

Consistency in Patients' Health and Treatment Expectations at a Geriatric Clinic

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ABSTRACT: This study focused on predictors of consistency and inconsistency in health and treatment expectations among 77 new patients (mean age, 73) at a geriatric outpatient clinic. Just before their first appointment, and again one week afterward, the patients were asked about their overall health status, their specific illness complaints, their reasons for visiting the clinic, and their expectations regarding treatment and the future outlook. Few predictors of consistency were found for such outcome measures as the number of health problems reported, present and future health status, and the duration, difficulty and benefits of treatment. Inconsistency and uncertainty were more evident in these geriatric outpatients' perceptions, especially among those with self-rated poor health and mobility. This study emphasizes: 1) the importance to the treatment context of geriatric patients' inconsistencies about their health, and 2) the additional burden clinicians must bear in dealing with such discrepancies.

Despite much literature about long-term institutional care, relatively little is known about the extended treatment of chronic problems and disorders in noninstitutional older persons. Because of the interactive nature of their several chronic illnesses, the health problems faced by geriatric patients cannot be understood only in terms of the etiology and treatment of specific diseases and conditions. Consequently, in addition to a disease framework, a personal and holistic perspective is necessary for understanding the implications of chronic illnesses for older persons' health-seeking and treatment behaviors.

Such an approach can benefit from identifying salient psychosocial factors in the process of making decisions about health care, including geriatric patients' perceptions of their own health status (1). For example, perceptions of illness and the appropriate remedial steps are dependent upon one's self-perceptions and perceived relationship to society, including socially-accepted illness roles, age-specific health norms, social class, and the

influences of family members and one's immediate social environment. Perceptions of a more personal or psychologic nature include lifelong health behavior, self-health perceptions, and long-term personal attitudes toward physicians and medical care.

This study examines various health expectations of the older patient once a decision has been made to seek outpatient treatment for chronic problems. There was particular interest in the patients' perceptions of their health after deciding that some form of care was needed, and the basis for anticipating how their health might change as a result of treatment. Reporting findings from the first phase of a longitudinal study, the present paper focuses on the consistency of selected health-related expectations of geriatric patients at the outset of treatment.

In a strictly sociologic framework, a person's perceptions of illness and health status depend largely upon social relationships. Response to illness, including the initiation of treatment steps, similarly follows from the extent to which social participation is maintained (2). Thus, the acceptance of a sick role is viewed as normative in society. However, the adoption of a sick role is based on the expectation that it is only temporary. Since chronic disorders obviously do not fit that

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expectation, the role of a temporal element becomes important to doctor and patient in extended illnesses. The sociologic perspective can be adapted to chronic illness and impairment by substituting for cure the notion of compensation and disengagement (or "cutting one's losses"), as the socially accepted direction.

However, in the absence of a socially accepted chronic illness role, personal decisions about health care may be determined less by social participation than by other psychologic or personal factors. Herzlich (2) has suggested that positive or negative perceptions of old age may well be the intervening personal factor in the acceptance of illness and the initiation of treatment. Other psychologic factors, however, appear to have equal saliency. For example, perceptions of chronic illness by the elderly appear to be highly differentiated, with considerable discrepancy between patients' and physicians' views leading to wide-ranging perspectives of "appropriate" treatment (3).

Haug (4) and others have suggested that another important age-related factor is the patient's attitudes toward physicians. This is a somewhat complex factor, however, since the older age group has greater faith in the physician than do younger groups; yet older persons' longer-term familiarity with themselves and their own problems should make them less trusting when discrepancies are apparent between their views and those of the physician.

Perceptions of both the potential *benefits* of treatment and the possible *barriers* (including costs) may define a patient's expectations about treatment outcomes (5). However, the importance of the temporal element in extended treatment for chronic illness (i.e., the duration of the condition and how it fits into the patient's temporal perspective) has not been measured in this framework. Along this line, Shannon (6) has noted the potential disruptive influence of illness or treatment on the spatial and temporal order of one's everyday life. Thus, Herzlich's and others' "perceptions of old age" concept may need to be further differentiated to include the significance of one's future, and how illness fits into one's temporal perspective.

