Why do patients not do as told by health care staff?

This article is inspired by daily practice in a department of gastroenterology at a large university hospital in Denmark. Many of the patients have liver disease caused by alcohol abuse, and some have liver disease of a different origin. Regardless of the cause of the liver disease it is obvious that alcohol abstinence is necessary for some people if they want to improve their liver function, and for some it is necessary in order to survive.

The targets set for health promotion and health education are often definitive and made by health professionals. One of the most important success criteria is for the patient to abstain completely from alcohol. The mission is to motivate patients to give up a habit which has been a central part of their lives for many years. It is not surprising that it is difficult for health professionals to be successful. Often health professionals notice only a limited motivation for change even in patients who are likely to die prematurely if they keep on consuming alcohol.

Inspiration to develop the health education of patients might be found in the "action competence approach". This approach has been used and developed in both environmental and health education research programs at The Danish University of Education.

To inspire health professionals globally and to illustrate similar problems in Denmark and New Zealand, this article will be printed along with an article on similar experiences in New Zealand. The intention is to publish both articles in a journal for nurses in New Zealand.

Literature review

How to deal with patients who are only slightly motivated for "action" or patients who refuse any changes of behaviour is often a difficult area.

If we look for inspiration in the literature regarding changes of behaviour only limited help is found. However "stages of change" for patients who are already motivated are often well described in the literature, but models on, and strategies of patients going from non-motivated to motivated are few (1-2).
Sometimes it is hard to motivate patients even to think and talk about changes of behaviour. The „action competence approach” contains elements that could inspire them how to deal with this.

The starting point of the approach is to consider education as much more than just academic schooling and behaviour modification.

The action component is described with reference to motivation and reasons rather than mechanism and causes. Briefly it is expressed that actions are intentional.

The competence component is associated with being able, and willing, to be a qualified participant.

The components in the „action competence approach” are briefly described as knowledge/insight, commitment, visions and action experience (3).

The „action competence approach” seems to be a useful tool for inspiration in relation to health education, but is it too idealistic?

Methods

The problems are studied by qualitative interviews with health professionals compared with relevant literature. The objective of the interviews is to collect descriptions of how motivation is regarded and handled by health professionals working daily with changes of behaviour in patients. Furthermore the health professionals are asked about their success criteria for health education. The interviews are carried out as semi-structured interviews mixed with narratives. Two nurses and two dieticians were interviewed.

Grounded Theory inspired the analysis (4).

Findings

Not surprisingly the main theme in the analysis showed that disease plays a key role in motivation for changes of behaviour. The sub-themes are:

- The patients show no major lack concerning knowledge about the connection between disease and behaviour, but they might need other types of knowledge.

Example

„Instead of regarding themselves as victims I try to let them realise that they can actually do something themselves. Most of them know very well which elements in their lifestyle need a change. They don’t have a lack of knowledge. It is important for me to let them realise why they are obstructive to themselves. They can only realise that themselves. I can’t do it for them. They have to see what basically keeps them from changing things – if that is what they really want.”

(Interview fragment 1, Nurse)

- The patients are far much motivated for changes if they can see the results on a short-term basis. It is harder to motivate the patients if the benefits for changes are fewer complications or prevention of a premature death.

Example

„There are social environments that are really rough and tough. When I think of living in these environments I could imagine an early death as a relief. They keep fighting and fighting and fighting but don’t get any benefit at all. Why the hell keep on fighting? Why should I quit smoking to live ten years longer when my everyday live is a hell? It can be hard to understand if you come from a pretty normal environment. Thinking about it, I do understand why some people die prematurely. I think they choose to. Where is the motivation to become ten years older if every day in your life is a struggle?”

(Interview fragment 2, Nurse)
ive changes in behaviour are a must. Others are satisfied as long as the patients are satisfied.

Example

“My success criteria for health education are that the patient is satisfied. Some of them come here and have changed their behaviour in a very restrictive way. Then it is my job to decrease the demands so the patient has a chance of maintaining his behaviour. My goal is not change if the costs are too high.”

