COPING AND COMPLIANCE IN CORONARY PATIENTS:

AN ACCULTURATION STUDY

by

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We accept this thesis as conforming
to the required standard

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ABSTRACT

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This is a study of the impact of a heart attack upon patients. The study examines the process by which a patient comes to terms with the condition, and what happens when they cannot.

When a person enters a treatment situation in an established medical structure (such as a clinical setting), he or she must adapt to that structure. This intense and continuous contact between the patient and the professional as representatives of different sub-cultures often results in a change in the patient through an acculturative process.

An effective treatment situation requires that the explanatory models used by both the patient and the professional be in accord. If the explanatory model of the patient does not agree with the biomedical model of the health care professional, the patient must choose which model to follow. This may create a classic double-bind of conflicting assumptions in which the patient must either disregard personal beliefs to follow the biomedical model, or must follow personal beliefs and thus be non-compliant, which also may violate a personal belief in complying with 'the doctor's orders'.

Thirteen subjects participated in this study. The patients were selected according to a criteria of first MI

(myocardial infarction), under age-65, and resident of the Victoria region. The research was conducted from May 1st, to September 30th, 1985.

Subjects were interviewed using standard participant observation techniques. Questions asked were open ended to allow for the greatest degree of freedom for the patient's description. Questions were aimed at eliciting the patient's explanatory model, coping strategy and belief structure concerning the condition. This was then compared with the standard biomedical model as found in the coronary care rehabilitation programme of the Royal Jubilee Hospital.

Results were interpreted in terms of a distinction drawn between disease (the specific etiology of a condition) and illness (a cultural concept). The programme gives the patients the technical information of the disease, whereas the patients are more concerned with their illness problems; how their condition will affect their lives. Consequently, the programme does not address an important aspect of the concerns and feelings of the patients. This study also indicates the advantage found in applying anthropological research methods to elicit the patient's point-of-view. Recommendations concerning treatment which takes the patient's point of view into account are made at the conclusion of the thesis.

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INTRODUCTION

The study described in this thesis examines the interaction of patients and health care professionals in a clinical health care setting. The problem examined centres on the health belief or explanatory model of the patient and the biomedical model of the professional in the creation of effective treatment.

When patients enter the clinical setting, they are placed in a position of having to adapt to an established power structure which takes control of their lives. Thus, the patients go through a process of acculturation.

The study described here focuses on the problem of non-compliance. It is suggested that non-compliance--essentially when a patient does not follow orders--is the result of a lack of effective communication between the patient and the professional. Effective communication is based upon the interaction of both communicants' health belief models. Both the patient's and professional's models are health belief or explanatory models, so they are distinguished hereafter by reference to the professional model as a biomedical model (BMM) and the patient's explanatory model as EM. The models are the frameworks by which each individual forms a set of beliefs which then influence behaviour.

The present study demonstrates a problem arising when the two models are not in accord. To be 'compliant' a patient must follow the biomedical model. If his or her own explanatory model does not allow for agreement, the patient is caught in a double bind. To be faithful to one model means disobeying the other. Deciding in favour of either model can create an difficult problem for the patient, that of non-compliance.

The thesis is divided into two parts. Part One begins with an example of the data from which the study is drawn, then proceeds to review the literature concerning the problem and the theories and methods used in the study. Part Two describes the results of the study, and gives more complete ethnographic data.

Chapter One provides an example of a typical interview conducted by the researcher. The insertion of the example at the beginning of the thesis is for the purpose of presenting the format and kind of data from which this thesis and its conclusions were drawn. It is assumed that the best way to understand the patient's health belief model from an 'emic', or 'inside' perspective is to begin with the core of the study: the patients themselves.

Chapter Two is a review of some of the literature covering the problem of non-compliance and the illness problems associated with cardiac problems; it is meant to

familiarize the reader with interaction in a clinical setting.

Chapter Three explores the theoretical base for why patients don't follow orders (non-compliance). The methodology examined in Chapter Four provides tools to elicit the information. The strategies described in Chapter Three provide tools for analysis of the data gathered.

Chapter Four covers the methodology that was applied to approach the problem described in Chapter Two. It also provides justification for the researcher having stepped 'outside' the immediate bounds of anthropology in his search for appropriate models.

As the beginning to Part Two, Chapter Five provides the reader with a history of the Cardiac Teaching Programme at the Royal Jubilee Hospital. It discusses in more detail the specifics of the information given to the patients while in the hospital. It is through this information that the patients are able to determine the biomedical model which they are being offered.

Chapter Six describes the other side of the interaction by showing the health belief model employed by the patients. This is the information that was gathered during the course of interviews with the researcher as 'participant observer'. The information in

Chapter Six allows the reader to discern, in part, what having a heart attack is like from the patient's point of view.

Chapter Seven attempts to tie the thesis together by describing the important conclusions drawn from the data. Heart attacks are regarded by patients as essentially 'normal' and are therefore hard to deal with at the level of cultural assumptions. The patient's primary concern is with the 'illness' and not the 'disease'. It is felt that this summary validates the pursuit of the problem and the methods and theories employed. It also shows the future value of this format of research for making practical, patient-oriented recommendations.

PART ONE

CHAPTER ONE

"A NORMAL TYPE HEART ATTACK"

The following interview is comprised of excerpts from verbatim transcriptions of different patient interviews. The words are those of the patients. This interview is included for several reasons. The excerpts will introduce the information that forms the basis for many of the following chapters. It also shows the scope and depth which the open-ended descriptive questions characteristic of participant observation can achieve. As important as the preceding are, of equal importance is the fact that this 'sample' interview allows the reader to observe the interaction between the researcher and the subject. The information following has been edited to eliminate any information which might directly identify the speaker; what you read is his experience.

The researcher is indicated by upper-case, and his statements too are verbatim from the transcriptions. The questions shown were fairly standardized in their presentation to the patients, which allowed for ease of categorization later.

HOW OLD ARE YOU?

56 [years old].

HOW TALL ARE YOU?

About 6 feet.

AND HOW MUCH DO YOU WEIGH?

About 200 pounds, I guess.

HOW DID THIS HAPPEN TO YOU? (note that heart attacks are as varied as the people who have them. This description, though a compilation, is more to demonstrate the experience)

I guess about a week and a half before I had this heart attack, I started to get some severe chest pains. They would come on strong and then go away. You've got so many things to do so you don't pay attention. Anyways, the night before I had the attack, and I was cutting the lawn. And usually I can whip right through it in no time, but this time, in 5 minutes, I had this pain in the shoulder, a funny feeling, short of breath, y'know? Something was wrong so I came and sat down here, and had

a smoke, and something to drink. Got up after ten minutes and it started all over again. Anyway, I finished the lawn, but about 7 o'clock it started to get really severe, and I went to bed about 10 o'clock. Wife came to bed about 10:30. I just couldn't sleep, but I found that it was more comfortable for me sitting up. So I sat up nearly the whole night with this thing, coming and going, coming and going. Anyways, I got some sleep, and, I don't know. It was early in the morning, and I was going to go get dressed, regular bathroom routine, and I felt a sharp pain in the shoulders. I thought it was indigestion, so I reached for the antacid, whathaveyou, and walked around. I felt a little pain in the front, but none of this grabbing business...and I thought I'd better sit down and think this over. And it went away. So I got into the car and I drove to work. Had no problem at all until I got there. By the time I had parked, and got out, I could hardly stand it, so I thought that there was something wrong. So I went and got into car and drove to the Jubilee, which was only a few minutes away. Anyways, I was feeling better a bit, so I walked in. I walked into the door under my own steam. I thought a guy who had a heart attack, they weren't to be able to walk like that? Anyways, then it happened. Gallons of water poured out of me. They're very good there. It's funny....they had me stripped in

about 30 seconds [laughter]. I couldn't keep track of all the stuff they were doing. They were so good. I'd completely lost track of time. I think that was the last thing you were worried about, time. But, I found out later that you can have a heart attack any number of ways. This clutching at your chest business doesn't necessarily mean a hoot in hell! Neck, back, shoulder. Pretty sharp pain, but it felt like indigestion. But it wasn't indigestion. Well, there you are.

DID YOU THINK THIS WAS SOMETHING THAT WOULD HAPPEN TO YOU?

Well, nobody expects it to happen to them.

I GUESS NOT....

You think, ahh, you get a little bit of a warning, and oh, you get some aches and pains, something like that. Then it sneaks up and hits you on the back of the head, just as easy as to sneak up and trip you a couple of times. I mean, I thought everybody else in my family would, but I never once thought I would. I had myself dying of lung cancer, emphysema,...because I smoked, and all these, but no, never, ever thought I'd have a heart attack.

WHY DO YOU THINK THIS HAPPENED NOW?

[pause] I really don't know why I got the heart attack, I can't tell you. Although sometimes you feel as though "why me?" y'know? Thought go through your head because it really involves a lot of things, y'know? Not only the healing time that you have to go through, but when I'm through that, and I'm ready to work, I face my employer, and my employer might have negative thought about that. And he may say now look, I don't want this, I want only that, and that could...I think about that. And they can probably squeeze you out. There is a possibility. I'm not saying that my company would do that, but there is a possibility that this could happen. Because you can't blame the company. They want the healthiest people possible, let's face it, so that the least amount of man-hours are lost.

HOW SERIOUS WAS THIS?

Now that's something that you, yourself, don't know, y'know. Only the doctor knows how serious it is to that degree of,...well, that you have to have this done to you, open heart surgery or something like that. From the way they treated me, you know from the treatment, I'd say

that it was a heart attack, but it wasn't a major, major one, you know what I mean. It was a normal type heart attack.

WAS IT...DID YOU THINK IT WOULD BE THAT SERIOUS?

Never gave that much thought. You'd have to have a damn good crystal ball to figure out it is gonna be a biggie or quite surprising. A couple of the guys I was in the ward with...one guy's had six of them. Six heart attacks! Well, that's one thing I've done. I've never gone to the moon, but I've sure as hell had a heart attack...well, I don't think that this was a serious heart attack. I suppose if I have another one, it would be, because of the fact that I've got heart damage now, you see. So that means that some of it's gone, that means that next time there'll be more gone, and so you just get to a point, I suppose if you have enough heart attacks, you get to the point where you have no reserve left as far as your heart is concerned.

WHAT ARE YOU DOING TO GET BETTER, Y'KNOW, NOW THAT YOU'VE COME HOME?

Since I've left the hospital I've been quite rundown. I found it very difficult to...where I was, two weeks ago,

I was walking several miles a day, I walked a lot at my work, always walking here and there. I find it very diffcult just to go around the block. So anyway that's where I am right now. I'm still trying...I'm still getting out, I'm still trying to walk slowly around the block. Now I've got a programme that I'm following. I'm doing a diet programme plus a standard walking programme. Now from day one to day, the first five days.... Well, rest is the main thing. Rest after every meal, lie down. Have a rest so's your feet are up so your heart doesn't have to do any work, y'know, to pump the blood. Don't cross your legs. Exercise is to go for a walk. I only go for a walk maybe halfway down the street and back again. But they give you this sheet that tells you how far to walk...

Yeah, this is from the Jubilee. I'm supposed to walk a quarter of a mile. But, I'm finding that I'm doing that with a great deal of difficulty. (reading from sheet) "The programme is designed in the stages to lessen the weakening effects of bed rest", so I guess that's where the bedrest has knocked me out. "The physical activity enhances cardiac function. It is expected that you will be walking at a slow pace for short distances throughout the day", and that's true. I cannot walk at a fast pace.

It knocks the hell out of me. Essentially they want me to walk slowly and to build it up as I go along. So its all marked out, so that I'll be where they want me to be. So this morning we did a little extra, and came back in, and the pulse hadn't changed more than eight beats, and five minutes after you're supposed to be back to normal. That's anybody, and I was. So I think that part of it seems to be working. So I felt good about that. I have to stay with these here programmes, I have to continue it. Just for the sake of getting away from the depression if nothing else, just for my own sanity if nothing else.

IT'S BETTER TO BE HOME NOW?

Oh, I'd much rather be home. It's more frustrating at home because you see so many things you want to do. And you think: "oh, boy I can do that no problem", and you want to do them, buy you can't, y'know. You have to do the stairs in two parts, you've got to go halfway up and then rest and then the rest of the way, and stuff like this, y'know? I feel like I'm an old man!

HOW DID YOU FIND OUT ABOUT THIS PROGRAMME? DID THEY COME AROUND AND TALK TO YOU?

Oh, yeah, the nurses in the coronary care unit are very,...they talk to you constantly about, y'know, what's happened to you and what you need to do to help yourself get better. Plus they have slides and tapes y'know, that they show you, and the tapes go along with it, and explain the whole thing to you as you're going. And they give you all these [handouts] to go along with it...

I GUESS ITS GOOD TO HAVE THESE AT HOME TO CHECK?

Yeah, right. I really find it very interesting. I would like to, well... I will talk to my own doctor, about what exactly did happen. Although I've had it explained to me, I need to have it explained again. I do know that the artery was blocked off and that, but y'know I'd just like to have a fuller explanation again about it.

DO YOU THINK THERE'S THINGS THEY HAVEN'T TOLD YOU?

Oh, I never get the answers I want from these guys. I don't like going to them in the first place. There seems to be a tendency for them to want to hold back, and I think, I believe I think its mostly because of a little knowledge is more harmful than a lot of knowledge. If they don't feel I understand the situation, and I'm sure that some of the questions that I've been asking indicate

to them that I don't know what it's all about, or didn't anyway, especially the first day or so. So, to what extent they'll open up, I don't know. I'd like some answers. I'd like to know some figures. Like, I'd like to know... when there's damage to your heart, apparently a lot of the, in the form of,... all ready I've forgotten in what form it takes. But they can measue heart damage right after it occurs by counts, some blood composition count that they do. I forget what it is. I want to know what that figure was, and how it relates to less, or more serious damage. So that's what I mean. Now, what I would have done with more information I have to admit I don't know, but just "normal" didn't really tell me anything. There don't seem to be any individual answers. There certainly are answers in classes and groups of people. Y'know, as I said, you can get quite educated after you've had,.....but I'd like to know, y'know, I'd like to know.

DOES YOUR FAMILY HAVE A HISTORY OF THIS?

I'd say yes and no. My dad died of the same type of heart failure problem, but he was in his sixties. My brother died, I guess a few years ago now when he was about how old I am now. I don't know exactly what got him. It was his heart. I did have an uncle die, but he

was in his sixties too, on my mother's side. I don't know if you'd call that a family history of heart problems or not. They jumped on that pretty quick at the hospital though. I don't know.

HOW LONG WERE YOU IN THE HOSPITAL?

About 10 or 12 days all told. I was supposed to be in for 14 days, but with good progress, the doctor said I could go home.

TIME OFF FOR GOOD BEHAVIOUR, EH?

Yeah, [laughter] I said if you keep me another day you can kick me across the road to Eric Martin [the psychiatric pavilion]....that's terrible....even if a guy feels good, they keep you in the hospital. The nurses give you pretty good attention. I really felt kind of embarassed to be there. Y'know, not feeling bad. Then I got moved to a ward, and I was there for 6 days. I didn't like that, at first, but you get used to it...

WHAT WAS WRONG WITH IT?

Well, I had a room all to my own, and those gals really make you feel good. I felt to be moved away from that, I

would rather have come straight home. Get dumped in an unfamiliar place with new faces....dark room..., I wasn't near a window. And then you saw other people in worse condition or better, depending on what was in the room. That first day on the ward though, boy, it hit me like a ton of bricks....that, hey, y'know, you're a casualty, you're in a different category.

HOSPITALS AREN'T EXACTLY MY FAVOURITE PLACES EITHER. HOW DO YOU FEEL YOU'RE GETTING ON NOW...ARE THINGS GOING WELL?

I don't know. I'm kinda worried it's gonna happen again. That's always in the back of your mind...you constantly know about your heart. That is now so embedded in your mind, because you don't want to go through another heart attack. But I know from other things in my life, like, y'know, I know from my experience that once you get back to the routine of living again, your normal life and your work situation and so on, a lot of the things you learn are forgotten. You know you just can't remember them. The same thing will probably happen. Sure I know about ways of relaxing and trying to get rid of stress and stuff, and I can do that now. But I imagine that once I get back to a regular routine as far as the work and everything goes a lot of those will be forgotten. I just

isn't possible to live a normal type of life and keep all those things in mind. And I don't think that I'm the kind of person anyway that relaxes a lot.

DID YOU WATCH THOSE SLIDE PROGRAMMES?

Yeah, I watched, we watched, the two of us both watched several of them. I think they're very...I think they're marvelous. They certainly enlightened me when it comes to the angiogram. I certainly knew what was going to happen. It does help you.