It is evident, for example, that people generally maintain an internal clock, or a temporal framework of past-present-future, that is meaningful in directing many of their behaviors. Their beliefs about their health are undoubtedly influenced by past experiences and by future expectations. The effectiveness of various health-seeking steps, along

with self-health perceptions throughout one's lifetime, are potential predictors of long-term care decisions. Similarly, future motivations and goals are important factors in compliance and rehabilitation. Some older persons maintain a restricted or limited anticipation of the future—an attitude that may well direct the steps they take to treat their health problems.

Although we know very little about how socially-accepted beliefs regarding illness and treatment differ from individual or personal perceptions of late-life chronic illness, it would appear that the temporal dimension is important. The extended duration of chronic illness and its treatment, combined with the perceptions of a time-limited future in late life, warrant the inclusion of future-oriented measures when investigating older patients' health expectations (7). Such health expectations and other characteristics of the older patient can potentially facilitate or complicate doctor-patient relations in the early phases of treatment, as well as during prolonged treatment. We do not know, for example, whether geriatric patients remain consistent in perceptions of their own problems, their overall health status, their personal futures, or their expectations of the efficacy of treatment and the difficulty involved in adhering to a treatment program. In a holistic approach, it seems important from the outset to go beyond illness-specific factors in identifying what may determine patients' overall views of their health and its treatment.

Given the complexity of this issue, and the wide-ranging variation among older people generally, this study represents an important step towards identifying predictors of consistency and inconsistency in health and treatment expectations.

MATERIALS AND METHODS

Subjects. These findings are based on a subset of 77 persons, drawing from data provided throughout 1979 by new patients at the University of Michigan's geriatric outpatient clinic. This sample represents patients who were available at two points of data collection, as noted below. The average age of these noninstitutional patients was 73, and three out of four were women. The participants, almost exclusively Caucasian, were at or above median income levels for their age group. The typical patient arrived at the clinic for the diagnosis and treatment of three to four health complaints.

The geriatric clinic was designed to deal with a

broad spectrum of health-related concerns among the older, chronically-ill population. As such, its clinical and support staff, the overall environment and location, and the various programs of the clinic provide an atmosphere of consideration for the total person, in contrast to serving as another potential barrier to the older patient. Although this clinic may not be representative of health care opportunities generally available to older adults, it seemed ideal for this type of research, since the clinical setting itself did not introduce a confounding factor in the data collection.

Data collection. Letters of invitation to participate in the research were sent to all clinic patients when they made their first appointments. Those patients who chose not to participate (approximately 50 percent of all new patients) were typically unable to, because of their more deteriorated health status.

This report summarizes and compares patients' responses at two early stages in their treatment: 1) a previsit questionnaire was sent to them before their first visit to the geriatric clinic; and 2) one week after this diagnostic visit (usually before receiving reports from the clinical staff regarding prognosis and treatment) they were sent a second questionnaire or interviewed by telephone. Protocol content at both points included most of the same basic items, with some variability in wording due to the different times of administration in relation to their contact with the clinic. Questions were designed to focus on patients' perceptions of their present health problems and status, on the extent of their future orientation, and on various anticipated aspects of treatment.

Outcome measures represented various health-related perceptions in which patient's consistency and inconsistency were believed to have potentially important effects on doctor-patient interaction. These variables included:

Problem report—a measure of the patient's description and enumeration of specific health problems for which treatment was being sought. (In)consistency was measured dichotomously in terms of whether the patient added or did not add other health problems after the initial visit to the clinic.

Present health was measured on a 5-point scale of the patient's current perceptions of general health status.

Future health, a similar measure, focused instead on patients' projections of how their present health status might change in the foreseeable future. In the analysis of the measures of present

and future health status, determinations of consistency were made on the basis of combining response categories at both data collection points into three: poor/fair, average, good/excellent.

Treatment duration, for those patients who anticipated some form of prescribed treatment, was measured in an open-ended question about how long they thought treatment might last. Responses were coded as reflecting either a fairly specific and immediate future treatment or a vague, distant or uncertain future in treatment.

Treatment difficulty was based on a 5-point scale of the patient's anticipations of how hard it would be personally to remain in, or comply with the prescribed treatment. As with the health status measures, determination of consistency was based on combining the two highest categories and the two lowest, yielding three overall.

Treatment benefits tapped the patients' perceptions of the overall efficacy of being treated generally, as well as in this specific clinic setting. Consistency was determined according to three response categories (effective, not effective, unsure).