(Interview fragment 3, Dietician)

Discussions

Some of the elements in the finding are presented and discussed below. First an attempt to capture the phenomenon of knowledge and its pluralistic use in health education. This leads to a discussion of education in general, and health education in particular. How do variations in the definition of education influence the success criteria for health education?

Finally the „action competence approach” is elaborated on as an inspiration to health professionals practicing health education.

Knowledge

The finding illustrates the diversity of health education. Health professionals have knowledge they would like to share with the patients. The argument for sharing knowledge is better health or/and longer life for the patients. A common success criteria for health institutions is results, e.g. change of behaviour. But the success criteria for the individual health professional might be different.

The kinds of knowledge that usually have the highest priority in hospitals are what you could call „scientific” knowledge. Evidence based knowledge regarding the connection between disease and individual behaviour, often based on a „pathogenetic” approach (5). The focus is on what makes people sick.

If patients have to act in relation to their disease they definitely need a certain knowledge regarding causes and consequences. But achieving this kind of knowledge does not necessarily lead to action. Health education must contain a wider aspect of knowledge. This could be an action-oriented knowledge, knowledge regarding personal experience or maybe tacit knowledge.

Experiences are closely linked to action. Individual actions are always based on previous experiences based on previous actions etc. This is what John Dewey calls „the continuity of experience“(6). The starting point for health education must always be the previous experiences and actions of the patient.

A common model to illustrate the link between knowledge, attitude and behaviour is shown above (see table 1).

Increased knowledge should lead to a change in attitude leading to a change of behaviour.

It seems this model is often used reversely. To obtain certain behaviour you must increase certain knowledge.

If health professionals believe in the model illustrated above the task in health education is quite easy to practice. It is easy to document that you have „delivered” your knowledge. Just tick a few boxes in the nursing record to document this. You do not have to get involved with the patient’s personal history and experiences. As a health professional you can keep your status as an expert. The only problem is the outcome. If you want to do more than just transmit knowledge to the
patients the model is weak. If the goal for health education is change of behaviour or increased action competence, a different model must be applied.

The first step is to acknowledge knowledge as an individual construction instead of an absolute concept that can be transferred. Furthermore certain knowledge must be linked to an experience component if action is the target. Aristotle described how humans are involved in three types of main activities: theoretical, practical and creating, with certain knowledge connected to each of these activities (7):

- Biomedical knowledge as we know it in hospitals must be classified as theoretical knowledge
- Practical knowledge could be called know-how, i.e. knowledge about what leads to a certain target
- Knowledge regarding creating activities is about which competences are needed in a certain situation (action competence).

It is obvious that biomedical knowledge alone does not necessarily lead to changes. The question is how the other types of knowledge are achieved and what role health professionals should play. Some health professionals would probably say that health education should be based on evidence only, anything else would be close to therapy. But the difference between education and therapy is not founded in involvement. It is more a matter of maintaining the integrity of the patient. How the variety of knowledge is emphasized is very much a question of contextual frames both in the individual health institution and in the health care system in general.

Orientation

To distinguish health education from general information, a multiple aspect seems obvious. It could be useful to focus on different definitions of education.

Education can be regarded as somebody having an intention to teach someone something. But if the patient is not interested in education at all, the intention leads to nothing.

A much more visionary definition of education could then be: somebody having an intention to create an intention in someone to learn something (8).

Then the targets for health education take on a new form. How do you create an intention in someone to learn something?

We have to think of orientation. At a health education session, the patient has one orientation; the health professional has another. A united orientation must then focus on the health education situation itself.

If united orientation is not established, health education is not taking place – only information.

Motivation for change is not only a psychological phenomenon, something you have or do not have. We can sometimes think that motivation can be created in someone by seducing the patients, persuading the patients, outwitting the patients or cheating the patients. If we want to create an intention in someone our only way is to try to convince the patient. United orientation is needed.