SO THAT'S HOW YOU FOUND OUT THE THINGS THAT HAD HAPPENED TO YOU?

Yeah, a little bit. But I found out more, I think, in that the doctor was real good to my kids, and my wife. He had a little chat with them afterwards, and explained <u>everything</u> . And he had even showed them on the machine what he did. And that afterwards with them telling me, I was anxious to see the film...the angiogram, and see what goes on. My son asked a lot of questions...

FAMILIES ARE GREAT...

Well, they give you a lot of support, and your friends.

I got calls from all over the place. All this kind of thing...all the cards [indicating a mantle full of get well cards]. It's encouraging.

DO YOU THINK THERE'LL BE THINGS THAT YOU WON'T BE ABLE TO ACCEPT?

I don't know. I don't think so. I don't think I have to change much, y'know. I've made up my mind. I'm lucky to be alive. That I want to go on living a normal life. They say that some changes are bound to come, I don't know. If that happens, I'll just have to accept that....just take the days as they come.

WHAT ABOUT THE FUTURE?

Well, I hope...just keep on going, getting better, y'know.

CHAPTER TWO

THE PROBLEM

When the seriously or chronically ill come into contact with members of the health care profession, a special kind of discourse occurs. The situation is unique in that the patient is often entering into a realm of which he or she possesses neither a firm knowledge nor a strong power base from which to negotiate. The matter is compounded by the fact that it very often is a matter of life or death. The basis of the negotiation between the professional and patient is the transference of information upon which the professional bases the diagnosis, and the patient develops trust.

Without the proper information, whether through misrepresentation or misunderstanding, the patient may be unable to adequately cope with his or her condition. It is the purpose of this chapter to look at the literature surrounding coping in cardiac patients, and to examine "non-compliance" with the medical regimen as indicative of the power structure and of the break-down of the process of communication.

The Treatment Process as Acculturation

In looking at the process of the patient moving through the Cardiac Teaching Programme at the RJH, what

was studied was the interaction between two different cultures or "sub-cultures". Chrisman and Maretzki (1982) suggest a view of biomedical culture as a separate social organization with its own rules for patterning behaviour. Therefore patients entering treatment come into contact with a different sub-culture. Although tacitly belonging to the same "Culture", the professionals and patients, within the confines of the health care system, must operate according to rules not available to the general public. This study focused on the impact on the patients as they adjusted to the structure of the hospital, the programme, and their condition:

> (I)n spite of the increasing complexity of issues and methodological emphasis on analysis of cultural subunits, the acculturation approach remains viable in the study of dynamics of change through culture contact (Bee, 1974: 119).

The subunits are the medical culture and the patient culture; the dynamics can be seen in their interaction through the culture contact of the treatment situation.

When looking at acculturative situations several parameters are important. First, acculturation is a kind of culture change (Bee, 1974: 96); it is change when two autonomous systems come into contact. Though in a strict sense the clinical subunits are not autonomous, in that neither is independent of a larger unit, the structure of

the medical system is such that it operates in an autonomous manner, particularly in the distribution of health care. Therefore the patient entering the system must adjust to an autonomous structure.

Second, the concept of "acculturation" may be used as an adjective when used in reference to a condition (Bee, 1974: 97). In this usage, it can be used to describe the state of being of a particular culture with respect to another culture. When used in the clinical setting, it is almost as though the terms "compliant" or "adoptive" may be substituted. The degree of acceptance in the patient, or how compliant they are can be a measure of how well they have adapted to the medical structure--how acculturated they are.

Third, acculturation is a process of change (Bee, 1974: 97). In a study of a clinical treatment programme where the focus or goal is to initiate a change in the patient's behaviour, by seeing change as a process, one perhaps arrives closer to the goal:

> "acculturation" refers to a process of change that has been distinguished from the processes of diffusion, innovation, invention, and discovery. Diffusion occurs in all cases of acculturation; obviously, traits or ideas have to be transmitted before they can have any sort of impact on the recipient cultures (Bee, 1974: 97).

These descriptions, provide the rationale for the

description of the study of clinical problems as an acculturative study. In a clinical setting the change to be evoked is made possible through the dissemination of information. The information, then, is one of the acculturative traits to be studied.

The process of acculturation is not without problems. It is not a situation of free exchange of ideas:

> In spite of the best efforts of the donor group, it is ultimately the perceptions and the interpretations of the recipients rather than those of the donors that determine the areas of agreement or disagreement between cultures and the degree of acceptance of proferred ideas or traits (Bee, 1974: 104).

Bee further describes the three stages of the acculturation process (1974: 104). First, the transmission of traits (diffusion). Second, the evaluation of the information by the recipients, using various perceptual and interpretive "filters". Third, the integration of the information or traits into the recipient's cultural system. This is very close to the pattern described in the sections following for the interaction of the patient and the professional in treatment situations.

Cardiac Diseases

Statistics Canada related ischaemic heart disease (a local anemia due to a reduction of arterial blood flow to a given part) as one of the leading causes of death in Canada between the years 1969 and 1980. Within Canada, diseases of the circulatory system were responisble for approximately 8% of hospitalizations for females, and 15% for males (for the years 1970-1978). The rate for men has shown a small but steady increase (Statistics Canada, 1983). The rates varied for men and women, with men at 250-300 deaths and women at 150-200 deaths (average per 100,000 population).

Between the years 1973 and 1983, however, the total number of potential years of life lost (PYLL) in Canada, for persons dying before their 75th birthday, decreased overall by 17 per cent (Litven and Smith, 1985: 1). The relative ranking has remained the same among the top three causes of PYLL (cancer, ischemic heart disease and motor vehicle accidents). In that time ischemic heart disease rates remained constant at just under 15 per cent of premature deaths in both 1973 (14.5%) and 1983 (14.7%)(Litven and Smith, 1985).

Heart disease and cancer continued to maintain their supremacy as the leading causes of death for both sexes in 1982, accounting for 69.3 per cent of the total (Smith, 1984: 1). Ischemic heart disease was the number

one killer for both males and females in 1982. Males suffered 28,796 deaths (28.9 per cent of the total) and females suffered 20,239 deaths (26.1 per cent of the total)(Smith, 1984: 2).

Though ischemic heart disease is the leading cause of death in both males and females, there are variations according to age between the sexes. Among males, between the ages of 15 and 34, only 127 deaths due to ischemic heart disease were reported in 1982. However, in the age bracket 35 to 64 this figure jumps to 8,444, and over 65 years of age ischemic heart disease accounts for some 20,206 deaths. Among females for the same age categories and year (1982) between 15 and 34 there were only 38 reported deaths, the figure rising to 2,219 for the ages 35 to 64. The figure for females does not begin to approach that of the male population until over 65 years of age, with a reported 17,966 female deaths due to ischemic heart disease (Smith, 1984). The majority of these deaths are related to arteriosclerosis, which is "hardening of the arteries" due to an increase in connective tissue in artery walls.

There are six main types of cardiac disease that afflict North American populations (Purtilo, 1978):

a) coronary arteriosclerotic (80% of all cardiac deaths),

b) hypertension (based on abnormally high blood

pressure, 9%),

c) rheumatic (associated with rheumatic fever which may lead to endocarditis and deformation of the cardiac valves, 2-3%),

d) congenital (those problems present at birth, 2%),

e) bacterial endocarditis (inflammation of the serous membrane lining the heart due to the presence of bacteria, 1-2%),

f) syphilitic (resulting from syphilis involving the aorta, heart and large vessels, and can give, for example, aortic insufficiency, less than 1%).

Of the six mentioned above it is obvious that the most significant affliction is arteriosclerosis. This can be accompanied by thrombosis (essentially the coagulation of blood in a vessel) and by myocardial and cerebral infarctions (interruption of flow to the given part leading to possible stenosis).

All the cardiac diseases are interrelated. Arteriosclerosis has three main variants (Purtilo, 1978). Atherosclerosis is the stage most commonly associated with the problem. It is characterized by the deposition of fatty substances (commonly termed "plaque") and fibrosis along the intimal lining which effectively narrows the arteries. Medial calcific sclerosis is characterized by the calcification of the media of the

arteries. The third variant, arteriolosclerosis, involves the thickening and hardening of the endothelium of the arterioles.

These conditions, severe in themselves, create further complications (Purtilo, 1978). Stenosis (progressive arterial narrowing) can cause ischemia in other organs through the deprivation of blood. Sudden thrombosis of an artery, or haemorrhage into the plaque will block the lumen, totally disrupting blood flow to that region. The weakened arterial wall may form an aneurysm (essentially a "ballooning" of the wall) which may subsequently perforate causing internal haemorrhaging into the body cavity. In this way arteriosclerosis can account for approximately 99% of all ischemic heart disease (coronary artery disease) created when the blood supply is arrested or reducted (Purtilo, 1978). This can progress through a more chronic condition (angina pectoris) or with severe sudden blockage a myocardial infarction (MI) could develop.

The modern technological revolution has provided the North American population with a plethora of items with which we can essentially "clog" ourselves. Rich foods, sedentary living, hypercholesterolemia, stress and associated hypertension all contribute to the downfall of North American cardiovascular systems.

The development of such a condition has great

impact upon the patient, both physically and psychologically. The condition can interrupt the normal "flow" of life that people enjoy (Ashworth and Rose, 1973). The warning associated with cardiac problems can create further stress (Monteiro, 1979). The interruption or cessation of working capability (and consequent lost income) for a prolonged period may create feelings of inadequacy, anxiety and depression and fear of the future for both the individual and his family (Ashworth and Rose, 1973).

STRESS IN CARDIAC CONDITIONS

Cardiac diseases may further create stress within the family for many reasons that can be summarized as uncertainty. They may alter the relationships between an individual and his or her children and spouse (Croog and Fitzgerald, 1978) with accompanying fear and possible awareness of impending mortality. Croog and Fitzgerald attempted to correlate the stability of the marriage relations with the ability to cope with life-crisis problems through application of the Subjective Stress Scale (1978). Levels of subjective stress were measured in the wives of cardiac patients at three time points over time.

It was discovered that the level of stress

remained constant over time from individual to individual. There did exist a slight increase overall in the stress mean from the period of the first interview (measurement) which was pre-myocardial infarction, to the third and final interview (Croog and Fitzgerald, 1978). The level of illness in husbands did not directly correlate with stress levels in their wives; however, other factors did (education, ethnicity, marital happiness). Furthermore, it was also discovered that the subjective stress level was more frequently associated with personality orientation and capacity for coping then with anything else. This may be a function of education and/or understanding, which in itself is dependent upon effective communication, both between spouses and between patient and professional.

What appears to be involved in Croog and Fitzgerald's study is the establishment of some form of positive interpersonal communication between all parties - or the failure to establish such communication. Effective communication will enable the patient (and those close to the patient) and the professional to enter into the treatment situation in such a way that the fear that is associated with the unknown, uncertain nature of the patient's condition may be modified or alleviated.

LABELLING AND BEHAVIOUR

The "labelling" of a problem may encourage the individual to act according to the label applied to him or her. There are socio/cultural parameters that influence the notion of "illness" both for the patient and for the society at large (see, for example, Foster and Anderson, 1978: 33-47, Jones, 1982). Prevailing models for causality of disease will be found within the belief system operative in a society at a specific time and so norms will dictate the form and nature of an acceptable rationale concerning disease. Certain norms will be prescriptive, in that pressure will be placed upon the individual to conform with normative expectations - deviance meeting with disapproval. Descriptive norms circumscribe the correct behaviour typical within a cultural group. This is what Murphy described as the "behavioural and the normative" aspects within culture (1971). The synthesis of the two working in conjunction determines the observable behaviour of an individual.

All of this is crucially important if we take the premise that "illness" (defined by Zola as the presence of clinically serious signs) is the "statistical norm" (Zola, 1966), and not the infrequent, abnormal phenomenom usually associated with the term. If this is the case, then it is possible to assume that there are other factors operating upon what is, and is not, conceived of

as an "illness". This in turn goes back to how the problem is defined: first by the actual prevalence of the situation, and, second, by dealing with the degree of congruence between the situation and the "value-orientations" within a culture (Zola, 1966).

The fit of the condition with the norms of the society will also determine the amount of attention which is deemed appropriate for the situation; what is ascribed by that culture to the Parsonian "sick role". The degree of cognition may then be traced to the prevailing norm of acceptability of behaviour (Zola, 1966). This will also have ramifications upon the etiology to which the individual ascribes the specific condition. This is a defense mechanism, in that it is adaptive for the individual to behave in the prescribed manner. By extension it is possible to consider the etiology for illness that is described by the society's norms to be "culture bound".

The above factors are all operative upon the expectations of illness available to patients. Expectations become implicated at every stage of the disease process (Jones, 1982), and may be thought of as the interaction of the cognitive domain with various physiological factors which in turn generate an acceptable, workable theory of disease (Schachter, 1964). Schachter's proposition principally involves the

experience by the individual of an altered physiological state, followed by the presence or absence of an explanation (presumably one appropriate to the norms of the society). From defining oneself as ill through the diagnostic process, the expectations regarding the form and nature of the condition will act upon the individual: "...the hypothesis underlying the model is that social psychological stimuli, which include expectations, can act as stressors that, in predisposed individuals, may lead to disease."(Jones, 1982). Therefore, the perceived ability to cope is implicated in the manner with which the individual involved may reduce the deleterious effects of the stress inherent in the condition itself.

The family can become involved in this process through their interaction with the patient during the illness and their involvement partly stems from aiding in the motivation of the patient. By far the most influential factor is the normative effect that the family can have upon the patient. The effect may be enabling or inhibitive but will affect the compliance of the patient through: (a) pressures to conform (or not to conform) to the requirements of the regimen; (b) interspouse communication and concordance on the necessity of the treatment; (c) attitudes and/or behaviours of one family member as a role model for the patient (Becker and Green, 1975).

The attitudes and beliefs that the patient has held during his lifetime will act together with the information received and allow the patient to formulate a personalistic (individual) theory concerning the nature of the condition (Hall, 1982). This personalistic theory will be a determinant in the nature of the health care sought, if the theory allows for the pursuit of medical treatment at all. Seeking help depends upon the perception of the individual's theory, and how it relates to the treatments, conventional or alternative, which are viewed as being available, and viable. Thus, the care of the patient should involve not only relief from pain but also from the stress imposed through the pain, or through its perception (Ray, 1982). Care in the treatment situation involves more than just the treatment of symptoms.

PAIN AND (DIS)STRESS

The patient in pain can be thought of as having to cope in three major areas (Blackman, 1982). First is the perception of the lack of control, second the lack of any concrete definition of what they are experiencing, and third is the unknown quality of the what is happening to them: "the pain is unbearable, and no one seems to understand" (Blackman, 1982). In order that they may

gain some control over what is happening to them, the individual searches for additional treatment, alteration of outside social activities, and so on. This is an obvious exhibition of what Sternbach refered to as a "disturbed life pattern" (1974).

Pain lends credence to an illness, and gives the professional a focus for treatment. However, with the chronic patient, there may be a tendency for those surrounding the patient to suspect that the pain actually lacks an organic basis (Sternbach, 1968). This, in association with the patient attempting to exert control over his or her fate and expressing this through becoming increasingly aggressive toward health care workers, can create a ready environment for the label of "difficult patient", or non-compliance. The end result is an increasing atmosphere of tension and distrust between the professional and the patient, and this too can act as a stressor on the patient.

The term "stress" here is problematic. "Stress" may be thought of as simply a "compelling force" (Oxford Dictionary, 1964). A better term to apply would be "distress" from the pressure exerted by pain, sorrow, fear, and frustration, because it gives a greater feeling of the anguish that can accompany what we normally and conveniently label "stress".

This leads back again to the expectations that

both the professional and the patient bring to the diagnostic process. Within the interview situation, Kassirer and Gorry (1978) indicate that the practitioner generates a hypothesis (expectation) about the status of the patient's illness relatively early in the situation. If there is concordance between the patient and physician as to the import of the symptoms in relation to feasible complaints, then the diagnostic interview will lend ease and accuracy to the communication within the treatment situation. However, if there is a difference in the attributes given to the sensations and symptoms by both the professional and patient, then the tendency is for the professional to use the initial hypothesis to move the interview tangentially away from the patient's experiences (Jones, 1982).

COMPLIANCE AND COMMUNICATION IN PATIENT/PROFESSIONAL INTERACTION

Problem-oriented patient/professional communication studies have lead to the recent development of numerous social theories concerning patient/professional relationships. Parsons' early model (1951) involves the development of the "sick role". The intervention strategy associated with the Parsonian model mainly deals with those disruptions that prevent the individual from fulfilling obligations associated with

social life: "Illness may be treated as a mode of response to social pressures, among other things, as one way of evading social responsibilities"(Parsons, 1951).