Outcome measures of consistency were based on comparable single items in the two questionnaires. Responses on all items yielded ordinal data for coding and analysis. Predictor variables of patients' consistency specifically included: (a) issues which precipitated their initial appointment; (b) perceptions of overall health problems and self-rated health status; (c) expected barriers to treatment; (d) expectations of the outpatient clinic; and (e) their future outlook.

Relationships were measured initially from bivariate contingency table analyses in which predictors were individually cross-tabulated with outcome measures. In a subsequent multivariate analysis, first-stage predictors were included in a multiple regression analysis to determine the most important predictors of health outcomes.

RESULTS

The Table summarizes the predictors of consistency and inconsistency of the six outcome measures in the bivariate analyses. It is important to note that in these analyses, either consistent or inconsistent reports by the patient might be more clearly predicted. Examination of percentage distributions in the individual contingency tables indicated in which direction the association was strongest. The Table was prepared taking into consideration both the relevant dimension of the

Chi-Square Values for Predictors of Patients' Consistency (and Inconsistency) in Projecting Health and Treatment Outcomes before and after Visiting the Geriatric Clinic

Predictors	Health and Treatment Outcomes					
	Problem Report	Present Health	Future Health	Treatment Duration	Treatment Difficulty	Treatment Benefits
<i>Reasons for Seeking Care:</i>						
seeking new physician	[3.91°]					
other specific reason				4.17°	8.89°	[8.33°]
mobility impaired	[4.81°]				[7.19]	
family initiated appointment					[9.01°]	
<i>Health Status Perceptions:</i>						
recent change in health		[6.53°]			[7.29]	
low/average health status (pre-visit)	[6.99°]		[21.76°]			
low/average health status (post-visit)	[13.73**]		[21.76*]			
peers in better health	[9.38**]	12.49°	[15.30**]			
reported many problems	[19.32*]					
reported few problems			12.28°			
stable future outlook				11.57°		
<i>Health Care Barriers:</i>						
difficulty visiting clinic	[6.78°]				[32.99*]	
treatment difficulty	[4.62]		[9.62°]			
minimal treatment difficulty					41.25*	
<i>Perceptions of Clinic:</i>						
positive expectations (pre-visit)	[6.10*]				[12.16*]	8.34
negative expectations (pre-visit)						[6.03°]
positive perceptions (post-visit)						7.26°
negative perceptions (post-visit)						[5.96°]

* p < .001.
 ** p < .01.
 ° p < .05.
 All others: p < .01.

predictor variables, and whether this dimension was associated most strongly with consistency or inconsistency of the patients' reports.

Problem report. There were no predictors of the consistency of patients' descriptions and enumerations of their specific health problems. All of the observed associations were most clearly related to inconsistent reports by patients. Those patients who indicated that they came to the clinic initially to seek a new physician, or because their mobility was impaired, added at least half as many new health problems when re-interviewed following their first visit to the clinic. The related reasons of the unavailability of any physician, or of impaired homemaking approached significance.

Patients who reported many health problems initially were not likely to report the same number after visiting the clinic. Also, patients who rated their own health status as average or below, or who perceived their peers to be in better health, tended to add other health problems at their follow-up interview.

Patients who perceived difficulty in visiting the clinic and/or following a treatment regimen, were more likely to mention at least half as many additional health problems when re-interviewed after their first clinic visit. Generally, therefore,

patients with less than absolutely positive perceptions of their own health and of treatment were most inconsistent about what was wrong with them.

An interesting and initially surprising finding was that patients with positive expectations of the clinic at the pre-visit were also inconsistent in describing their own health. It is possible that the confirmation of their expectations when they visited the clinic encouraged them, in anticipation, to enumerate many more health concerns.

Present health. Predictors of consistency and inconsistency of self-rated, present health status were few. Patients who reported that their own health had changed only recently were most inconsistent about rating their health status at the two times of data collection. On the other hand, patients who compared their health negatively with that of their peers at the second interview were consistent in rating their own health.

Future health. Patients with below-average self-rated health, who anticipated difficulty following treatment, or who compared their health negatively with peers, were most inconsistent about projecting their health status into the foreseeable future. Perhaps this reflected their basic uncertainty about their health.

