(^5\) state that there is much evidence suggesting that patients' interpretations of their symptoms are governed by "concepts and ideas of considerable complexity and variety".

In developed countries the contemporary "high-tech" medical practice has in recent years failed to meet lay expectations. Modern doctors diagnose and treat diseases, whereas patients suffer illnesses. Illness is culturally shaped in the sense that how we perceive, experience and cope with it is based on our cultural belief system. Kleinman et al\(^6\) have proposed the term: patient's explanatory model, which entails beliefs not only in terms of the cause of the illness, but also regarding the social and personal meaning of it.

The meaning of illness conceptualises the concerns which the patient has about the problem. Lay concepts of illness may have powerful symbolic significance, which cannot be conveniently expressed in so many words by the patient, but which form an essential element of the meaning of the illness experience. Doctors and other health workers may too narrowly limit the search for meaning if they only look for references to bodily symptoms or causes in the lay ideas of illness.

As to Pendleton's concept of Health Understanding, it can be viewed as not only encompassing Kleinman's patient model (causal explanations and meaning of illness) but also the patient's factual knowledge of the disease and its course.

Still another element to be considered is the concept of locus of control. Lefcourt (1976) quoted by Lau (1988)\(^7\) – has written that it is determined by the degree to which individuals perceive events in their lives as being a consequence of their own actions and thereby controllable (internal control) or as being unrelated to their own behaviour, and therefore beyond personal control (external control).

Several major reviews of the literature linking locus of control beliefs to health behaviours exist.\(^8\) Richard R. Lau\(^7\) has stated that this concept has been applied to the area of health for at least 25 years, and is regarded as a generalised, relatively stable aspect of personality. "Internal beliefs" have been linked to health protective behaviour and to the desire for more information about a disease one is susceptible to or has already contracted.
Though its predictive value must be interpreted in combination with a high value placed on health, the concept of locus of control has implications as to the design of treatment regimens to optimise patient participation.

Jaspars et al (1983) point out that individuals are motivated by far more complex processes than simply their level of control over events. They state that one of the most fundamental drives in human behaviour is the need to make sense of the environment. This means finding some ways to explain events, and this is often achieved by searching for their causes. This leads us to the concept of causal explanations of illness — see Kleinman et al above.

Jaspars et al (1983) also emphasise that one must distinguish between control and causality. An individual may believe that an illness is caused by something external such as a virus, but at the same time that the illness can be controlled by personal behaviour (internal control).

These lay beliefs and theories about illness can be made more explicit by considering the site of illness aetiology as Helman (1984) does in his book. He postulates that lay theories of illness place the aetiology of ill-health in one of the following sites:

1. Within the individual patient
2. In the natural world
3. In the social world
4. In the supernatural world

Social and supernatural aetiologies tend to be a feature of some communities in the developing world, while natural or patient-centred explanations of illness are more common in the Western developed world. Fitzpatrick et al (1984) claim that one of the most striking qualities of lay concepts of illness is their very complexity, and that the structure of lay beliefs is also more flexible than one might think.

In the light of the foregoing, the major elements of Health Understanding are:

1. The meaning of illness
2. The patient's explanations of the cause of illness
3. Factual knowledge of the disease and its course
4. The concept of locus of control

As the patient's health understanding can be seen to consist of these major elements, doctors clearly need some form of clinical strategy enabling them to quickly and effectively elicit these health beliefs.

THE PRACTICAL RELEVANCE OF HEALTH BEHAVIOUR

How do these aforementioned theoretical considerations of lay concepts actually relate to countries outside the developed Western world, such as those of the Middle East, where transcultural differences are greater?

Anthropological and social studies justify the conceptual distance we make between disease and illness. Where only disease is treated, care will be less satisfactory to the patient and less clinically effective than where both disease and illness are treated together. Of paramount importance is the negotiation between the patient's explanatory model and that of the doctor, leading to an agreement, especially as related to expectations and therapeutic goals. This becomes pertinent in the management of chronic illness, in particular. Unfortunately, the traditional biomedical viewpoint of medicine has disregarded these lay concepts of illness.

As mentioned above, optimal health outcomes depend on the extent of behavioural change achieved by the patient. Therefore, eliciting the patient's model becomes a major challenge. Kleinman et al outline a clinical strategy by putting forward a set of specific questions to that end.

With regard to the applicability of such instruments of enquiry into these lay theories, the transcultural differences pose a particular problem concerning their reliability and validity. However, despite these difficulties and the fact that the instruments are mostly adapted from the West,
these instruments have to be re-evaluated in each cultural setting, as do other tools of measurement for the assessment of subjective health status.

RELEVANCE TO THE SULTANATE OF OMAN

In Oman, with its traditional Arabic culture now being offered 'alien', 20th century health care, the dichotomy between the patients' understanding and expectations and those of the physicians is broad indeed. Given the continued prevalence of traditional medicine - wasm (branding), shamanistic practices, and Ayurvedic-like herbal and 'hot-vs-cold' treatments - which are all much more readily acceptable, even to many urbanised Omanis, there is obviously a great need for appropriately designed health education in its widest sense. That this situation applies similarly in other Arab countries is evident from a study reporting the health-beliefs and behaviours of Saudi women, where it was shown that there was a lack of understanding of specific causes of various illnesses.12

To answer some of the questions posed in this article, the authors suggest appropriately designed research into these aspects of health beliefs and understanding, including and audit of the research's effects regarding improved health outcomes.

CONCLUSION

The open discussion of patient's concerns and ideas is an essential first step to offering personally appropriate health information.2 However, the prerequisite for the patient's health understanding is appropriate information, and if patients do not understand even the basic premises, they don't ask questions.13 Therefore, it is essential to offer an explanation of the diagnostic label as well as of any advice offered, and, furthermore, an explanation that makes sense in terms of the patient's own world view. Secondly, it is important to offer a treatment plan that matches the patient's own concepts as well as the prevailing cultural belief system. Studies have shown the difficulties attendant upon the utilisation of Western models of health behaviour and beliefs in Middle Eastern countries14, and it is to be expected that such cross-cultural diversities between medicine and society as exist elsewhere in the world would pose similar problems. In line with this, Pendleton et al. (1984)2 write of patients' beliefs, concerns and expectations as being major elements of health understanding and of the importance of achieving a shared understanding of the problem between the doctor and the patient.

The challenge faced by health care providers is to properly identify the health beliefs and understanding of their patients, and then to offer an appropriately matched patient education and treatment regimen. On the basis of this, doctors and patients should be able to plan together the optimal management of health problems, more confident that patient acceptability will be achieved and that improved compliance, through greater understanding, will follow.

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