Parsons focused on the patient's validation of the relinquishment of his social obligations through contact with the health care professional. He further asserted that seeking exemption was not only the right of any individual, but actually an obligation within the social system. Others (notably Mechanic, 1968, 1972, Freidson, 1975) have focused on the adaptive behaviour of the patient with regard to the disease and illness condition (Mechanic, 1968, 1978), and on the control that the professional has over the patient and his role in social life (Freidson, 1975).

What dominates theories surrounding patient/professional interaction is the impact with which two varying world views concerning disease and acceptable behaviour may have upon the suffering individual. The whole issue of communication becomes literally a matter of "life and death" when viewed in this general way. The level and degree of communication can either encourage or inhibit the acceptability of any information passing between the patient and the professional. This also has important ramifications for the behaviour of an individual in the health care situation. If trust and respect have been established, treatment will proceed

naturally. However, once a breakdown has started, the acceptability of the situation diminishes: indeed, it can exacerbate the patient's condition.

Compliance with a regimen of treatment is an indicator of the acceptability of the treatment plan to the patient (Speigel and Backhaut, 1980). Davis (1971) studied the question of acceptability in terms of patient's compliance with the physician's directives, emphasizing doctor-patient interaction and discovered that the degree of compliance was associated with patient agreement and the release of tension in the situation. These were found to have a positive relationship in that the more orientation given by the professional, the more likely there would be agreement (compliance) in the patient. Conversely, rejection by the patient (non-communication) tended to exacerbate the situation leading to noncompliant behaviour.

Komaroff (1976) gave a listing of six factors that determine the compliance of the individual: (1) social characteristics of the patients, including education; (2) patient personality, such as hostility to authority; (3) patient understanding of illness; (4) patient understanding of the treatment; (5) patient/professional relationship; (6) professional attitudes (cited in Speigel and Backhaut, 1980). All six factors can be seen to be dependent upon some form of

positive communication between the patient and the professional (of the form described by Davis, 1971). All six are also reactive to the measure of the patient's acceptance of the treatment plan which has been formulated from contact with the professional.

There appears to be no one single general theory from which the analysis of compliance may be instigated: people are too individualistic, and unpredictable for this. One possible method was suggested by Becker and Maiman (1975) whereby attempts to explain the behaviour of the individual in the health care setting might best draw upon "'value-expectancy' models, which try to describe behaviour or decision making under conditions of uncertainty" such as found in an acute care situation.

The theory of motivation, which Becker and Maiman draw mainly from the work of Lewin (1935), has been utilized to create the Health Belief Model (HBM) with which to predict compliance with preventive health recommendations. The model involves three essential elements: (1) the individual's subjective state in being prepared to instigate action, (2) the individual's evaluation of the advocated behaviour, and (3) the stimulus that will initiate the appropriate health behaviour. Becker and Maiman suggest that if the HBM provides a satisfactory explanation in the realm of preventive behaviour, it should be possible to extend the

model to those patients with prescribed therapies who are ill(1975).

The HBM should then be able to determine compliance among the ill through the individual's perception of severity of the condition, his or her susceptibility, and various benefits and costs (Becker and Maiman, 1975). There are factors which also modify the perception of the individual (patient/professional relationship, physician continuity, social influence/pressure, demographic and personality) that Becker and Maiman felt where obtainable through the use of a questionnaire (Becker and Maiman, 1975: 20-21).

Though the model presented by Becker and Maiman is viable as an orientation for the instigation of research, the format of a questionnaire by its very nature determines the response. The questions put forward limit the kinds of answers received. Moreover, it is possible that the answers could be significantly different through the posing of differently phrased questions. Factors that influence and may predict the individual's response are highly personal and individual, and to that extent are perhaps best delineated through an interview procedure, or participant observation.

The disengaged approach of questionnaires has been well documented in the literature and typifies the approach used in the past by some professionals, namely,

the determination of patient status based upon minimal interaction.

A Medical World News article described indicators of the non-compliant patient (no author cited, April 21, 1972). The title of the article itself ("Why Patients Don't Follow Orders") is indicative of the impact and control over the patient that is part of the patient/professional relationship as seen by professionals. A 1972 questionnaire by the American Academy of Family Physicians contained the question "What is the single most annoying thing patients do (aside from not paying their bills on time)?"(Medical World News, April 21, 1972). Some 33% of respondents asserted what were described as various noncompliant categories.

Blackwell (1973), in describing patient compliance with drug therapy, relayed the feeling that it was not possible to expect, nor even hope for, compliance in the patient: "Every patient is a potential defaulter; compliance can never be assumed". Moreover, the actual illness itself could be utilized as an indicator, in that "when relapse is immediate or severe (as with heart failure) the patient is less likely to deviate"(Blackwell, 1973).

Not surprisingly, Blackwell found that "poor compliance occurs more often in those who are less well educated, are poorer or have language difficulties",

whereas, by way of a contrast, "a study of minor tranquilizer use showed that good compliance was associated with being middle class, well educated and white"(Blackwell, 1973). It may have been possibe to indicate through the use of a personality test to determine the "at-risk" patient (such as those who are immature)(Blackwell, 1973).

Unfortunately, Blackwell's formulation of the problem of non-compliance does not assume that it is the patient's reality with which one has to deal in order to formulate effective treatment. Blackwell does point out the necessary components for the prevention of noncompliance: recognition of the "at-risk" patient, thoughtful treatment planning, and proper explanation to the patient (Blackwell, 1973). However, these latter components are not simple items in themselves and might better be addressed via understanding patient realities than by merely predicting variable outcome.

What the literature represents is the attitude that the professional may bring to the interview situation. Patients, if viewed as "annoying" and as potential noncompliants will not be receptive to the exchange of information that is so vital in the health care situation. What keeps recurring as a theme is the relevance of effective communication; communication, however, is not the topic of the studies themselves.

The patient/professional relationship is based upon three kinds of interaction: 1) instrumental--the application of the professional's skills, 2) expressive--dealing with the emotions created by the situation, and 3) communication (Vuori, et al, 1972). Following the instructions of the professional is seen as primarily a function of communication. However, it was shown that often the interaction follows the format of the first two variables while neglecting the third, communication.

The interrelationship of the professional and the patient was examined through the inferential nature of the subjective nature of the patient's experiences (see Vuori, et al, 1972). "These experiences need not correspond with objective reality; they influence, however, the patients' satisfaction with the doctor-patient relationship and their willingness to continue and renew it." (Vuori, et al, 1972). The older, or less educated, the patient was, the more difficulty they encountered in understanding the terminology used by professionals. This affects the quality of interaction, and places the doctor's competence at risk in terms of the patient. The failure of effective communication increases the unwillingness of the patient to encounter the same situation again and so increases the chance of noncompliance.

The effective level of communication, or its format, thereby implicates the power relationship into which the patient and professional enter. McKinlay (1975) sought to show the relationship that language, as access to understanding, had in the health care setting. By studying those medical terms that fall between common usage and incomprehensibility, it was hoped to formulate a range that would typify the "grey zone" of misunderstanding.

Part of the situation involves the health care worker's concept of the patient's level of information, assessing "(a) what the patients level of information should be, and (b) what they thought the patients actual level of information was" (McKinlay, 1975). It was discovered that physicians consistently misjudge the level of word comprehension amongst lower or working-class respondents.

There are four plausible explanations why this barrier to effective communication may exist. First, limited communication keeps the interaction with the patient at the strictly instrumental level, and in line with the functioning of the hospital. Second, not informing patients about the nature of their illness will prevent the personnel from "unmanageable" reactions from those individuals who may not "understand". Third, it prevents the possibility of any emotional interference

wih the patient's capability for recovery. Fourth, the less information given to patients, the less chance of the patient discovering errors and incompetence in the work of the health care worker (Skipper et al, 1964).

COMPLIANCE AND THE LOCUS OF POWER

It is evident that the communicative nature of the patient/professional relationship has a function in maintaining power in the structure of modern medicine. Power affects the labelling of the noncompliant or "bad" patient, who is perceived as a threat to the power structure of the medical community and its practitioners. Mystification via language and preservation of a valid role for the practitioner in terms of intervention in another life are part and parcel of power and the "locus of control" in therapy.

The treatment of the patient as a non-person is a process by which the health care worker reduces the sense of autonomy in the individual in order to achieve the results that will "clearly benefit the patient" (Lorber, 1975). Just what part this plays in validating the care role lies unexamined. The process, initiated through the categorization of the patients for the busy health care worker's convenience, minimizes the potential for the individual to create discord: "The chief method for minimizing the potentiality of patient to make trouble

for doctors and nurses by criticizing their work is to withhold information, so the patient cannot argue from adequate knowledge"(Lorber, 1975). Somewhat ironically, it is just this practice that creates some "non-compliant" patients.

The labelling of the patient as deviant by the staff sometimes creates a situation wherein the patient is not willing to accept the power structure and becomes "bad", with the result of inadequate care (Lorber, 1975). The bad patient does of course obstruct work, and the good patient also facilitates work (even though the work is to benefit the patient).

Lorber points out that the most frequent method for dealing with complaints in clinical settings is the use of sedative or narcotic drugs (1975). This is followed by other methods that are less frequent: talking to patients, physical methods, and mechanical devices. The less favoured methods take more time to administer than the use of drugs once every few hours, which was the favoured method by 69% of personnel in the study (Lorber, 1975). By using sedatives to regulate the emotional state and cognitive awareness of the patient, the power structure is reaffirmed. For the patient, the label of "noncompliant" will create a stigma that will further jeopardize any future interaction with the health community. In order that he may be effectively treated,

the patient must forego autonomy to the established power structure, or suffer the consequences: he must be powerless to be compliant; he is expected to be powerless and yet recover.

The disposition of power in the relationship between the professional and the patient allows the chronically ill patient to be categorized in terms of several psychological reactions to the ill condition (Miller, 1983). The prevalent theme among these psychological reactions is the lack of control that the condition often exacerbates, and that by encouraging and enhancing the patient's power and respective control, one will facilitate the coping with the chronic condition. Much of this revolves around the resources that can be mobilized in the patient (physical strength, belief structure, motivation, self-concept) (Miller, 1983).

A classic double bind is created from two conflicting sets of assumptions: to be compliant the patient must relinquish control and to get well the patient must take control. The nexus of power is therefore the problematic theme of patient/professional communication.

Hellenbrand (1983) discussed part of the impact of powerlessness in terms of noncompliance. Several of the variables associated with the concept of powerlessness revolve around security, illness-health

attitudes, the complexity of self-care, and patient knowledge and control. Many of these are functions of the communicative nature of the health care situation. The complexity of various therapeutic regimens may be negatively correlated with the degree of compliance (Hellenbrand, 1983). This is associated with the patient's knowledge and control over his or her state of being. This further relates to the previously mentioned Health Belief Model, the norms and values within which the individual operates. Everything discussed to this point is part of the expressive nature of communication: the transmitting of information that allows the individual to formulate coherent beliefs and conceptions concerning his or her situation.

The impact of therapeutic communication upon the behaviour of patients is evident in their compliance with the instructions of the professionals and can be constrained through the manipulation of many variables which determine the form of interaction that takes place. Power will alternately focus in one "corner" or the other, thereby significantly altering the interactive nature of the treatment situation. In the worst possible scenario power may become the source of a double bind that defines the patients as bad whatever they may do.

ALLEVIATING POWERLESSNESS

Pfister-Minogue (1983) describes the alleviation of the powerlessness within the situation as dependent upon the mobilization of the patient's power resources - those of knowledge and motivation. Unfortunately, patient education has only been defined in terms of the provision of the information. There has been little attention paid to the actual comprehension and understanding of information by patients. The behaviour of the patient will be constricted through the corpus of data from which they have to draw in formulating a framework of action; they can only make an informed decision based on the information at hand.

In this model, if learning, as a function of information and education, is defined as the change or modification of a form of behaviour, then evidence for the lack of learning can be in the manner in which patients choose whether or not to follow instructions. The rate of noncompliance is determined by the degree of comprehension of the patient who is, effectively, being acculturated.

Perhaps the best way to ensure that the patient is fully cognizant of the treatment process is to develop a model by which the individual is able to interact positively within the context of his or her condition (Pfister-Minogue, 1983). The patient must be motivated toward a particular goal, and the patient must also be

able to estimate the degree to which the particular action taken will result in the achievement of his or her goal, but it must be his or her own goal. Cardiac disease decrease one's power as a function of the condition itself, therefore any therapeutic regimen that decreases patient power while simultaneously suggesting it should be increased will prove to be confusing and ultimately iatrogenic.

To conclude, noncompliance, especially in cardiac patients, may be a function of the understanding of the condition by the patient. The noncompliant patient may not be educated, or informed enough to ensure that he or she will make a reasonable decision concerning his or her treatment. Access to information, or the lack of information, may be indicative of the power relationships in which the patient and pratitioner are enmeshed. This is indicative of the locus of control, or power, in the treatment situation. By an increased awareness or sensitivity to the delicate nature of the relationship, the misunderstanding and misapprehension that may govern the behaviour of both the patient and professional, may be lessened and hopefully eliminated along with the condition that brought them together in the first place.

CHAPTER THREE

BRIEF THERAPY AS THEORETICAL FRAMEWORK

Studying problems in a clinical setting requires the use of as many varied strategies and theories as there are patients. The preceding chapter demonstrated that if one is to study the interaction between the health care professional and the patient, and particularly the manner in which the patient is using the information gained from that encounter, one is studying communication.

This chapter deals with the analysis of clinical situations through strategies derived from certain family therapies, called strategic or 'brief' therapy (Watzlawick, et al, 1967, Haley, 1976, Selvini-Palazzoli, et al, 1978). I will attempt to show how, in the interaction between the professionals and the patients, the patients who cannot use the information at their disposal, for their own benefit, or the patients who rejects such information as irrelevant given their own explanatory model (EM), may be labelled 'non-compliant' in a self-perpetuating system.

Non-compliance may involve, at the least a single contradiction, and at most a paradox in the interaction of the EM of the patient and the professional. It is discord between the BMM and the EM that creates the state

of contradiction that I am interested in analyzing. Brief therapies provide a framework of suggestions that deal with contradiction in general. Therefore paradox, as used here, places greater emphasis on the situational aspects of the problem.

I hope to show that non-compliance is based on communication in a manner beyond that which was described in the preceding chapter. The problem of patient compliance inolves not only discord between patient and professional, but the contradiction between the two 'world views' serves only to exacerbate the situation.

PATHOLOGICAL BEHAVIOUR AND DOUBLE-BINDS

The following is based upon the concept that repetitive sequences of behaviour (the 'embedding' of behaviour through reinforcement from the repetitive nature of the behaviour) will define the operational hierarchies. It is the interaction of systems theory and hierarchy (Haley, 1976: 123). The hierarchy is moulded by the behaviour of the individuals involved; it is positively reinforced through the repetition and redundancy of the action. This creates a "governed system that is error-activated in that deviance activates a governing process. If the person deviates from the repeating behavior and so defines a different hierarchy, the others react against that deviation and shape the

behaviour back into the habitual pattern"(Haley, 1976: 124).

The concept described above is similar to my suggestion concerning compliance and coping behaviours. If the behaviour of the individual is such that it does not conform to the typical sick role (Parsons, 1951) the behaviour is viewed as 'deviant' and is thus discouraged. The typical role associated with an illness or disease will label the person with a preconceived set of behaviour patterns. The patient will act in accordance because it is adaptive for them to do so. If not, then the individual is non-compliant and by definition 'bad'. This is the 'pathological behaviour' based upon the paradox inherent in the situation:

> Pathological behavior appears when the repeating sequence simultaneously defines two opposite hierarchies, or when the hierarchy is unstable because the behaviour indicates one shape at one time and another shape at other times (Haley, 1976: 124).

OVERVIEW OF BRIEF THERAPIES

In the study of problems in a clinical setting, brief therapies have been adopted due to underlying assumptions that makes them applicable to the problem at hand. The patient who is non-compliant due to his or her disbelief in the medical model follows the basic assumption of brief therapies that problems "persist only if they are maintained by ongoing currrent behavior

of the patient and others with whom he interacts"(Weakland, et al. 1974: 145 emphasis in original). If the behaviour is changed or eliminated, the associated problem will be eliminated.

The main principles of brief therapies are (Weakland, et al. 1974):

1) the focus is on the symptom; the therapy as such is symptom oriented. The focus is on the situational problems, which occur as problems of interaction. The approach does not deal with multiple problems, but one specific problem with one goal in mind. The problems are thought of as the outcome of everyday 'life' difficulties. These are often due to the transition from one stage (such as health) to another (such as illness). Problems will develop through an over- or under-emphasis on these difficulties in living.