Success criteria

How often are the success criteria for health education described as establishment of a united orientation? Often the success criteria and targets for health education are changes in behaviour. Definitive targets do not necessarily serve benefit of the patients. They serve to document health education and the legality of health education, as well as establishing confidence and intimacy in relation to the patient.

If success criteria are measured against the increased demand for documentation of all actions taking by health professionals, a paradox will appear. Health edu-
cation with focus on action competence or orientation will hardly fit into standard documentation programs.

There is a discrepancy between the easy way and the effective way. It is easy to document that you „delivered” certain knowledge to the patient. This kind of documentation does not serve the benefit of the patients, it only serves the documentation.

The „action competence approach”

The „action competence approach” was briefly introduced at the beginning of this article. Can the approach inspire health professionals to improve their skills within health education?

First it might be useful to consider the difference between what has been called „the moralistic and democratic paradigm” within health education and health promotion (see table 2).

In table 2 it is illustrated how a health education strategy with focus on changes of behaviour in order to prevent disease is classified. It is moralistic and must be regarded as a „top-down” activity. This is different from the aspects in the democratic paradigm, where the „action competence approach” is used.

If the ultimate target is that patients should change their behaviour in a previously determined direction, the difference between behavioural change and action is obvious. This is the same difference as between the two fundamentally different targets for health education: behaviour modification and action competence. Related to action, there will always be a conscious making up of one’s mind. This is not necessarily the case with behavioural change. It could be motivated by the need to please other people, e.g. relatives, doctors or nurses (3).

The WHO definition of health is well known: „Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (10).

Table 2.

<table>
<thead>
<tr>
<th>Moralistic health information</th>
<th>Democratic health pedagogy</th>
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</thead>
<tbody>
<tr>
<td><strong>Health perspective</strong></td>
<td></td>
</tr>
<tr>
<td>Behaviour/lifestyle</td>
<td>Living conditions and lifestyle</td>
</tr>
<tr>
<td>Disease</td>
<td>Quality of life and absence of diseases</td>
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<tr>
<td>Health as a definitive approach</td>
<td>Health as an open approach</td>
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<tr>
<td><strong>Pedagogic perspective</strong></td>
<td></td>
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<tr>
<td>Target: changes of behaviour</td>
<td>Target: increased energy to act</td>
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<tr>
<td>Moralistic</td>
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<tr>
<td><strong>Evaluation</strong></td>
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<tr>
<td>Measurement of behaviour</td>
<td>„Measurement” of action competence</td>
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In somatic hospitals focus is mainly on physical well-being, cure and prevention of diseases. Maybe this dilemma is similar to health education as illustrated in table 2. Theoretically we often see that practicing the moralistic paradigm does not lead to the expected outcome, i.e. changes of behaviour. Using the more democratic
paradigm might serve health, as described by WHO, better. Still the moralistic paradigm seems to dominate in hospitals. Could it be because it is easier to handle and easier to document?

What is the „action competence approach” then? It does not give any answers on how to practice health education, but it rather indicates the direction of, or a perspective on, the questions (3).

An obvious conclusion must be that it is very much an individual issue if you, as a health professional, want to serve definitive targets and documentation, or the outcome for the patients, when you practice health education. It seems hard to serve both at the same time.

Before any health education can take place a united orientation must be established, i.e. orientation which focuses on the health education situation. The contents of the health education must be based on the patient’s action-experiences. Along with knowledge regarding the connection between disease and behaviour, the health education must contain other types of knowledge.

It seems useful to consider the use of documentation vs. the outcome for the patients. Furthermore it seems useful to discuss the content of health education in hospitals vs. health information. If health education is to be part of a hospital activity, are the frames then set for it? Or should health education take place in other arenas, leaving health information as the only pedagogic task in hospitals?

The „action competence approach” seems to be a valuable inspiration in these discussions.

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Literature