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Positive self-assessed general health in patients with medical problems

A qualitative study from general practice

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Background **– Patient and doctor do not always agree on the status of the patient's health. By underestimating the patient's strong sides, the doctor may be contributing to disempowerment and bypassing knowledge needed for adequate medical diagnosis and management.**
Objective **– To understand how our patients with medical problems assess their general health as good.**
Design and setting **– Qualitative observational study based on audiotaped material from general practice consultations in authors' practices (Norway and Denmark). The patients were asked to rate their current state of health on a scale ranging from zero to 100, and then to explain their score.**
Subjects **– From 41 consecutive consultations we compiled a purposeful sample of 12 patients who reported positive self-assessed general health although medical problems were present. The 7 women and 5 men were aged between 43 and 96 years, and had been diagnosed with musculoskeletal disorders, heart disease, cancer, depression, headache or severe menopausal symptoms.**
Main outcome measures **– Salutogenesis, represented by the authors' Health Resource/Risk Balance Model, and Antonovsky's Sense of Coherence (SOC) concept comprised the theoretical framework. Transcripts from audiotaped consultations were used for qualitative text condensation analysis, inspired by Giorgi's phenomenological method. Analysis was theory-driven, applying comprehensibility, manageability and meaningfulness as entries to elaborate patients' accounts of positive health.**
Results **– Patients' answers demonstrated how a feeling of logical reasoning related to symptom perception could provide comfort and sometimes lead to advantageous coping strategies. Personal and social resources were mentioned as essential means for tolerating and managing the burden of disease. Even fairly extensive endeavours could be experienced as worthwhile when sometimes providing relief, even only temporarily.**
Conclusions **– Patients' accounts of general health can challenge the traditional medical views on assessment of health and disease.**

Key words: **general practice, patient perspectives, qualitative study, salutogenesis, self-assessed general health, sense of coherence.**

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During years as general practitioners, our attention has been drawn to situations where patients and doctors arrive at discordant conclusions about the patient's health (Fig. 1) (1). Discordance occurs when the doctor finds no sign of disease, although the patient complains of illness (2), or when patients with medical problems regard their health as good. *Self-assessed general health* is an independent, strong predictor of coronary heart disease, mortality and functional disability (3–6). Yet, patient and doctor do not always agree on the status of the patient's health. We explore the discordance represented by positive self-assessed general health in patients with medical problems in the context of clinical practice.

According to the *Health Resource/Risk Balance Model*, health is the outcome of the balance between symptoms and strains on the one side, and the patient's strong points on the other (7). Antonovsky replaced questions of *pathogenesis* by asking for the origins of health (*salutogenesis*) (8). He presented the concept *Sense of Coherence* (SOC) to incorporate foundations for successful coping with stressors, consisting of comprehensibility, manageability and meaningfulness (9) (Fig. 2).

Our preconception was that patient perspectives can be enhanced when discordance between doctor and

Self-assessed general health is an independent, strong predictor of coronary heart disease, mortality and functional disability.

- Patient and doctor do not always agree on the status of the patient's health.
- The doctor can contribute to patient empowerment by exploring and recognising the patient's self-assessed view of his/her general health.
- Knowledge about the patient's self-assessed general health belongs to the core content of clinical practice.

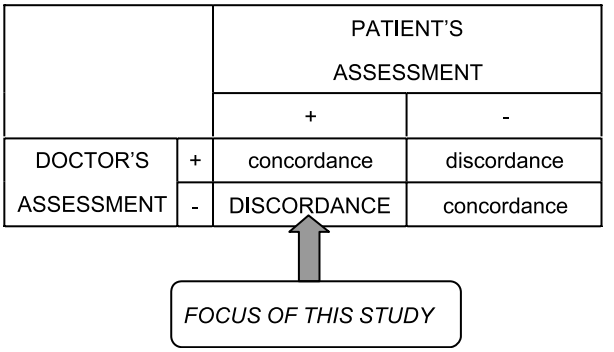

Fig. 1. Assessment of patient's health.

patient about the patient's health status is challenged. In this study, we aimed to understand how our patients with medical problems assess their health as good by exploring the balance between patients' symptoms and strong points with Sense of Coherence as a lens.