2) an emphasis on the difficulty presented as a 'problem' and thereby abhorrent and as something that is deviant, will only serve to exacerbate the situation. The feedback associated with this 'labelling' will amplify the original stimulus. In this manner problems become problems through repetition and redundancy in a positive feedback loop.

3) treatment of the problem is through the substitution of a new behaviour to interrupt the 'vicious cycle' of behaviour repetition. In this way, the therapy is a

pragmatic, or 'goal oriented' approach.

The reason for the use of a family therapy model in analyzing problems in a clinical setting is due to its emphasis upon the communicative interaction between individuals within a social network:

> A focus on communication and interaction within the family leads to much more emphasis on actual behaviors, what is observably going on in the present, rather than on the past, the internal, and the inferential (Fisch, et al. 1982: 8).

Importance is not placed on the inferred underlying factors behind the problem, but rather on "...identifying clearly the problem behavior--what it is, in what way it is seen as a problem, and by whom"(Fisch, et al. 1982: 12). The problem is exacerbated through the reinforcement of the behaviour that is "continually being shaped and maintained (or changed) primarily by ongoing reinforcements in the particular behaving individual's system of social interaction"(Fisch, et al. 1982: 12).

Brief therapies arose in the mid-1960's based on the work of Gregory Bateson and Milton Erickson in the 1950's who began a shift away from the study of individuals in isolation from others. What they initiated was a study of the individual as interacting in a social network: "The problem is no longer how to characterize and classify these individuals; it is how to describe and classify the habitual patterns of responsive

behavior exchanged by intimates"(Haley, 1977: 33).

The problem is a function of the individuals operating as a system within a system. Behaviour is understood as a series of linked inter-relationships based upon the exchange and interpretation of messages, in this case in the form of behaviour. The impact of the social orientation, or the norms, modify the value-system with which the individual encodes his world. If behaviour is idiosyncratic, and an example of social interaction, then non-compliance, as pathological behaviour in a clinical setting, should be thought of as a systemic interaction as well.

Brief therapies are useful in a practical sense. The model deals with behaviour: "All purposive human behavior depends greatly on the views or premises people hold, which govern their interpretation of situations, events, and relationships"(Fisch, et al. 1982: 5). There are limitations to the application of a theoretical model in any practical format because:

> ehavior...We do not see theory as necessarily something elaborate, complex or final...but, rather, as only a set of relatively general ideas or views that are useful in integrating particulars of observation and action in a systematic and comprehensible way (Fisch, et al. 1982: 6).

The description above is the premise behind the theoretical model drawn from brief therapies. The model

given in this chapter is one that allows for the interaction of the theory and the data; the theory should fit the data, not the reverse:

> One cannot meet challenges to understanding social behavior by systematically excluding from consideration significant behavioral variables because they cannot be sufficiently controlled within a theoretical system offered by one particular segment of the anthropological discipline (DeVos, 1975: 77-78).

In this manner, the application of brief therapies in a clinical model will involve using those portions of the major approaches that are best suited for the task at hand. The framework will be made from the strategies of the Mental Research Institute (MRI), the work of Jay Haley, and the work of the Milan associates. The goal is to use the strategies described here as a general guide for analysis of problems in a clinical setting.

Brief therapies are used here as an analytical mode of inquiry. It was felt that the models offered a possible method by which dysfunction in the treatment situation could be examined. The emphasis upon a single problem that has its basis in contradiction, coupled with the nature of the dysfunction was felt to be representative of the problem of non-compliance. Brief therapies do offer a strategy to alleviate the problem. However, the present researcher is unqualified to apply

the theories in this manner. Therefore, in terms of the 'pilot study' in hand, brief therapies remain an analytical tool.

MODEL FOR THE STUDY OF COMPLIANCE

Communication

Obviously there is a close relationship between the behaviour and communication of an individual, "...a recognition that the most important aspect of social behaviour is its communicative effect and that communication is the major factor in the ordering of behavior socially"(Weakland, 1974: 274). Each behavioural act invokes meaning systems, those of the 'sender' and those of the receiver. Each deals with the messages through his or her own code prescribed by his or her own value/meaning systems. The sender is relaying messages of meaning that are produced as the observable end-products of the code.

The message is transmitted and interpreted by the receiver through the filter of their own meaning system. The form of transmission in this case is the behaviour of the individual(s) involved. In this manner, the interaction of the behaviour of individuals may operate in the manner of a 'system'-- a view of communcation as "pervasively and basically interactional-as a system, in which uni-directional attributions and various

punctuation occur but in which these (even our own) should be seen only as aspects of the larger system"(Weakland, 1974: 274). This is the general pattern of communication, the exchange of 'messages' and information which are interpreted and modified by those involved in the interaction.

The interaction of behaviour and communication as an explanatory model is therefore based upon a concept of function. The meaning involved is a variable only in the way in which it interacts with other variables (Watzlawick, et al. 1967: 24). The interaction is based upon the dynamics involved in the transference of information and subsequent feedback. This feedback may be negative (homeostatic) or positive (leading to change). Therefore it is the 'content' of the message that influences behaviour in the interaction between individuals.

Interaction as System

The model of interaction used here is loosely based upon General Systems theory (Watzlawick, et al. 1967: 119). Simply stated, the theory is that everything operates in a system and that each system is comprised of two basic contradictions: the drive toward homeostasis and the capacity for change (Selvini Palazzoli, et al. 1978: 4). It is the focus on a set

of objects, together with the relationships between the objects, and between the attributes of the objects.

The interaction is the process of two individuals defining the nature of their relationship. This involves a shift in the emphasis on the individual as a unit onto the individual as part of a social unit of interaction (Haley, 1976). The interaction is limited. Each exchange of messages in sequence further limits the number and direction of possible interactional sequences that may follow. This is the way in which the feedback is incorporated into the interaction and behaviour. Each exchange reinforces that which has all ready gone before.

By including the interaction of the researcher in the situation, the focus is shifted from the symptom as 'irrational' and idiosyncratic, that it is a "one-person phenomenon"(Haley, 1976: 10). In viewing the symptom as a 'handicap', the therapeutic problem seems to be able to reasonably solved through the interview of one person. "Symptoms, or problems, were considered to be maladaptive and inappropriate. Therefore, there was no reason to bring in more than the one person who was being maladaptive"(Haley, 1976: 10).

If the presenting symptom is a response by the individual to the nature or condition of his interaction in his environment, then the researcher must consider the environment as a system. To better understand the manner

in which the individual formulates the symptom, one must delve into the organization, the symptoms in 'context'(Haley, 1976: 11). In doing so, the dichotomy between the individual and the 'others' disappears, and one is left with the fusion of the individual, and the researcher, into a system of interaction.

This interaction is based upon communication as a reciprocal process. It is human interaction in which the communication is analogous to that which is observable in the interaction, the behaviour of the individuals. It revolves around the process whereby the individuals act and react to the 'message' content of behaviour - the "behavioural effects of human interaction" (Watzlawick and Beavin, 1977: 57).

NON-COMPLIANCE AS PRAGMATIC PARADOX

Paradox is "a contradiction that follows correct deduction from consistent premises"(Watzlawick, et al. 1967: 188). The paradoxes are pragmatic in that they will affect the interaction of the individuals, and thereby behaviour. Moreover, the effects can ramify to challenge the concepts and 'world views' of the individuals.

There are three ingredients to paradoxical injunctions (Watzlawick, et al. 1967: 194):

1) that there is a complementary relationship between the

individuals, often with one assuming an superordinate, and the other a subordinate role, (for example that of patient and professional),

2) an injunction is given that must be obeyed, but must be disobeyed first to be obeyed,

3) the person involved in the subordinate position cannot step outside the frame and thereby dissolve the paradox by commenting on it. This equals insubordination and creates an untenable position for the individual.

This pattern fits that of the doctor-patient interaction and the problem of non-compliance in the treatment situation. The individuals are in a complementary relationship as in (1) above, and if the explanatory models cannot come into accordance, then the patient is placed in a position of contradiction (2), and if the patient seeks to change the situation, they become non-compliant (3).

This is the "double-bind" as an effect of pragmatic paradox, where the discord in the interaction will affect the individual's relationship with others in the system, and may eventually reflect back in their relationship with the individual. Where the double-bind is of some duration or chronic, a situation is created that affects the expectations on the nature of the relationship and the world view. This does not require further reinforcement and may develop into a

self-perpetuating pattern of interaction and communication.

If a patient initiates a behaviour that is labelled as non-compliant due to a lack of effective communication between him and the practitioner, and then has the behaviour 'reinforced' by further lack of communication taken in an attempt to rectify the situation, a pattern is created that will further enhance the problem. The patient, in following the norms of his own idiosyncratic EM, chooses to disregard the directions of the physician, will only make the dilemma worse by being labelled 'non-compliant' and treated as such. The paradox is that the patient is doing what he knows is best according to his EM; as is the physician.

Example 1:

> The patient [case two (chapter five)] spent much of the interview seeming to rationalize to the researcher why he could not follow the programme as designated. He expressed a contradiction over how important the rehabilitation programme is, but why he could not follow it:
>
> [patient] Well, I do more than I'm supposed to, and you know, you can't help that. My wife gets after me all the time. But you know you're always doing things you're not supposed to...be lifting and that [indicating large pile of boxes that he was in the process of moving], but...you've got to keep going, y'know?
> [Sean] Do you think it's important to follow [the programme] right down the middle?
> [patient] No, I think it's

> important. I think if you can that that's what you should do 'cause I think that they've come up with their particular theory and procedures after a lot of research and so on. I think that they know what they're talking about, y'know. It's just that I find it very difficult to do that.

In this thesis, examined from an 'emic' perspective, the behaviour of the individual is not 'irrational' or even neccessarily pathological. It is his or her behaviour in response to situations through the application of his or her own beliefs and value systems. It is simply his or her reality.

The behaviour is reduced to those items that are at its most fundamental; not the most striking or dramatic, but those items that are a regular and general feature of the interrelationship. The behaviour is then reduced from the abstract negative position of aberrance, to the level of the ordinary. The behaviour of the individual <u>is</u> his or her behaviour; it is the manner in which he or she interacts.

<u>Symptom as Metaphor</u>

The activities, conscious or unconscious, in which the individual engages may be thought of as a metaphor of that person's life. These 'bits' or their sum, will be imaginatively descriptive of the individual's life. The action may not be specifically

applicable to the frame of 'metaphor', but its impact as analogous or representative of another state supports the notion of metaphor.

We may take the symptoms of a condition as a metaphor, not of the disease, but of the illness. On the basis that the perception of 'illness' is a cognitive one, and metaphor is derived from the individual's EM, and ultimately from the norms of the society. It is not the disease etiology, but the perception of the condition. The symptom, as representative of the specific illness concept, is analogous to the impact of the illness problems on the individuals life. These illness problems are simply stated the manner in which the illness permeates, or disrupts, the domestic life of the patient.

The brief therapies emphasize the analogy between the problem of the individual and the 'cause' of the patient's presentations. The 'family-oriented', or systems oriented, researcher will look on the presented problem as conditional and contextual: "...he will assume that the patient's statement about his heart is analogic to his current situation"(Haley, 1976: 91). The emphasis is on the manner in which the analogy presented, here considered as symptomatic, is incorporated into a person's meaning and value system. This in turn will play upon the interactive processes in

the individual's social interpersonal network.

The Nature of Dysfunction

What has been presented is a model of brief therapies as applicable to the study of non-compliance in a clinical setting. The format given here is derived from an assortment of different approaches to family therapy; essentially operating through three major models (Mackinnon, 1983: 425):

1) brief therapy - following the model presented by Watzlawick, Weakland, ad others associated with the MRI (Mental Research Institute, Palo Alto, California),

2) problem-solving therapy - principally taken from the work of J. Haley (see Haley, 1976),

3) the work of the Milan associates (see Selvini-Palazzoli, et al. 1978).

Each of these models presented a framework that fits research needs in a clinical setting. The models emphasize a focus on one present problem, any planned interventions will be on this focus, and they use paradoxical strategies.

Brief therapy, as in the Milan model, is systemic in looking at the interactive process. The dysfunction occurs "at points of natural transformation when the system is unable to make the leap to a new way of functioning"(Mackinnon, 1983: 430). However, in brief

therapy the symptomatic behaviour is cyclical, and not circular as with the Milan model. Where the Milan model emphasizes the homeostatic nature of the system especially in terms of a family epistemology, brief therapies suggest that a wrong solution, if taken, will emphasize the difficulties and exacerbate the problem in a self-reinforcing cycle. It is the wrong solutions, the over- or under-emphasis on the difficulties the individual is experiencing that creates the dysfunction.

Problem-solving therapy looks at behaviour of a repetitive sequence and is symptomatic of the condition. The hierarchy is inferred by noting the behaviour involved in the exchange of information. The symptom is conceived of as a metaphor connected to interpersonal interaction in a current context. Because of the emphasis on hierarchy and information exchange, this approach is useful in looking at responses to power or powerlessness in a clinical setting.

Therefore, three main approaches were utilized to model the nature of dysfunction given here. This thesis focused primarily on an individual's attempt at a wrong solution as means to improvement and the response of the individual to the hierarchy found in clinical settings.

SUMMARY

It has been my hope to show that in a study of

the compliance of a patient, that a model derived from brief therapies would be the most successful. If non-compliance is based upon the disassociation, or non-accordance, of the EMs of the patient and practitioner, we are describing a situation based upon the ineffective exchange of information. Communication, or more precisely effective communication (being the successful exchange of information), is the format for study. If the communication is ineffective, and it goes further to exacerbate the very condition it is to help alleviate, then a seeming paradox is involved. It is my hope that the model presented here will allow for an efficient study of this contradiction, and perhaps lead to more effective treatment.

CHAPTER FOUR

CONCEPTS AND METHODS IN CLINICAL ANTHROPOLOGY

It has often been suggested that there is a need for a behavioural science perspective in the approach to the various problems found in clinical settings (Weidman and Egeland, 1973). The perspective needed is a comparative approach that will integrate the differences in "life-style", or world view, between the patient and the health care professional. The ultimate goal is improved treatment and delivery of health care services to the patient:

> sis as more than a question of availability and efficiency. It is more than the rendering of services in a medical context...the common spirit of the behavioral perspective is to protect the differing value profiles of all participants in the caring process and hence to demonstrate that it is the caring, in a human context, that is the central issue (Weidman and Egeland, 1973).

In this chapter I will describe the various strategies and methods that have been suggested for application in a clinical setting. I hope to produce a broad framework for the social science approach in a clinical environment and to show how this study fits into that framework. Part of this will be based upon the coping strategies used by the patient in the clinical setting, and how these may influence their compliance.

As a side note, the term "compliance" is value laden and may lead to judgemental interpretations. Other terms (accordance, or adoptive/non-adoptive) may be better. However, the term "compliance" is used here because it is found in the literature and has widespread use among clinicians.

The patient's coping strategies will determine the nature of the clinical strategies based upon the communicative nature of the patient/professional interaction itself. These strategies may then be formalized through the traditional anthropological tools used to elicit data.

Good and Good described a meaning-centred approach to understanding clinical practice in the translation of the findings made by a social science into models that may be used by the clinician and for medical education (1981: 166). This meaning-centred approach utilizes language and symbolic systems to provide a framework for interactive process analysis. Both language and symbolic systems, as representative of belief systems, provide an entrance into the communicative nature of the treatment process.

THE PATIENT/PROFESSIONAL INTERACTION AND COMMUNICATION

Communication is the transference of information from one individual to another. The information is

intrinsically associated with the meaning system which each of the individuals involved is using. Each individual is describing what is essentially their own world view based upon their own reality.

In a clinical setting, this can best be understood by making a rigourous distinction between diseases and illnesses. Diseases are of a fairly fundamental and pragmatic nature involving the etiologies of the specific conditions. Illnesses are derived from the value and meaning system of the individual. As such they are essentially "semantic" (Good and Good, 1981: 167). Illnesses involve a human experience that may not necessarily have a biological or pathological correlate: "All illness realities are meaningfully constituted. Explanatory models and networks of meanings, grounded in medical subculture, are employed in all medical systems to construct and interpret experience"(Good and Good, 1981: 167).

In this manner, a framework for the study of clinical transactions and interactions must maintain awareness of the values placed upon the symptoms as described: "...a meaning-centered approach recognizes all clinical transactions to be fundamentally hermeneutic or interpretive"(Good and Good, 1981: 167). The meaning systems of the individuals involved, and the behaviour associated with these symbols, are culturally determined,

and will reflect in the interaction of the patient and professional (Mumford, 1977).