The only predictor of consistency about future health was found among patients who reported less than the average number of health problems each time they were interviewed.

Treatment duration. Those who came to the clinic for a specific purpose (i.e., typically for a confirming diagnosis), and those who perceived their future health as basically stable, remained consistent in estimating the length of time they would be under treatment. No other significant predictors of this outcome measure were found.

Treatment difficulty. Predictors of consistency in the difficulty of following prescribed treatment were mixed. Patients who anticipated little difficulty prior to visiting the clinic, as well as those who went to the clinic for a specific reason, were most consistent in their responses at both interviews. It is not clear why patients who anticipated difficulty in visiting the clinic, or those with positive expectations from it at the time of the pre-visit, were inconsistent about how difficult treatment might be. The only other significant predictor was that for patients whose visit to the clinic had been initiated by a family member. This group was inconsistent about treatment difficulty.

Treatment benefits. Patients who maintained negative perceptions of the clinic were inconsistent about the efficacy of treatment. On the other hand, those with positive expectations tended to be consistent about the clinic's important role in their future.

Other predictors. The importance of the future in present health status and treatment anticipations was evident in some of these reported findings. This was additionally supported from other responses. For example, patients who expected treatment benefits to occur in either the very near or quite distant future remained consistent in their expectations ($\chi = 6.23$; $p < .05$). Also, patients who reported no more than one real health concern following their first visit were positive about their future health status ($\chi = 11.54$; $p < .05$), perhaps reflecting realistically that poor health was not a factor in their future outlook. This was further supported in this same group by their vague and inconsistent responses to questions about whether the clinic would affect their future ($\chi = 9.70$; $p < .05$), and whether benefits would accrue from coming to the clinic ($\chi = 25.00$; $p < .001$).

Finally, a bivariate analysis of all responses by age of respondent was conducted on the presumption that older patients would be least consistent about their health, treatment benefits, and anticipated futures. When examining the outcome pre-

dictors by age, we found the oldest participants to be most inconsistent in their expectations of the duration of their treatment ($\chi = 6.69$; $p < .05$). Although this was the only significant age-related finding, there was evidence of a trend in this direction. When examining other outcome measures by age, several approached significance, e.g., problem report, present health, and treatment difficulty.

The various predictors significantly related to selected outcome measures in the bivariate pairings were then subjected to regression analyses to determine their relative predictive value. Analyses were conducted for the outcome measures having the largest numbers of predictors. Since it might not be possible to check all of these first-stage predictors in many clinical assessment situations, the multivariate analyses attempted to determine which were the best predictors of the various health outcomes based on this geriatric outpatient sample.

The first regression equation examined the relationship of various first-stage predictors of consistency in reporting health problems at both interviews. The only significant predictor in the ANOVA ($f = 3.23$; $p < .004$; $r = .73$) was for patients who initially reported more than the average number of health problems, i.e., those who reported more problems initially were more likely to add other problems following their visit ($p = .002$).

Predictors of treatment difficulty approached significance ($f = 2.25$; $p = .06$; $r = .67$). Variance was attributed to the inconsistency of patients whose initial visit to the clinic had been prompted by their children ($p = .03$), and patients who anticipated difficulty in getting to the clinic ($p = .002$).

The ANOVA result for consistency of predictors of present health status was significant ($f = 6.05$; $p = .001$; $r = .60$), suggesting that each of the first-stage predictors of health status (indicated in the Table) might be important for clinical use. Patients who went to the clinic initially because of a recent change in their health were most inconsistent about health status ($p = .03$), whereas those who rated their health very positively were the most consistent ($p = .001$).

DISCUSSION

The data in the Table, when viewed as a whole, suggest that there are few, if any, broadly useful predictors across outcome measures of health status and treatment concerns. Preliminary analyses

of subsequent three-month follow-up data on the same patients gave further support to the inconsistency and variability to geriatric outpatients' health expectations over time—a potentially useful finding for the clinical setting. Although further research with different populations and measures is obviously warranted, important general research and clinical implications are evident in the present investigation and its early findings.

Anything less than feeling “very good or excellent,” or anticipating “no difficulty” with treatment, was associated with inconsistency. Predictors of consistency in describing one's present and future health, and in anticipating the implications of treatment were not easy to find. Consistency may well be inversely related to perceptions of (chronic) illness as a limiting factor in one's life. The uncertainties that accompany chronic illness, i.e., how limiting it will be and how long it will last, may cause patients to become less sure about their health and the outcomes of treatment. In this regard, healthy older people may be more like many younger people in considering the impact of illness on their lives and futures only when they are sick.