MATERIAL AND METHODS

The material was drawn from audiotaped consultations from our own general practices. We aimed for patients who assessed their general health as positive although medical problems were present. An initial sample was drawn from 41 consecutive audiotaped consultations (21 women and 20 men, aged between 15 and 96 years). Three additional patients did not give their consent. Patients were asked to indicate their current self-assessed health status (Fig. 3). Our question was adapted from the EuroQuol instrument for health-related quality of life (10). After providing a score, patients were asked to explain their choice. The conversation following the question was transcribed. The EuroQual score in this study was used only to identify the subsample of patients with positive *self-assessed* health, interpreted as EuroQual scores above 50.

The transcripts were used to identify a subsample of discordance, represented by negative doctor-assessed health and positive patient-assessed health. The first issue was operationalised as the presence of symptomatic medical problems. The two doctor-researcher-authors negotiated and consented upon the situation for each patient. We attempted to maintain a view mainly informed by the medical facts. While keeping the patients' scores hidden, we concluded dichotomously on whether or not medical problems were present. Twenty-three of the 41 patients were classified as having medical problems. Only 5 of the 23 had given themselves a negative health assessment.

We drew our final study sample from the remaining 18 patients with medical problems and positive self-assessed health state, including transcripts from consultations that comprised information about patients' strong sides as well as their symptoms. Such information, found in 12 of the 18 transcripts, was required in order to consider the balance between strong points and symptoms. The core *discordance* group included 7 women and 5 men aged between 43 and 96, diagnosed with musculoskeletal disorders, heart diseases, cancer, depression, headache or severe menopausal symptoms.

A global orientation that expresses the extent to which one has a pervasive, enduring, through dynamic feeling of confidence that

(1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable
(2) the resources are available to one to meet the demands posed by these stimuli; and
(3) these demands are challenges worthy of investment and engagement.

These three components are called comprehensibility, manageability and meaningfulness

(from Antonovsky 1987 (8))

Fig. 2. Definition of Sense of Coherence (SOC).

"If I ask you to rate your health on a scale ranging from zero, as the worst imaginable current health state, to hundred, as the best imaginable current health state, which score would you choose then?"

(adapted from Brooks et al. 1996 (10))

Fig. 3. Question put to patients about their current self-assessed health.

A qualitative theory-driven template style analysis was conducted (11) using comprehensibility, manageability and meaningfulness as predefined categories for interpretation of accounts from patients with medical problems who assess their general health as good. Systematic text condensation analysis (12) was inspired by Giorgi's phenomenological analysis (13): 1) reading all the material to get an overall impression, bracketing items that conformed with our preconceptions, 2) identifying units of meaning, representing the different components of sense of coherence and coding these, 3) condensing and abstracting the meaning within each of the coded groups, 4) summarising the contents of each code group within each of the predefined categories. Both authors participated collaboratively in the analysis, continuously checking a mutually consistent understanding of emerging patterns.

RESULTS

Patients' answers, further elaborated below, demonstrated how a feeling of logical reasoning on symptom perception could provide comfort and lead to advantageous coping strategies. Personal and social resources were mentioned as essential for tolerating and managing the burden of disease. Extensive endeavours could be experienced as worthwhile when sometimes providing relief, even only temporarily. Quotations are marked by a number assigned to each informant.

Comprehensibility

"I know I cannot sit down too long"

Many patients referred to a logical comprehensibility of their symptoms. They spelled out anatomical details that provided trustworthy biomedical explanations. Some reported very specific experiences of conditions worsening the symptoms, and subsequent avoidance strategies. One woman with a neck injury related how she became worse in cold weather. Another woman had found out that her symptoms varied according to posture.

Emphasis was frequently put on the awareness that the symptoms made sense and did not indicate any dangerous condition. A man with chronic headache, requiring daily medication, declared that beyond his terrible headache, he felt well and was seldom ill. A house assistant in her sixties, long-term sick-listed for shoulder and elbow symptoms said:

"Apart from my arms, I feel healthy and fit. I look forward to the dawning day." [12]

Manageability

"I am not the kind of person who just sits down and complains"

Patients mentioned a variety of personal health resources they use when the demands from symptoms or disability are encountered. Manageability could be attributed to assets related to their personal nature or attitudes, to their environment or to the health care system. Patients also told about health resources related to behaviour or actions they would take, or to strategies they had learned.