ILLNESS AS PARADIGM

We have been provided with a concept of an "illness behaviour" to use in the study of the response by individuals to situations that result in the lowering of their health status. Health in this instance may best be defined as the absence of clinical conditions. However, if we follow the premise described earlier that "illness" (defined as the presence of clinically serious signs) is a "statistical norm" (Zola, 1966) even in those members of the population considered healthy, then perhaps a better definition of "health" would be a successful adaptation to the presence of those clinical signs.

The situational perspective of this paradigm assumes that the social world is inherently unstable and subject to constant flux and change (Alonzo, 1984: 501). Given this world, the individual is constantly placed in the situation of creating responses to the constraints placed upon him, both physical and social. This interactionist perspective essentially ignores the disease etiology and creates as its focus "...the processes of disease definition and evaluation and their social consequences" (Alonzo, 1984: 500).

An illness paradigm provides a method through which the clinician is able to adjust the treatment situation to reflect more accurately the needs of the patient. The behavioural science approach gives the data from which this framework for interaction may be built. The behavioural, or social, researcher through concern over concepts rather than conditions, can provide a descriptive analysis of the patient's perspectives. This analysis would ultimately be applied for the betterment of the treatment situation.

COPING STRATEGIES IN PATIENTS

It was previously noted that the behaviour of the individuals involved in the treatment situation was constructed from the norms under which each individual was operating. This constructed (and constrained) behaviour is developed into the strategies that the patient employs to cope with the illness situation or condition. An understanding of these strategies is necessary if methods of eliciting data and later analysis are to be created. These strategies themselves will be based upon factors involved that are specific to each condition. As mentioned earlier, the following examples follow the aspects involved in coronary patients, or those suffering from CHD.

The psychiatric aspects of CHD are varied and

pervade all facets of the patient's life. These are made up of a number of different factors: social, psychological and physical (Newstadt, 1983). Psychological variables play a role to the extent that emotional stress due to fear, anxiety, anger, elation are all accompanied by a correlated change in the rate, rhythm, output and stroke of the heart (Newstadt, 1983: 201). Various life situations make burdensome demands of the body's ability to adapt (for example, psycholgical stress). Moreover, the actual clinical condition itself may exacerbate the situation through the addition of auxiliary stress and the development of anxiety and/or depression. As such, these may manifest themselves in coping strategies that are best described as "maladaptive" because they do not lend themselves to an alleviation of symptoms in the treatment situation itself. These may include psychiatric disorders, deviant illness behaviours, or disregard and denial of the illness and medical treatment (Newstadt, 1983: 202).

This pattern may carry over into the process of rehabilitation, when the patient is getting well. Rehabilitative patients have been described to have as their main problems the anxiety and depression often associated with recovery from the condition (Zimmerman and Vyden, 1983: 353). Zimmerman and Vyden further note that the psychological problems most often seen in the

coronary patient, in order of frequency are "anxiety, fear of sudden death, lack of confidence, loss of motivation, and fear of recurrent heart disease"(1983: 354).

All the responses relate to a common feature, that of the stress involved in the cardiac episode. The patient's reaction to the event will be reflective of the manner in which the patient deals with past and present conflicts in their domestic life: "The stress of adapting to coronary illness parallels the stresses each individual experiences at various stages in the person's early development"(Cowen, 1983: 403). The shock of the impact of the condition upon their lives requires the patient to respond by using the behaviours they rely on the most, those as determined by their meaning system. They respond in a manner that may be atypical, but never to themselves when viewed in terms of their own set of norms. The psychological aspects of myocardial infarction (MI) have long been described, such as those involving denial, repression of affect, displacement projection, and rationalization (Whipple, et al. 1972).

The strategies used by the patient are associated with the personal preferences of the patient in terms of their meaning systems. These strategies all focus on the ability of the individual to reduce the stress they are experiencing. The strategies involved are: action,

control, escape, interpersonal, fatalism and optimism (Viney and Westbrook, 1984: 490). Action strategies, such as information seeking, require active motivation upon the part of the patient. Control strategies alleviate the feeling of powerlessness, but are inflexible and do not allow for the expression of feeling. Escape strategies may take the form of avoidance or denial. Interpersonal strategies involve the patients social support network, and as such are much more flexible and centred in the patient's own reality, their domestic life. Fatalism and optimism may be viewed as two sides of the same world. In each case the patient is maintaining control over his internal world in those instances when they have no control over the external.

In their study of these various coping strategies in the face of chronic illness, Viney and Westbrook discovered that, in a clinical setting, coronary patients favoured optimism more often than patients of other clinical conditions (1984: 495). They also suggested that there may have been a difference in the preference of strategies stated by patients in a domestic rather than a clinical setting. Hospital patients as a whole were more optimistic and they attributed this to the environment (Viney and Westbrook, 1984: 495). Coping with CHD and recovery in the technological and medical world of the clinical setting was very different from

coping with a chronic illness in the domestic sphere.

COPING STRATEGIES AND COMPLIANCE

As can be seen, coping strategies influence the way in which patients respond to a prescribed method of treatment. This is widely defined as the patient's compliance and is fundamentally the degree to which a person's behaviour coincides with the medical advice given to them (Haynes, 1979: 2). As mentioned previously, this term is value-laden and so Haynes suggests in its place the use of "adherence" (Haynes, 1979). However, since the terminology is so firmly rooted in the literature its use will be maintained here. Furthermore, the use of such a connotative term may keep the ethical and social issues associated with it in plain view, and not hidden through the use of a more neutral or euphemistic term (Haynes, 1979: 2).

Compliance is a crucial aspect of the patient/professional interaction. The two variables involved (interaction and compliance) are difficult to measure (Hulka, 1979: 63). There is no clear cut method or measure against which the variables may be judged. In her study Hulka used several formats as measures of the professional/patient relationship: communication between physician and patient, physician awareness of patient concerns, and patient satisfaction. In some instances,

such as errors related to drug use, almost 60 per cent of the patients in the study were inclined toward errors of omission or mis-scheduling. This is a high degree of non-compliance if one considers the severity of the conditions Hulka studied (congestive heart failure and diabetes mellitus). The conclusion reached in her study indicated that effective communication of instructions and information was inversely correlated with errors in drug use; the better the information the lower the rate of drug error (Hulka, 1979: 76). This would seem to indicate that a methodology for study which was centred around the communicative nature of the interaction would be most effective.

EXPLANATORY MODELS FOR METHODOLOGY

To place all of the pieces together, the patient's (and professional's) perceptions will influence the behaviours that each will use in the treatment setting. These perceptions and associated behaviours, or the explanatory model (EM) will affect the compliance of the patients and the way in which they respond in the communicative setting of the care-giving interaction (see, for example, Becker et al. 1979, Becker, 1974).

The Health Belief Model places emphasis upon four variables involved in the maintainence of the individual's EM (Becker, et al. 1979: 78). These are

based upon the individual's perceptions of 1) their level of susceptibility, 2) the degree or severity of the consequences, 3) possible benefits in reducing the likelihood of the condition, and 4) barriers or costs related to taking action in seeking health care.

These strategies, and their impact upon the compliance of the patient, are centred in the beliefs and realities of the individuals involved. In the interactive process between the professional and the patient, each is commmunicating their model to the other through the medium of their behaviour. The strategies will prescribe the way the individual will cope, and how the health care professional will deal with them. Therefore, any methodology to study the situation must be based upon the examination of the principal factors involved, that is, examination of the exchange of information as communication of the explanatory model (EM).

If we accept these principles as the premise upon which the patient/professional interaction is based, we can then create explanatory models to focus on the problem. These models, or strategies, will involve the interpretation of behaviours, perceptions, beliefs in a framework that may then be applied clinically. These clinically applied strategies will translate the data gathered, combined with the knowledge of the strategies

involved in the coping and adjusting of the patient, into usable prinicples to better the treatment situation.

The use of the patient's EM in the communication and subsequent negotiation in the treatment situation falls into the realm of what Good and Good described as a cultural hermeneutic model for clinical practice (1981: 178). This provides the attending health care professional with a model of the patient's illness (note: not the patient's disease) as a symptom of meaning. The meanings are the patient's own associated condition creating the problem.

This may be reflected in the manner in which the information concerning the condition is elicited. The standard biomedical model (BMM) is essentially a review of systems, with the underlying premise that the condition is the result of a pathological deviance within the system. However, the emphasis in a hermeneutic approach is that "Elicitation techniques in the hermeneutic model include investigation of a patient's explanatory model and the "decoding" of a patient's semantic illness network"(Good and Good, 1981: 178).

With the BMM, the ultimate goal is the diagnosis and explanation of the condition, and its subsequent alleviation. The emphasis from an hermeneutic model is on understanding. It is not the direct causal etiology of the condition, but rather the interpretive process

involved in the patient's understanding and adjustment to the problem. This interpretive process involves the researcher in initiating a dialectic within the situation, and moving "...from the part (the "text", the symptom) to the whole (the "context", the illness network) and back again, to bring to understanding the illness from the sufferer's perspective"(Good and Good, 1981:180).

The rationale behind these strategies is based upon strategies for health and illness behaviour. These strategies have been described extensively (Kleinman, 1975, Kleinman, 1980, Katon and Kleinman, 1981). Much of this is based upon the patient's explanatory model (Kleinman, 1975, Kleinman, Eisenberg and Good 1978, Kleinman 1980). This consists of the patient's understanding of the cause, reason for onset, and why at this specific time, expected course of treatment and prognosis of the illness, and the course of treatment that will be the most effective for recovery. Moreover, the nature of the data necessitates care in the elicitation of the information: "It is elicited by open-ended questions in lay terms, so that the model is not contaminated by the physician's assumptions"(Kleinman, 1982: 100).

From a strict ethnographic perspective, it would appear that the elicitation of data approaches the

superficial and that it "does not fit into an indepth assessment of personal and contextual meanings"(Kleinman, 1982: 100). However, given the limited time frame in a health care setting, it may not be possible to extract information of greater detail and depth. This form of interview is by its nature focused upon the specific problem at hand, with a specific goal in mind.

From the explanatory model can then be gathered the illness problems present in the patient's domestic life. These problems, such as the distinction between disease and illness, involve life concerns that are evidence of the problematic effect of sickness on the patient's life (Katon and Kleinman, 1981: 260). As a corollary, the distinction between disease and illness, or any of the focuses of illness problems emphasize the limitation of the BMM. By its nature it delineates illness as a lay category, and a definite psychosocial reality for the patients involved (Kleinman, 1982: 101).

These illness problems are the situations that develop in the individual's life through the introduction of the disease condition. These problems would include such situations as family problems created or worsened by sickness, breakdown in communication between the patient and the professional (Katon and Kleinman, 1981: 261). All of these are reflective of the life problems that are associated with the stresses involved in the particular

treatment regimen, or disease condition.

STRATEGIES OF NEGOTIATION

The next stage in the process of these clinically applied strategies involves negotiation (Katon and Kleinman 1981, Kleinman 1982). Negotiation is the interaction of two variables in an effort to come to some form of accordance; bargaining to reach an agreement. As a process it revolves around the behaviour of two parties and their proposals. As each proposal is offered it is analyzed and evaluated in terms of explicit goals and then modified into a form of counterproposal. The counterproposal is then used by the next party as the basis for their evaluation and subsequent counterproposal. This process is continued until one of two events occurs. Either a settlement is reached or the whole process grinds to a halt. If the process is rendered ineffective, then the basic goal of the negotiation has been negated: "The goal is to reduce conflict in a way that promotes cooperation"(Katon and Kleinman, 1981: 262).

This process seems to be a natural progression from the use of the patient's explanatory models in the treatment situation and the incorporation of the illness problems into the life of the patient. The goal in a clinical setting is to use the patient's EM and the BMM

in order to form a working alliance between the two.

Katon and Kleinman describe several barriers to successful negotiation in medical care (1981: 262-264). Many of the problems centre on the framework of the medical hierarchy; the traditional power structure associated with contemporary patient/professional interaction. The professional plays the role of the socially sanctioned "health giver". Negotiation requires that the professional accept, for the time of the negotiative process, that the patient has a more equal share of the power framework. The patient/professional interaction has lead to a differential distribution of power, and that by encouraging the professional to seek the patient's requests "...places the patient in the role of a shopper in a medical supermarket and thereby dilutes the physician's ability to influence the patient through his sanctioned authority-- the feared outcome of which is clinical helplessness in the face of ceaseless consumer demands"(Katon and Kleinman, 1981: 263).

The negotiation between the patient and the professional follows a certain pattern that may be thought of as the stages in negotiation:

1) the professional elicits the patient's explanatory models of illness and illness problems,

2) the professional then uses this knowledge in association with his knowledge of the biomedical etiology

of the disease problem to present the information in lay terms of the medical explanatory model for his condition and the treatment regimen,

3) at this point, the patient may shift his EM to that of the professional. The opposite is also true, that the professional who works with a greater knowledge of the patient's EM and illness problems, may shift his recommendation more toward the format taken by the patient's expectations of treatment.

These are the main stages in the negotiation process. It is expected that there will remain discrepancies between the models of the patient and the professional. This conflict should be openly acknowledged. "Perhaps as a result of understanding one another's conflicting explanations the doctor, the patient, or both will change their position so that a mutually desired treatment can be agreed upon"(Kleinman, 1982: 104). In this framework the professional's role becomes that of the expert technical advisor in providing the reasons for certain treatment recommendations. The patient has the final responsibility and right of choice in the form of treatment.

The patient may provide at this point a counterproposal once again, as in any negotiation, and once again the professional must decide based upon his expert knowledge whether to accept this proposal. Should

this lead to a stalemate, and the patient's suggestion remain unacceptable on either biomedical or bioethical grounds, the therapeutic contract is broken. The patient then becomes free to seek further information from other professionals. This is not, however, a matter of the individual becoming a "bad" patient for so choosing: "Rather than see this option as noncompliance or 'doctor-shopping', the physician must recognize it is an absolutely legitimate option for the patient"(Kleinman, 1982: 104).

As can be seen, these strategies are based upon the interactive features of the patient/professional relationship. The goal is toward a working partnership that will create the conditions for effective treatment and response by the patient to that treatment. The partnership is based upon a committment by each member to work toward a mutually desired objective, which is the improvement of the patient.

The interaction is based upon the exchange of information from the patient and professional. Any methodology to study this interaction must therefore be oriented with the communicative nature of the situation being primary. Such methods will rest on the symbolic interaction underlying the exchange of information (Spradley, 1979: 6). The language will fall under two headings: 1) using the language and terms of the

informants themselves as a method of discovery and 2) the further use of a language or code for description in the translation of the informants' point of view through that of the researcher.

RESEARCH DESIGN AND METHODS

Given the need to elicit the information of the patient's EM as described in previous sections, those methods that will place the individual at ease in a stressful situation will be of greatest use. The illness creates anxiety and uncertainty in the patient due to unfamiliar and often imposing environments, separation from loved ones, and the patient who is trying to be "good" may not wish to disturb the doctor with questions. Any of these illness problems require a patient sensitivity from the professional.

As anthropological researcher, one must be aware of these parameters and understand their importance in the clinical setting. The researcher as well as the professional must elicit information in a non-stressful, non-threatening fashion. The patient must feel that it is permited for them to express themselves on the matters that affect them deeply. The researcher must then use those elements of non-verbal communication that will be the most receptive to the patient.

Interaction in a research setting may be thought to fall within one of four categories: biomedical experimentation, psychological experimentation, survey research and participant observation (Cassell, 1980). In terms of the structuring of power and control in the different research situations, fieldwork by participant observation poses a comparatively low level of stress. With the researcher as part of the experience, his control over the setting is minimal; he goes where the subjects are. The researcher has no control over the the context of the research, and consequently no base of power that may be perceived by the subject (Cassell, 1980). In this fashion the direction of the interaction between the researcher and subject is two-way, if anything the locus of control remains more with the subject than the researcher.

These clinical strategies were applied to the traditional anthropological field technique of participant observation centring on long, structured interviews. Ideally the researcher attempts to become a functioning member of the society, and as such he must learn the rules. He has an additional role as well. It is not merely the rules which the researcher seeks to understand, but also why the rules are as they are. By trying to understand the underlying premise behind the rules, the researcher is concerned with themes:

"...(the) process of searching for common principles that cross events and define the context in which accounts occur..."(Agar, 1980: 115).

The design of the research followed the form of open-ended questions that allowed for description of the cardiac experience by the subject in his own terms. Questions were set up in such a manner as to "elicit material in culturally significant dimensions, and each set of dimensions can easily lead to many other branching questions"(Pfifferling, 1981: 206). The questions followed the manner in which the patient's EM is brought forward: How would you describe your problem?; how long have you had this problem?; what do you think is causing you problem?; why this problem, and why now?; what will help clear up this problem? These questions allowed the patients to describe the problem from their own perspective, with their own etiology, their own perceived place in their value network, and their treatment objectives (Pfifferling, 1981: 208). In order to understand information from an emic perspective, the researcher must give the subject the opportunity, and freedom, to describe that which is most important to them and not necessarily to the researcher.