Inconsistency and uncertainty were more evident in many geriatric outpatients' perceptions, especially in those with poor self-rated health and mobility. They were uncertain about the length and difficulty of the treatment they would be required to follow, and about their future health status. Although they might have positive views about the clinic itself, their chronic illnesses tended to make them inconsistent about the clinic's long-term efficacy in their lives. This may have been a realistic uncertainty in the process of accepting the age-related chronicity of their problems. Three explanations of the observed inconsistency seem likely: 1) for some patients, their first visit confirmed their “worst expectations” about their health, thus causing them to extend their treatment estimates; 2) others found relief in learning that perhaps they were not as sick as they believed, thus revising their treatment expectations positively before the second interview; and, 3) some patients were sufficiently “unsure” to respond differently each time.

The inconsistency in problem reporting among patients who approached the clinic with high expectations may be explained in a slightly different way. Having found a supportive health care setting, where there was real interest in them and in their health concerns, these patients may have added problems in the optimistic hope of cure or

relief. Although this may not be a realistic expectation, it is somewhat analogous to reports of older persons' positive attitudes towards their physicians (4). Thus, inconsistency in the patients' health reporting may reflect an increased belief in, and reliance on the physician necessitating more accurate, or at least more detailed reporting. It will be interesting to observe, over a longer period, how these patients change in their expectations and health status perceptions, and whether they will be more willing than others to comply with prescribed treatments.

Anticipations of difficulty in following treatment resulted in a great deal of inconsistency among our participants. Various predictors of inconsistency in treatment difficulty again suggested the importance of perceived barriers to health care, in agreement with numerous studies of the health beliefs of other age groups (5). On the positive side, the perception of family support and the family's potential role in reducing barriers remains to be determined among our participant group of outpatients (8).

The importance of time in the assessment and treatment of geriatric patients seems an important finding. Many of our participants obviously “changed their minds” about their health after visiting the clinic for the first time. Whether, and in what way, they changed over a longer period remains to be seen. The initial changes, however, may have important effects on clinical diagnosis and assessment processes, as well as on subsequent treatment compliance. For example, it is not clear whether the patients' initial perceptions were more “accurate” than their health reports following a clinic visit, nor what the effect of these various discrepancies were on the information possessed by the clinical team. In the long-term treatment of chronic illness, such discrepancies over a relatively short period may negatively affect doctor-patient relationships by replacing positive attitudes with concerns that the “doctor does not really understand my problems.” Deciphering these discrepancies and effecting good communications about problems and treatment place an additional burden on doctors and nurses who treat geriatric patients.

The temporal dimension is important in another way; the future seems to be less clear to people with negative health perceptions. Our data do not go so far as to suggest that the future loses its motivating force for those who are most sick (typically the most elderly patients), but this issue must be raised for its clinical value in treatment.

On the one hand, inconsistency about future health may reflect real uncertainty about present health and its impact on the future. However, with the extension of health problems over time, uncertainty about the future may well mean certainty about *no* future. The long-term result could be the absence of a powerful motivation for following treatment, relying instead on such present-oriented factors as pain reduction. Perhaps this also makes financial burdens seem even more difficult.

CONCLUSIONS

These early findings from a continuing study of geriatric clinic outpatients underscore the importance of the patients' own self-health perceptions in the assessment and treatment of chronic illness. Relatively negative perceptions of one's health, of the difficulty of treatment and of the future, lead to inconsistency and uncertainty. As suggested earlier by Maddox and Douglass (3), older persons tend to maintain a strong reality orientation about their health. Unlike these earlier findings, however, our patients' self-health ratings did not seem to be as stable following contact with the clinic. Possibly the absence of an accepted socialization model for the chronic illness role, combined with the variability and heterogeneity that exists among older people generally, may be more sig-

nificant factors in the inconsistencies manifested in late life.

Although not specifically addressed here, the clinic itself was a factor in the formulation and modification of self-perceptions. An empirical question that remains to be tested is whether older patients know what to report about their health, and what questions to ask of their physicians.

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