Several patients remarked that although the symptoms gave them trouble, it was somehow tolerable. Some of them explained that this was because other, more important elements of their health were sufficiently good. Some compared their present state of health to previous periods, concluding that it was nearly as good as before. Many informants praised their social network, such as having a wonderful family, or being with colleagues. A woman suffering from whiplash syndrome, said:

"The reason of my well-being is that I have established a good network. I am no longer so isolated any more, which gives me the strength to say no." [36]

We heard different stories about activities and behaviour balancing the suffering related to symptoms. A woman of 83, recovering from depression with anxiety and suicidal behaviour, said that although her pace was still reduced, she went out every day to art exhibitions or to the library. Some patients were proud to tell about their physical ability, such as a 90-year-old woman who had walked all the way from her home to the doctor's office, although she visited because of extensive fatigue. The positive impact of being able to go to work was often mentioned. Different strategies for self-care were also reported. For some, rest and protection from demands were important, while others planned or followed training schedules to recover, such as this woman:

"I have actually been able to work – I am not lying down. I have been able to stop another total locking of my back. But my body is not very kind to me these days. However, I try to be kind with it instead." [8]

Meaningfulness

"Pleasure is the gain of the efforts"

In different ways, our patients spoke about their suffering and disability as challenges worthy of engagement. Even fairly extensive efforts could be justified when leading to relief, joy or other kinds of benefit. An old woman said that when she came home

after walking, she was very tired. But, she added, there was nothing unusual about that. A brewery worker in his forties, under inquiry for a serious heart condition, said that he now felt more prepared to do more than before, since his capacity had increased. A woman in her eighties, whose range of activities had increased considerably, said:

"Maybe I overestimate myself and believe that my condition is better than it really is?" [4]

Yet, some patients provided accounts about sacrifices and restrictions due to their condition as the price to pay for future well-being. Instead of surrendering to the symptoms, resourceful strategies were conceived, even when the cost was high. A woman planned to go to a party. She spared her painkilling medication earlier that day until departure for the party, and would then be able to spend 4 h there with people she loved. A truck-driver with bad hips who had recently set up his own business said:

"Even though it hurts, I can still go to work." [36]

DISCUSSION

Whose assessment can we trust?

Our study supports previous experiences and research on the existence of discordant assessments – taking the patient's answer as the gold standard, we underestimated the patient's health in a majority of cases in our material. The conceptual validity of doctor-assessed health in this study may certainly be discussed. First, our crude measure of medical problems present does not represent health assessment on the same level as we asked the patients to provide. The previously recorded patient scores could also have influenced the assessment. Our joint negotiations accomplished months after the fieldwork, with the patient scores hidden and mostly forgotten, may actually have balanced the authors' enthusiasm for personal health resources and contributed to strengthening the external validity of doctors' assessments of patients' health. As practitioners, we specifically intended to explore knowledge available in the clinical context. According to the aim of the study, no quantitative elaboration of the EuroQuol scores was considered appropriate. We therefore preferred an observational setting with ourselves as the doctors, rather than an interview study performed by external researchers, in order to strengthen the contextual validity of the findings. Conflicting views on the same reality is an important part of everyday life, and should be included in the base of knowledge about health. Yet, our study emphasises that doctors cannot take for granted that the patients share their assessment of health status. Benyamini and co-workers observed similar phenomena in a study of self-assessed health in older adults, concluding that knowing more about the ways in which these perceptions are formed could contribute to more effective communication (14).

A situational view on health and disease

In a study of patients with backache, Gannik found that people established a "*personal disease model*", supporting the control of symptoms in daily life (15). Gannik argues that the diagnostic logic of medicine may clash with patients' personal disease models, and emphasises the "*field of disease action*" – the relationship between environmental and living conditions on the one hand and disease on the other. This approach to the discordance phenomenon is supported by our material from general practice, a medical context where patients can be encouraged to present their personal disease models and health resources (16).