It was hoped that, for certain patients, the elicitation of a life or case history would aid in the analysis. This was based on a premise that some patients

would be more receptive to the research, and would be able to express their beliefs in a more lucid manner, or that the individual involved had the appearance of a typical case, in that portions of their history might reflect trends that seemed to have a bearing upon the issue studied. However, it was found that time constraints, coupled with my concern over distressing patients, rendered this approach inadequate. Briefer personal histories were often volunteered by the patients. More often than not these would be better described as case histories in that the information dealt more specifically wth those aspects of their personal and medical background that they felt necessary to include.

Radin (1933) suggests that there are several factors involved in the elicitation of a life history. Of primary importance is the acquisition of the internal evidence as the subject tells it, followed by the personal and cultural history involved in the same framework of time. These are the contextual-situational aspects that delineate and interact with the subject in his sphere of experience. In a clinical setting, this requires the garnering of the patient's EM (including all the information concerning illness problems), in association with cultural parameters, such as setting.

The methodology for analysis of the case history

can be thought of as the synthesis of the data in relation to a preselected category (or categories) that are determined by the particular theoretical orientation to which one subscribes (Little, 1980). What is then understood about the life in the data will emerge determined by the categories selected. The comprehension of the understanding by another is the measure of the success of the analysis. The interest is not in the specific details of the individual's case, but rather it is the interest in the individual for his own sake in relation to the framework or system in which he operates.

This is what is meant by "contextualization" and it is a process of understanding "every component of a unit in which health care is provided and then tracing a patient's movement through that system..."(Weidman, 1981: 218). By using the case history in conjunction with the structure of the system, it may be possible to recognize weaknesses in the system in terms of patients' perceptions and relationships within the system. One may find out why the system is ineffective in dealing with the individual involved because one has the benefit of added knowledge derived from the patient's life history.

The fieldwork itself was done within the Cardiac Teaching Programme of the Royal Jubilee Hospital, Victoria, British Columbia. This programme was chosen for many reasons. The Royal Jubilee Hospital (RJH) is

recognized as a leading coronary care facility in Canada. The programme offered a complete, "packaged" BMM against which the patients EM could be compared. The RJH does not represent the only hospital with a coronary care unit (CCU) in the Victoria region. A smaller unit is available in the Victoria General Hospital. However, the pattern as described to me was for the more seriously afflicted patients to be transferred from the VGH to the RJH, the referral hospital. As such, the RJH serves as a "clearing house", not only for the Capital Regional District, but also for Vancouver Island communities north of Victoria.

The fieldwork was conducted from May 1, to September 30, 1985. During this time approximately 50 patients came through the CCU who fit the criteria of having suffered their first MI, under 65 years of age, and residing in the Victoria region. Criteria were arrived at by following trends that seemed to be presenting themselves from research into the problem, and from discussion with health care professionals, both physicians and nurses. It was assumed that the impact of the condition upon the lives of the individuals would be greatest following the primary infarction. The individuals involved should not, by that point, have prior experience with the condition. The age restriction came through assumptions that the life-concerns of many

of the patients change dramatically following age 65. As many of the patients are male, age 65 reflects a change in their life following retirement. The restriction to the Victoria residency was due to the nature of interviewing the patients following discharge. If the individuals did not reside withing easy access distance, they would not be interviewed.

Of the approximately 50 patients who initially were thought to fit the criteria, 10 were dismissed as unsuitable due to place of residence (for example, Ontario, Oregon, Campbell River). Of those left who did fit the criteria, 16 were not contacted by the researcher due to discharge from the hospital. Part of my restrictions through the research proposal was that, to minimize stress on the patients, initial contact would be through introduction of the researcher by a professional. Initial contact was to be made just prior to each patient's discharge from the hospital. As the average stay in the hospital is two weeks, but can range from eight days to several weeks, if the initial interview was not timed properly, the patient was gone before contact could be made.

Twenty-one people fitting the criteria were approached. One patient's interview was dismissed upon learning of prior MI. One patient turned down the study during the initial contact. Four more originally agreed

to participate, but later declined. One last patient could not be contacted due to misinformation on their chart as to place of residence. Several of the patients put off the interview several times past the agreed upon appointment. This was for various personal reasons, but all mainly revolving around, as one patient eloquently phrased it: "I'm feeling really bummed out by this, y'know?"

This left me with a sample population of 13. This was approximately 28 per cent of the original 50 patients considered, and approximately 66 per cent of the 21 approached.

The reasons for the small sample are varied. The main problem in obtaining participants was the restriction to doing the interview in the patient's home following discharge. When the patients were approached in the hospital, they were all very willing to have a "chat" at their bedside. The initial contact was constrained to a brief five to ten minutes, in order that the patient would not be duly distressed. Mostly I found them bored and eager to speak. For future studies of this nature, a longer initial interview is desirable. I feel the stress on the patients is minimal (see chapter one for sample interview), and it would benefit in greater rapport between researcher and participant.

Much of this description in this chapter has

centred the communication process between the patient and the professional. Barriers that limited contact with the patients in the hospital, associated with the small sample, meant that the actual communication process was not studied. Reports of the process by the patients had to suffice because the researcher was not part of the situation in which the interaction occurs. Reliance upon patient reports follows anthropological tradition in which credence must be given to oral histories.

SUMMARY

The goal of the strategies and methods described here is to create a framework by which that information that will lead to a more successful professional-patient interaction may be gathered, analyzed, interpreted, and explained. The verbatim transcriptions of interviews with the patients suggest that the models discussed here could be used. The behaviour of the professional is crucial to this interaction (Stewart, 1984: 174): "...a positive outcome depends on physician behaviour which is facilitating rather than dominating". The behaviour involved is a function of the communicative nature of the interaction. Anthropological methods based upon the symbolic study of the process of information exchange in a clinical setting provides a means of eliciting the perspective of the patient, which may then be used to aid

in the treatment situation. It is hoped that the successful therapeutic contract will involve the patient's EM and the standard BMM coming to a form of working accordance. It is then that the effective interaction of the patient and professional will appear.

PART TWO

CHAPTER FIVE

THE CARDIAC TEACHING PROGRAMME

THE PROGRAMME - A HISTORY

The Cardiac Teaching Programme at the Royal Jubilee Hospital (RJH) was started in 1962, based on the work done at the Emory University School of Medicine, in Atlanta, Georgia. Much of the work in Georgia focused on the long-term management and successful treatment of the cardiac patient, such as the establishment of the Georgia Heart Clinic System in 1949 (Wenger and Johnson, 1979). Many of the techniques of long-term management are still incorporated quite fully in the programme at the RJH (such as patent activity levels, to be discussed later).

Much of this information is based upon conversations with staff members of the RJH. There have been several programmes in the RJH since 1971, the year of a study of alienation and social learning conducted there (Gauthier, 1971). During that time various techniques were initiated, such as one nurse having responsibility for all aspects of patient care and education. This was continued until approximately 1978 when it was found to be ineffective by the staff. At

that point the rehabilitation role was allocated to the primary nurse. At least this was the goal. In the daily operation of the system, the duty falls upon several nurses, owing to the impossibility of one nurse being available, and with the patient, at all times. This was viewed as a better approach, for it allowed more contact and an "individualization" of the programme in terms of the patient.

The nurses required training in the dissemination of information contained in the programme and, again for a format, the hospital looked to Georgia. In the RJH this has meant the evolution of a core curriculum that deals with what were described as the "common areas of discussion". The information package was individualized for each person; the approach was in the form of a "soft sell".

The sheer numbers of staff involved in both the areas of coronary and cardio-vascular care means some variation in the presentation of the information. The variation was described as an "accepted loss", though it does ensure the "development of rapport" between the patient and the professional. The family, or any in a social support system close to the patient, are involved in the rehabilitation so that they "will know what to do once the patient is at home".

In 1983 there was an internal review conducted as

to the effectiveness of the rehabilitation programme. A telephone survey was conducted of 100 patients (50 from each coronary and cardio-vascular wards). The study showed that the patients, two weeks after discharge, had the knowledge of the technical side of their condition (such as what pills to take when), but they showed signs of what were described by staff as "problems with head space". In other words the patients could remember the details, but had problems wih depression.

Based upon this finding the programme was reorganized and incorporated Wenger's model of coronary patient rehabilitation in 1983. The model is based upon the premise of three stages to illness (see Wenger, 1978: 296-302):

1) anxiety within the patients, such as intimations of mortality, with a usual duration of one day,

2) denial of the illness and condition, which usually lasts a few days, but may last for the remainder of the individual's life,

3) depression based upon a feeling of helplessness, and can assume the form of withdrawal.

As it was described, the redesign of the programme in 1983 had the goal of putting the person "in touch" with their usual coping mechanism (if it worked in the past), to give them the information on how to change, and to get them to a level of acceptance.

Once the patients have returned home, they are visited by one of the Home Care nurses. These nurses are part of the Capital Regional District Community Health Services. The patients are referred by the physician. Although described as for those who do not have a good social support system at home, all of the patients spoken to had been visited. The first visit is on the first day home from the hospital, and then the visits are daily for three or four days until the patient is comfortable with their return home. The visits are reduced for six weeks until the patient returns to see the cardiologist, or until they see their family physician. If the patient is older, and "fragile", then periodic checks are maintained.

The home-care nurses have various tasks, such as checking the patient's vital signs, their pre-exercise and post-exercise pulse, and so on. They also do counselling of the patients concerning their activity and their medications; mainly reaffirming the hospital's programme and helping the patient to adjust to the new restrictions on their life.

THE HOSPITAL SETTING

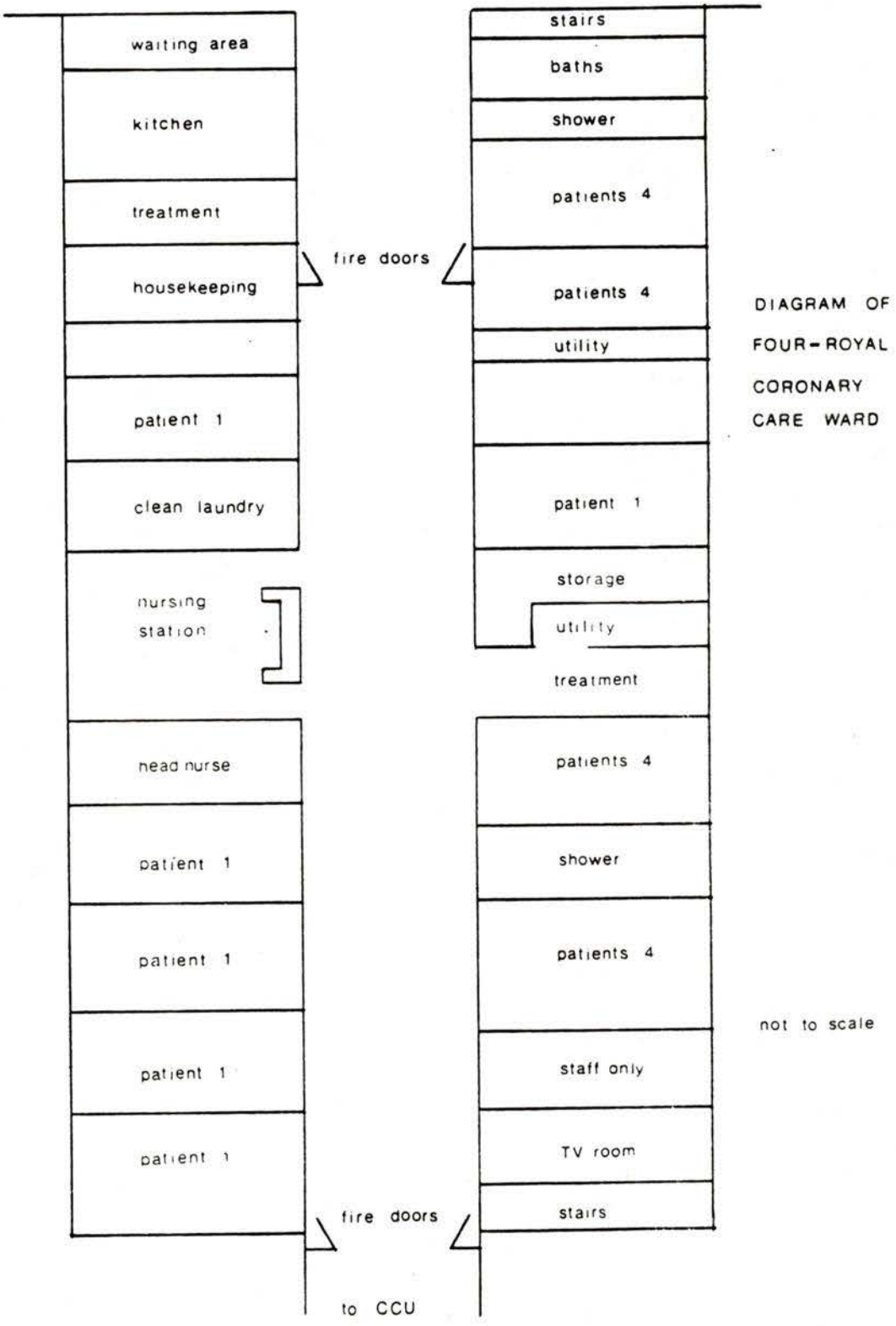
The coronary care unit and the coronary ward

occupy the fourth floor of the "Royal" wing of the RJH. The coronary care unit is most often referred to as the CCU, and the coronary ward as "4R", or "4Royal". This will be followed here as well.

There are eight beds in the CCU and 30 on 4Royal, which are in constant demand. The average stay in the RJH is about 12 days; four to six in the CCU and the remainder on 4Royal. In the CCU there are four nurses on duty 24 hours per day, seven days a week. This gives a ratio of one nurse for two patients. On 4Royal this changes to between four and six patients per nurse during the day and evening, to a ratio of ten to one at night.

For the CCU alone, the number of patients admitted in a one year period (unspecified) was 522. The number with a proven MI was 464. The number of MI patients who survived their stay in the CCU was 419. The age range of those with proven MI was from 18 to 99, with the mean of 67 (these figures were supplied by the staff).

FIGURE 1


waiting area
kitchen
treatment
housekeeping
patient 1
clean laundry
nursing station
head nurse
patient 1
patient 1
patient 1
patient 1
fire doors
to CCU
stairs
baths
shower
patients 4
patients 4
utility
patient 1
storage
utility
treatment
patients 4
shower
patients 4
staff only
TV room
stairs
fire doors
DIAGRAM OF FOUR-ROYAL CORONARY CARE WARD
not to scale

FOUR ROYAL

The coronary ward is in the main building of the RJH. The ward is for those patients with coronary problems not requiring major surgery. The cardio-vascular ward, for those requiring surgery, lies perpendicular to 4R on the same floor.

The rooms on the ward are arranged along both sides of a main hall. On the ward are some 30 beds for patients that are in continuous use and demand. The arrangement of rooms on the ward was changed during the initial portion of the study. The telemetry and the nursing station were moved to a central core around which the main support services of the ward are situated. The rooms for the patients are situated on both sides of the hall, and on both sides of the station.

There are two sets of fire doors on the ward. However, their importance for the patients in not equal. One set between the CCU and 4Royal has a much greater impact upon the patients. As a physical representation of the differences between the CCU and 4Royal, the area between the entrance to the CCU and the fire doors emphasizes a change in patient status.

In the nursing station are maintained the patient's files, the telemetry equipment, and is where the administrative chores of the staff are conducted. The station is a large open area enclosure, separated

from the main hall by a partition. Extended along two sides of the station are the telemetry which monitor the patients. Beside each bank of monitors are sections in which are filed the patients charts.

The last room of the hall is the television room, which contains "comfy" chairs and figures prominently in the daily routine of some patients, expecially if the patients wish to spend their day watching the television.