Why do many people with serious and persistent disabilities report that they experience a good or excellent quality of life when to most external observers these individuals seem to live an undesirable daily existence (17). This statement comprises the *disability paradox*, examined more closely by Albrech and Devlieger in a qualitative study of 153 persons with disabilities. In this group, quality of life depended upon finding a balance between body, mind and spirit in the self and on establishing and maintaining a harmonious set of relationships within the person's social context and external environment. Our material extends these findings by elaborating the clinical consequences of the disease action field coping with symptoms and suffering to what we could call the general health assessment paradox.

Kleinman describes the cultural construction of illness, where illness contains responses to disease which attempt to provide it with a meaningful form and explanation as well as control (18). *The explanatory models* of professional practitioners are oriented towards disease, while those of the laity are oriented towards illness. Kleinman's perspectives support our interpretation of the culturally embedded discordances between doctors' and patients' assessments of a particular patient's health state.

So what?

The patient-centred clinical method requests the doctor and patient to approach common ground (19). This is not the same as achieving a common understanding, which can hardly ever be accomplished. The power patterns of the medical encounter

assign the doctor the authority to administer definitions and draw conclusions. The doctor can challenge this pattern and contribute to patient empowerment by exploring and recognising patients' self-assessed views of their general health. Such knowledge belongs to the core content of clinical practice (20).

REFERENCES

1. Hollnagel H, Malterud K. Patientens egen vurdering af sit generelle helbred og sine stærke sider (The patient's self-assessment of general health and strong sides). Månedsskr Prakt Lægegern 2001;79:985–92.
2. Malterud K. Symptoms as a source of medical knowledge. Understanding medically unexplained disorders in women. Fam Med 2000;32:603–11.
3. Idler EL. Self-assessed health and mortality: a review of studies. Int Rev Health Psychol 1992;1:33–54.
4. Idler EL. Self-assessments of health: The next stage of studies. Res Aging 1999;21:387–92.
5. Idler EL, Stanislav VK. Self-ratings of health: Do they also predict change in functional ability? J Gerontol Soc Sci 1995;6:344–53.
6. Møller L, Kristensen TS, Hollnagel H. Self-rated health as a predictor of coronary heart disease in Copenhagen, Denmark. J Epidemiol Community Health 1996;50:423–8.
7. Hollnagel H, Malterud K. Shifting attention from objective risk factors to patients' self-assessed health resources. A clinical model for general practice. Fam Pract 1995;12:423–9.
8. Antonovsky A. Unraveling the mystery of health. In: How people manage stress and stay well. San Francisco: Jossey-Bass Publishers, 1987.
9. Antonovsky A. The structure and properties of the sense of coherence scale. Soc Sci Med 1993;36:725–33.
10. Brooks R with the EuroQuol Group. EuroQuol: The current state of play. Health Policy 1996;37:53–72.
11. Miller WL, Crabtree BJ. Clinical research. A multimethod typology and qualitative roadmap. In: Crabtree BF, Millller WL, editors. Doing Qualitative Research, 2nd edn. Thousand Oaks, CA: Sage, 1999:20–4.
12. Malterud K. Shared understanding of the qualitative research process: Guidelines for the medical researcher. Fam Pract 1993;10:201–6.
13. Giorgi A. Sketch of a psychological phenomenological method. In: Giorgi A, editor. Phenomenology and psychological research. Pittsburgh: Duquesne University Press, 1985:8–22.
14. Benyamini Y, Leventhal EA, Leventhal H. Elderly people's ratings of the importance of health-related factors to their self-assessments of health. Soc Sci Med 2003;56:1661–7.
15. Gannik D. Situational disease: elements of a social theory of disease based on a study of back trouble. Scand J Prim Health Care 2002;1(20 Suppl):25–30.
16. Malterud K, Hollnagel H. Women's self-assessed personal health resources. Scand J Prim Health Care 1997;15:163–8.
17. Albrecht GL, Devlieger P. The disability paradox: High quality of life against all odds. Soc Sci Med 1999;48:977–88.
18. Kleinman A. Patients and healers in the context of culture. An exploration of the borderland between anthropology, medicine, and psychiatry. Berkeley CA: University of California Press, 1980:71–83.
19. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Patient-centered medicine. Thousand Oaks, CA: Sage, 1995.
20. Malterud K. The art and science of clinical knowledge: Evidence beyond measures and numbers. Lancet 2001;358:397–400.