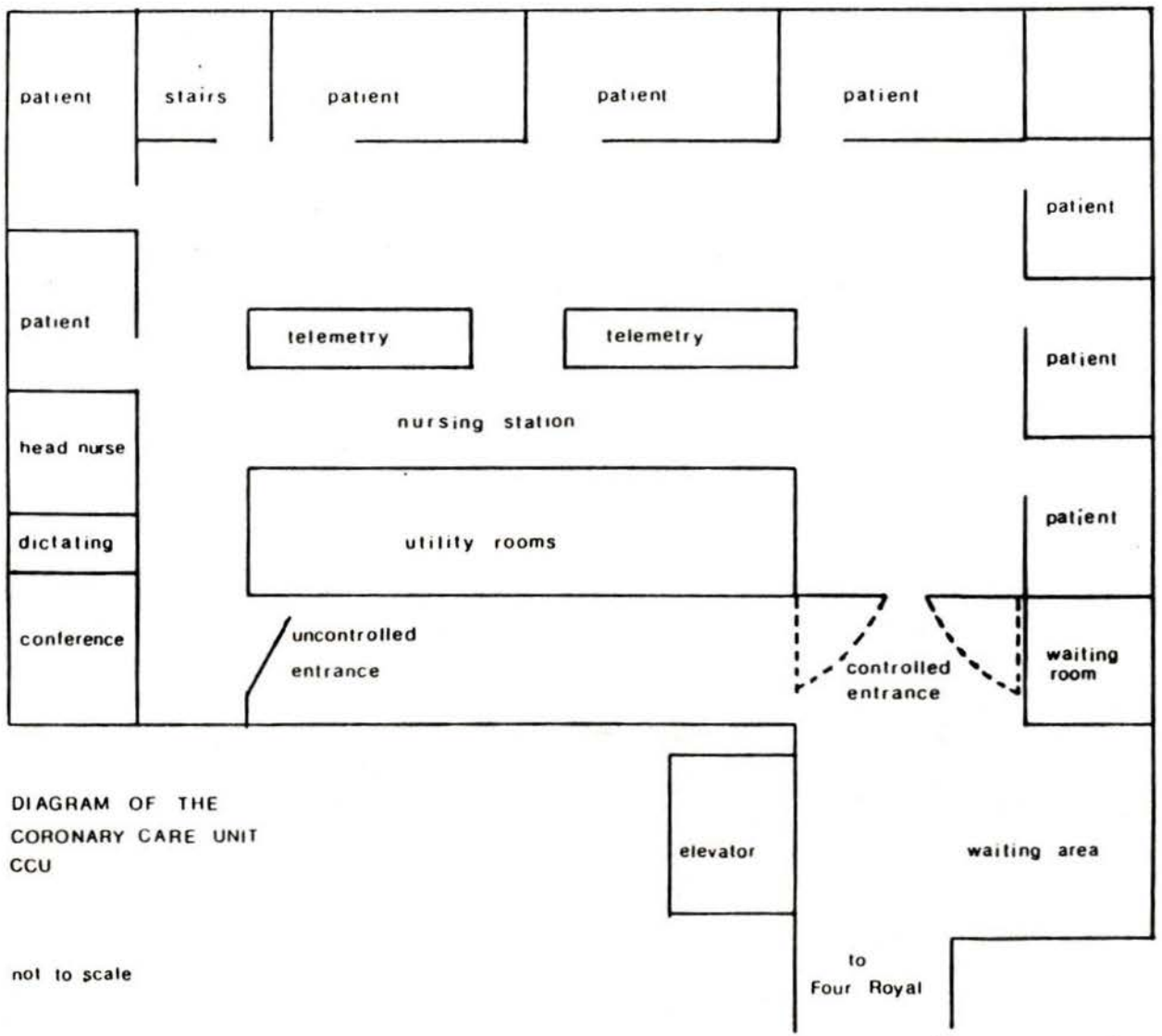


DIAGRAM OF THE
CORONARY CARE UNIT
CCU

not to scale

FIGURE 2

THE CORONARY CARE UNIT

Upon leaving the coronary ward, one passes through the set of fire doors mentioned earlier, which mark the end of 4Royal, and the beginnings of the CCU. Here there is a small waiting area, which is open, and a waiting room that may be made private by shutting the door. It is in this area that visitors to the patient must wait before being allowed access.

The CCU is situated at the end of the ward, in a new addition to the hospital that has been completed within the last few years. This section has its own elevator that allows acces to both the CCU and 4Royal.

The main access to the CCU is through a controlled entrance. Upon approaching the unit, the visitor must first make contact via an intercom connection to the nurses within. Once permission is granted, a large button on the wall is depessed that activates the opening of the "Magic Doors"; the double doors of the CCU entrance. The doors may be shut once a visitor enters via the depession of a complimentary button in the unit. The doors are not shut all of the time; they are left open for regular hospital visiting hours. There is an alternate access to the unit, which is used by the hospital staff. This is an uncontrolled, non-mechanical entrance at the end of a hall to the left of the elevator. It is sufficiently removed that

visitors would not approach it.

Inside, the CCU is comprised of rooms for eight patients, plus rooms for the Head Nurse/Clinician, a conference room and various utility rooms. The patients rooms are arranged along the perimeter of the unit, which comprises the very end of a hospital wing. Each room has a window to the outside, and access to the central area of the unit through a large sliding glass door. In the centre of the unit's main area are the monitors similar to those on 4Royal. These are placed in a partition similar, though not as imposing, as that of the coronary ward. This area has the same function of the 4Royal nursing station, providing administrative as well as care functions.

On the opposite side of the unit from the controlled entrance are the conference rooms, the office of the Head Nurse and the Clinician, the doctor's dictating booth, coat rack, and washroom. The central block which forms the fourth side of the square is taken up with various utility rooms (soiled and clean), and storage areas. Opposite the door to the conference room is the uncontrolled entrance/exit, which allows egress to the waiting area, and from there back along to the main ward and central core of the hospital.

THE PROGRAMME - BIOMEDICAL MODEL

The information for the following model was derived from a variety of sources, including tape/slide shows, information handouts, and staff interviews in the RJH. The following model is not one of a patient taking a particular form of action, but rather of the action that should be taken in the view of the health care professionals. All quotations are taken directly from the interviews, handouts and slide shows, and are included to give clarity to the model. Information is shown in categories derived from the different models of methodology described in chapter four. The categories are a compilation from the relevant sections of the Health Belief Model (Becker, 1974), the Explanatory model (Kleinman, 1975, 1982), and coping strategies (Viney and Westbrook, 1984). The reasons behind the use of these different approaches have already been discussed. Information is presented in this fashion for ease of comparison with that taken from the patient interviews.

The focus or goal of the programme is to get patients "back on their feet" and to reduce risk factors. There is a feeling that the majority of the people who come through the CCU will die of heart disease. The professionals admit "you can't say to the patient that if they do this or that that they will live so many years

longer". Therefore the expressed emphasis of the programme is on the quality of life and not the quantity. What the programme seeks to do is to "push" the things that will make a difference in how those years are lived.

There are four main points that are focused upon: activity (walking), smoking, nutrition and stress. As described, the emphasis is on "things with a good return". In the description that follows, these will be the four points emphasized. Descriptions of each are necessarily brief as much of the technical information was covered in chapter two. What follows are the main points in each category.

Susceptibility (of the patient to the risk factors).

The programme is based on the premise that "if they're a survivor at life, they'll survive a heart attack". Smoking affects the lungs and therefore the heart too, due to the extra strain of diminished oxygen. Stress plays a part in that:

> we are daily subjected to...stress. Some people have developed a behaviour pattern that thrives on stress. Many of our patients fit into this category. This specific behaviour response is called a "Type A personality". (Handout - Stress)

Nutritionally, cholesterol has been linked to heart disease, but the link between cholesterol intake and blood levels is not understood. Exercise will aid the

recovery, or more precisely the lack of proper exercise does not enhance cardiac function.

The susceptibility of a patient to further cardiac episodes then is dependent upon their management of these risk factors.

Seriousness (of the risk factors to the patient).

The programme suggests that much of the fear of heart disease is due to a person's lack of understanding. Smoking causes the heart to beat faster, increases the blood pressure, and therefore puts strain on the heart. Carbon monoxide either puffed or inhaled decreases the carrying capacity of the blood. Stress in a long-term, cumulative sense does damage to the heart. The increase in adrenalin gives a "fight or flight" reaction, which is not beneficial if suppressed. Cholesterol is of low seriousness.

> However, if you [the patient] wish to start a low cholesterol diet, it won't do any harm and some physicians feel it can be beneficial (Handout - How Well Do You Eat?).

Exercise, once again, will enhance cardiac function and return strength. The importance of the risk factors lies in their impact on the health of the patients. Therefore the programme emphasizes those factors that are seen by the professionals as the most serious.

Benefits (from taking the prescribed action to lower the risk factors).

Based on a premise that:

> we [the professionals] believe recovery and return to a normal lifestyle is made much easier if patients and families understand what has happened to the patient, his heart, and what can be done about it. By giving the patient and family some of the responsibility for learning about the heart, its normal function, what went wrong and what can be done now, we hope to reduce or eliminate misunderstandings (Handout - Beginnings).

Therefore, the programme can be characterized as emphasizing the information that, when introduced to the patient, will create conditions for optimum recovery. As a result many of the benefits are expressed in terms of statistics and results:

> Research has proved that the incidence of death from heart disease is decreased dramatically among those who stop smoking, almost to the level of people who have never smoked! Thus, it is worth the effort to stop smoking, regardless of the number of years you have smoked (Handout - Smoking: Who Needs It?).
>
> Although we cannot escape stress, we can learn methods of coping with it that are not damaging to our health (Handout - Stress) [for example, in the slide show Road to Recovery, the professional elicits the patient's EM mainly with a focus on stress].
>
> Research shows that the benefits of starting a low cholesterol diet

> decrease as a person gets older. However, if you want to start it, it can't do any harm (Handout - How Well Do You Eat?).
>
> The physical activity programme is designed in the first stages, to lessen the weakening effects of bed rest; and later higher levels of physical activity to enhance cardiac function (Handout - Standard Walking Programme).

Costs (of taking the prescribed action to lessen the risk factors).

Almost nothing was mentioned of any cost to the person in terms of following the prescribed treatment. The only clear-cut description of a problem that might occur was the loss of the psychological benefits from smoking and possible associated weight gain. While the costs in individual terms may be best dealt with by the individual physician, in general terms this was the area most keenly felt by the patients, which will be discussed at length later.

Modifying Factors (factors that may affect the response/attitude of the patient).

According to staff interviews, in the hospital, there is a significant amount of boredom, and that most people are depressed or have a sense of loss. There is a possibility that the sense of loss may be felt more

strongly at home than in the hospital. Denial is always present, even if just mild. The professional will allow "a lot of denial, to get it out of their system". The denial is usually in the form of the "I can't believe this happened to me", that may be used to "test the professional's perceptions". According to the staff it is in the hospital where patients decide upon what action to take and whether "it's worth the gamble or not" to follow the recommendations of the programme.

Cues to Action (internal)

Relating to bodily states, the professionals expressed the opinion that the strategy a patient uses varies from patient to patient, and in that patient over time. Mostly it is what they have done before. For the "type A personality" it is often logic, in that the programme assumes the patients respond best to statistics to which they can "relate".

Cues to Action (external)

People often respond more to personal experience. The staff believe that patients acquire more knowledge of the disease through interaction with people they know who have had the disease. The programme itself is set up so that the patients may avail themselves of the type of information they are most concerned about (staff

interview).

The RJH Cardiac Patient/Family Teaching Library has 17 slide-tape programmes aimed at disseminating information to the patient and family. The shows are viewed on a Kodak Ektagraphic viewer that allows for the synchronization of tape and slides. The programmes run about eight to fifteen minutes in length, often with 80 or more slides. The viewer is wheeled into the patient's room for viewing, either by the patient themselves or with their spouse. This is in either the CCU or 4Royal.

The staff admit there is a "mild" pre-planned sequence to the presentations, but feels it was designed not to give the patients an "information overload". For example, a character in the slide show Road to Recovery indicates common reactions to the condition, and the goal of the staff in treatment: "...(a) big part of the recovery is up to me now...I want to make some changes".

Coping Strategies

In a sense the entire programme encourages one form of coping strategy, that of action. The premise is goal-oriented, and focuses on actively seeking health-care. However, other strategies are implicated as well, such as the emphasis on the inter-personal aspects:

> We [the professionals] encourage the patient's family to become actively involved in this programme, so that after the discharge the patient will

> have a "coach" to help him remember some of the small things that are so easy to forget (Handout - Beginnings). The family is never placed in a caretaker role by the professional (staff interview).

The staff do encourage the family to be involved in lifestyle changes (smoking, diet, exercise) and try to help the family in the changes:

> If the interaction is destructive, the professional tries to step in and point it out, but you can't change people who have interacted like this for years (staff interview).

This last point seems somewhat paradoxical or contradictory, in that the goal of the programme is to change their behaviour to help them. From a staff description part of the coping strategy used by the patient involves control: "the type A personality often responds to stats and uses logic...". From this one would assume the programme seeks to place the locus of control within the patients.

SUMMARY

The rehabilitation programme emphasizes change on the part of the patient. The change has to do with the reduction of risk factors by the patient. The information therefore is centred on behaviours that should allow the patient to take care of himself once home. The information is tailored to fit the patient in

that each package is comprised of handouts that are felt to deal most closely with the factors that place the patient at the most risk. However, the handouts themselves are standardized, and it is only their distribution which is individualized.

The cardiac rehabilitation programme has a long history of change and adaptation to better meet the needs of the patients. This process continues today. The hospital operates on the assumption that through the introduction of new information to the patients, they will be able to make a change to better their lives. Information in the programme emphasizes a reduction of what are seen as the more serious risk factors. These factors are smoking, nutrition, exercise and stress. By giving patients the information package, the programme therefore should provide the tools that the patients can use to their own benefit. The next chapter will describe the patient's point of view, and whether information from the programme meets their own concerns. It would appear that patients are less concerned about behaviour surrounding the risk factors than they are about the impact of the condition on their lives.

CHAPTER SIX

RESULTS - THE PATIENT'S POINT OF VIEW

The following is a description of patient beliefs and concerns. It is presented here in the same manner using the same categories as the presentations of the hospital programme (see Table 1). This is to facilitate comparisons between the two. Table 2 shows patient compliance with the Cardiac Teaching Programme itself.

All the information that follows is taken from the verbatim transcriptions of patient interviews. The personal histories of each case have been altered to maintain the anonymity of the subject. However, the descriptions are close and convey the general structure of the patient's personal history.

Categories shown here in Table 1, and previously in Chapter 5, represent the pre-selected areas of focus for this study. The rationale behind these categories has already been discussed (see Chapter Four). Information represents the concerns and expressions patients themselves express.

It should be noted that the data in the categories of Table 1 appear incomplete. Some categories, which from reviewing the literature the researcher had expected to find (such as a family epistemology), were not found once the research was

started. Other categories (such as Coping Strategies) elicited no specific response from some subjects. Many categories in Table 1 consisting of a single response (often in the "Yes" column) only represent the actual subject responses. To assume that responses not in one column automatically reside in the other is an assumption not supported by the data. Further research in this area would have to address this non-response.

Information in the text not found in Table 1 comes from the patients, but could not be adequately represented by the categories in the table. Information is included in reference to those categories with which it is associated. Due to the flexible nature of the format, there is an inter-relationship between many of the categories, represented by comparable findings, which comes out in the discussion to follow.

Table 1 - Patient Responses

CATEGORIES	YES	NO *
Susceptibility (to condition)	31% (4)	69% (9)
Seriousness (of condition)	69% (9)	31% (4)
Benefits (in following programme)	92% (12)	8% (1)
- mainly excercise for return to health	53% (7)	
Costs (from condition or from following programme)	100% (13)	
- expressed frustration	53% (7)	
- expressed depression	61% (8)	
Modifying Factors		
- family history of condition	76% (10)	24% (3)
- married	84% (11)	16% (2)
Cues to Action - Internal		
- exhibiting disease knowledge	100% (13)	
- exhibiting good disease knowledge (beyond reading from handouts)	53% (7)	
- expressed bodily concerns (weight)	47% (6)	
Cues to Action - External		
- mass media influence	30% (4)	
- Inter-personal	100% (13)	
Health professional influence	76% (10)	
Coping Strategy		
- Action	61% (8)	
- Control	61% (8)	
- Inter-personal	84% (11)	
family best	69% (9)	
Dysfunction		
- Wrong solution attempted	46% (6)	
- Response to incongruent hierarchy	53% (7)	
- Family epistomology	15% (2)	

* Responses in this table represent only those actually expressed by the subjects. The responses in the "NO" column represent only those negative responses to the programme the subjects themselves admitted. While the researcher may suspect negative responses in many of the categories, to assume negative responses simply because the positive responses are less than 100% would be an assumption not based in the data.

Susceptibility

Case One:

> A 60 year old woman suffered a MI before leaving for work. She lives in a one bedroom apartment in the centre of the city. Though married twice, she is a widow. She has two children, though neither child lives in the city. She recognizes that she has a family history of heart problems now, although her two parents lived well into their 90s. Two of her siblings died of heart attacks, and another has undergone bypass surgery. She never felt she would have a heart attack:
>
> > I thought everybody else in my family would, but I never once thought I would. Actually, there are only three of us left out of a family of eight. But, y'know, my younger sister is far heavier than I am. She's over 200 pounds. I keep telling her, y'know she's a real candidate for a heart attack, to get your weight down. Constantly bugging her about it, never once thinking I would have it. I had myself dying of lung cancer, emphysema, because I smoked, and all these...No, never, ever thought I'd have a heart attack.

Perhaps not surprisingly, 69% (n=9) of the patients had never felt they were susceptible to the condition. Even if they recognized that they were subject to excesses according to the four main categories of emphasis in the hospital's programme, they still felt it would affect someone else,--but not them. The few who had recognized heart disease as a possibility, based their assumption upon their own family history, perhaps coupled with a previous experience with cardiac problems. These previous experiences included such things as

triglyceride counts, and served to provide an initial awareness of the potential for problems.

The family history often brought the possibility to mind, such as due to a sibling's death, "I always thought it was a problem that might develop". They recognized the potential but did not have the information to forestall it. As such, though they thought there was a chance, it did not mean they recognized it or believed what was happening when it finally occurred. The ones who did recognize the possibility were all male, and all in their 50's (n=4). Perhaps this is indicative of a change in life concerns at that age.

However, the patients as a whole never gave heart disease much thought; it was " a bolt out of the blue, a total surprise". Of those patients who recognized a family history (n=10), only 30% (n=3) correlated it with a potential within themselves. More than likely what is involved is a degree of acceptance, perhaps subconsciously, that cardiac episodes and heart problems in general are something to be expecte--and accepted.

Seriousness

Case two:

> A 56 year old man. He has been married for 30 years and has two sons. He works at the managerial level in one of the stores in the city, and actually suffered the heart attack while beginning work one day. He expressed his concern over the seriousness of the MI:

> I had some heart damage. I guess close to about a third of the left ventricle has been damaged. Now that's what has to take the time to heal. You know you feel good, you even look good, and you feel like you could be back at work, but that's the thing that they warn you about. Well, I don't think that this was a serious heart attack. I suppose if I have another one, it would be [serious] because of the fact that I've got heart damage now, you see. So that means that some of it's gone, that means that next time there'll be more gone, and so you just get to a point, I suppose if you have enough heart attacks, you get to the point where you have no resources left as far as your heart is concerned.

Many (69%, n=9) patients recognized the seriousness of their condition, very often depending on what information they had been given by the professional: "it's as dangerous as it sounds, I guess. The doctor said...". If their own internal perception of the severity of what they had been through did not correspond with that of the professional, they were willing to defer to the professional's judgement: "I didn't feel it, but apparently it was very, deadly serious". Many of their perceptions were based on the severity of the damage. More precisely the fact that there was damage <u>at all</u> emphasized the notion of severity.

One area of agreement that cross-cut a recognition of severity was the acceptance of the condition. Even if it was a serious MI, it was taken to

be a "normal" one, just what one would expect from a heart attack. For those who did not recognize the severity of the attack, they recognized that the next one might be, but not this one. The important factor here is that, whether they recognized the severity or not, they mostly assumed that there would be another one later on. The fact of the patient's acceptance of an MI in their future does not bode well for a programme trying to evoke a change to circumvent that possibility.

Benefits

Case three:

> A 55 year old man. He has been married for 25 years and still has one child left at home. He has worked in a local production store as a supervisor, a role that has placed him under increasing stress, and where his work went from doing manual labour to almost none. He said he felt a premonition during the days before the attack, and so expressed his relief at the programme's ability to provide him with the answers to some of his questions:
>
> > I had a premonition that things weren't stacking up right. Just weren't as good as they could be, and that something had to give. Well, to the point where a day or two after it happened I almost felt it was going to and it was a relief to know, to get it over with and to get a few answers thrown at me. It gave me some answers in knowing what to do about it. The thing that bothers me the most about the whole thing is it's gonna happen again, or it could more likely happen again. But balancing that I have some pretty good feelings that [by] proper dieting I can avoid increasing the

> risk and by proper excercise I can incease the chances of overriding the risk a little bit with a better pump.

The benefits discussed were to either the programme or the condition itself. The patients did not make much distinction between the two, "lumping" them together into their cardiac experience. Almost everyone (92%, n=12) foresaw benefits from following the programme, and in a very positive manner. The benefits focused on the fact that the programme will make the patient "better", but for 53% (n=7) this was only exercise for a return to health. The patients often mention the specific benefits they will gain, depending upon what they emphasized themselves: "exercise will help the circulation - and my sanity", "the programme makes you slow down and appreciate life", "I quit smoking at least".

However, those with a prior cardiac experience (such as triglyceride count, n=3) or who had been exposed to information through interpersonal or media exposure (n=5) were more reserved. They were more apt to admit that "it's all well and good, but I know I won't remember once I get back to normal". The assumption here is that the programme is good, but only if you continue with it, which is hard to do in "normal" life...and the "normal" life may create another "normal" heart attack.

The main benefit of the programme to the patient

is that they are now starting to get some answers to their questions. The patients expressed a need to have individual answers that would respond to each patient's unique concerns.

Costs

Case four:

> A 48 year old man who has worked in a department store in the city. He has been married for 25 years and still has one child living at home. He is a nonsmoker, and has been told by his cardiologist that, according to the risk factors, he should not have had a MI. He felt constrained and frustrated by the condition, and was concerned about the effect the condition will have on his future:
>
> > It's more frustrating at home because you see so many things you want to do. And you think "oh, boy, I can do that, no problem", and you want to do them, but you can't. You have to do the stairs in two parts, you've got to go half way up and then rest and the rest of the way...I feel like an old man! Thoughts go through your head because it really involves a lot of things y'know. Not only the healing time that you have to go through, but when I'm through that...I face my employer, and my employer might have negative thoughts about that...they can probably squeeze you out...I'm not saying they will do that, but they want the healthiest people possible, let's face it, so that the least amount of manhours are lost.

For the patients there were costs associated with both the programme and the problems caused by the impact of the illness on their lives. The most apparent

costs/problems were depression (61%, n=8) and frustration (53%, n=7). The two worked in unison on the patients (53%, n=7, expressed both), often in a positive feedback situation that exacerbated the experience.

Frustration was felt both at the hospital and at home. The main problems were associated with the cessation of normal activities. In the hospital the frustration was directed toward the incoveniences associated with the hospital experience: "it's all so programmed....can't do this, can't do that". Many patients felt that if only they could have more control over themselves, they would feel better. In the hospital, the reaction was to the controls implemented through the "rules and regulations" that govern the daily lives of the patients while they are there.

The impact of the condition is heightened with discharge and return home. In the hospital the patient had a tangible focus for their concerns in the form of the hospital's restrictions. Once home the impact of the condition of their everyday lives was brought into sharp focus. They had returned to an environment with many reminders of the change in their lives. They were around the same stairs they could once take two at a time, the same workshop where they could previously "putter", the same garden where they used to rake leaves and cut the lawn, all just two weeks ago. The frustration leads to

depression that begins the cycle once again. They're home where they can think about "all the things I'll have to change".

In this manner the patients, though exhibiting a good disease knowledge, expressed concern that "I never get the answers I want" concerning their illness. They can repeat the technical side of their condition, but what they want help with is whether they will ever again be able to go up the stairs two at a time. They want help with the change to their lives that a heart attack means.

Modifying Factors

Included in this category are those items that may have a bearing on the patients perceptions. Using the categories from the HBM, the main focus was whether there was a family history or not, age, weight, and other miscellaneous data that did not fit anywhere else. The sample was 84% male (n=11). The age range was from 40 to 65 years of age, with a mean of 53.

Most (84%, n=11) of the subjects were married, many for over 25 years. This factor was important for a number of reasons, mainly their interpersonal cues to action and their coping strategies. It also highlighted problems in family interaction that could hamper their return to health.

Many (61%, n=8) of the subjects had smoked, although most (n=7) found the shock and fear of the heart attack was enough to encourage them to quit.

Two of the people interviewed were diabetic. One was diabetic before admission and one was diagnosed as such during their stay. This condition brought its own complications to the situation by affecting the patient's EM through their internal perceptions of bodily state.

The most common factor was family history. Three-quarters (76%, n=10) of the subjects expressed a family history of heart problems. Many had experienced the death of parents and siblings within recent years, and for a few patients the condition had cut a swath through their families. As was described earlier, a knowledge of a family history was not directly associated with perceived susceptibility to the condition.

Cues to Action - Internal

Case five:

> A 41 year old man. He has been married for 15 years and has two young children. He has a family history of the problem. His grandfather had a heart attack, and his father has had two. However, he expressed his opinion that he was too young to have a heart attack:
>
> > Grandfather died of a heart attack, but he was 85 years old. That's too old anyways...Well, I never believed it [the MI] y'know? I run, I work out with weights. I can't believe

> it. I still don't believe it...I'm still young, y'know? I can't change much. When you're in the younger days, y'know, you heal pretty quick, and you still got a lot of heart when you're young. When you're old, your heart all ready weak anyway, y'know?

This category included those items that would affect patients EM and knowledge, such as theories of causality, perception and response to bodily states. Bodily states are the individual responses to internal perceptions and information about themselves that the patient uses to formulate an EM.

As has been previously indicated, most patients expressed satisfaction with the technical knowledge of their disease, but again they wanted to know about the illness in individual terms. All the patients had some disease knowledge. The knowledge was better in some (n=7) in that they had assimilated more of the hospital's text and could spontaneously recall the material.

All patients were happier to be home, but were finding home difficult to adjust to. This struggle with the frustration and depression was expressed in concerns over their lifestyle, which they recognized as tiring for them. For example some patients (47%, n=6) were concerned about their weight. Some (n=3) were pleased at having lost weight in the hospital but were afraid of "blowing up" to their pre-hospital weight.

In causal terms, some (n=3) patients expressed

their opinion that smoking had caused their heart attack, even though volunteering that they were "far too stressed" and that stress was probably the major factor. From the tenor of the interviews, it appeared that these patients felt they could do something about the smoking by quitting, but they felt control of stress was beyond their grasp, that once things were back to normal (condition before the MI), stress had to be accepted: "what can I do about that?"

The significant factor came in comparison of the ages of the patients. Ages ranged from 40 to 65 years. The perceptions of the impact of the condition appears to change with age. Those patients in their 40's (n=3), although amazed at having had an MI, expected recovery to a complete and full life. Those in their 50's (n=6) hoped for full recovery but were concerned about the security of their jobs if full return to health was not achieved (see case four). Those 60 years of age or older (n=4) hoped to get better, did not expect to return completely to normal, and expected to have another, perhaps fatal, MI. Therefore, the internal age perceptions played a major role. This can be reduced to the basic premise that it is normal to have a heart attack, and the old are supposed to have them.

Cues to Action - External

Case six:

> A 58 year old man. He has been married for 35 years and has three children. He has worked at an executive level in the city and was planning his retirement when the attack occurred. He had been, and still was, very sick. His stay in hospital was over 20 days compared to 12 days normally. He recognized how sick he was, but expressed his pleasure at how well he was coming along. I asked him from where did he get his information:
>
> > I watched, we watched, the two of us both watched seven of them [slide programmes]. I think they're marvelous. They certainly enlightened me when it comes to the angiogram. I certainly knew what was going to happen. It does help you...But I found out more, I think, in that Dr.--- was really good to my kids, and to [wife]. He had a little session with them afterwards, and explained everything. And he had even showed them on the machine what he did...afterwards with them telling me this, I was anxious to see the film and what goes on.

This category deals with mainly with the modes and mediums by which the patients gather information about the condition. For the subjects most of the external cues fell into one of three categories: the mass media, the hospital programme/slides, and inter-personal cues (such as relationships with professionals and family).

In considering the mass media influence, the opinion is that the image found on television and motion pictures is wrong. The image of the man clutching at his chest, the 360 degree spin, followed by the dramatic

collapse did not prepare the patients for what really happened. The patients who recognized their response to the image (30%, n=4) replied that the image, although wrong should be kept or else "people wouldn't take it seriously". Of course, people can only take it seriously if they recognize what is happening to them in the first place.

The hospital's programme (the slide shows and the information package) were well received. The patients accepted them as reference tools. In terms of action to be taken, the programme has a much bigger impact. It reassures the patient that "what I'm feeling is normal". More importantly the patients found that it told them "how I'm supposed to act". The very fact that the patients are concerned that they are not "acting" properly brings into focus all the problems associated with labelling. The patient concerned in this way will want to act as expected, which may or may not be the way they really feel like acting.

The strongest external cue to action was through the patient's interpersonal relationships, especially with the professional and the family (see Table 1). The influence of interpersonal interactions was felt by all patients. The family was seen as best by 69% (n=9) of the subjects. Interaction with professionals, in either a positive or negative manner, was expressed by 76%

(n=10).

Many of the relationships a patient has with the hospital staff are perhaps constrained by the power structure inherent in the situation and are reflected in their boredom and frustration at the rules or programme. The doctor's authority rests on a base of power within the hospital structure to which the patients lack access.

The patient's response is a response rooted in powerlessness. The added weight of the doctor's authority heightens the intensity of the doctor/patient relationship: "But if a doctor tells you smoking caused it, it scares you into quitting!" The patients take the reponses of the professionals as indicative of the nature of their own condition: "...they [nurses] work hard, they're so helpful and nice to talk to. If they're not concerned, why should I be?"

All patients expressed a framework based on the degree of perceived effectiveness in interpersonal interactions, most effective were family, followed by family physician, nurse and specialist. Patients thought that the nurses were more help than the doctors, and the family physicians were more help than the specialists. Further, they suggested that the doctors are good at telling the mechanics of what went wrong, and the nurses better, but they imply a strong need to have the illness problems addressed.

One of the reasons that nurses are perceived as better at disseminating the information is the amount of time they spend with the patient. For a patient, time spent is interpreted as care given. Although the patient may not absorb the information any more carefully from the nurse than from the doctor, because of the time spent the patients feel they are getting better care. Being more in tune with the daily routine and concerns of the patient, the nurse is able to address the illness problems better.

Most of the patients using an interpersonal coping strategy (n=11) feel that the best people to help them are their own families (n=9). Through them the patients have a strong external cue to action. The patients felt that most of the good information they learned was from their families. From knowing them over the years, the patients felt that it was their family that was the translator of new technical knowledge into the pattern of their daily life. The family can be seen as the interpretor of their illness concerns by the way in which the family members assume responsibility for the implementation of the treatment plan once the patient is home. In this manner, the opinion of the family is of great importance to the patient, and one of the telling ways in which the patients respond to external cues to action.

Coping Strategies

Case seven:

> A 46 year old man. He was divorced and had remarried. He moved from the east to Victoria 15 years ago to further pursue his career. He had the previous cardiac experience of an angioplasty two months prior to the MI. It was perhaps because of this that he demonstrated action and interpersonal coping strategies:
>
> > I've talked to the people at the Y [the YMCA's cardiac rehabilitation/fitness programme]. In this programme everybody, they're all people with cardiac problems. I guess I'm getting a lot of support from them. That's one of the ideas of the programme, everybody should be supporting each other. It's a good programme in that sense, and its easy for me to talk to them about it. Because they're all in the same boat anyway. So yeah, I'm able to talk to people about it in that sense. Plus my wife. I talk to her about t. I'm not entirely sure whether she fully comrehends how I am, or how I feel. She, like myself, knows how I was before I went into the hospital. You know I could do so many things that I feel I can't do today. Two weeks ago I'd go out here and climb mountains. Today I hesitate going down them.

Of the coping strategies discussed in the methodology, the patients exhibited strategies in three major categories: action (61%, n=8), control (61%, n=8) and interpersonal (84%, n=11). No one strategy was the only one used by any patient. More often the patients responded with a myriad of techniques for getting better, which fell into the strategies discussed. The main

strategies presented are the ones most often mentioned in discussion with the patients.

Control strategies are often used in a response to powerlessness imposed by both the hospital and the condition itself. Most of the time the belief is that one has to follow the instructions as closely as possible (according to how much they are willing to do): "You get better...only if you do what you are told", "I've made up my mind...". How much control over themselves patients feel they can retain, or how much more they will acquire by following the programme, often determines strategies that follow.

Action strategies are essentially those that allow the patient to actively seek health, or a return to health. The patients felt that they would follow most of the programme and thus actively seek a return to health. For the most part this is in keeping with the goals of the programme as well. What does not correspond to the programme design is the patients following the programme by doing only those things that they rationalize as being the most important. This was dramatically shown by one patient who took the occasional puff from his wife's cigarette during the interview. His feeling was that, since his wife, who had herself suffered cardiac problems, could still occasionally smoke, it should be all right for him to adopt this

behaviour as well.

By extension of their illness concerns, the patients adopt those segments of the programme that meet the requirements that they are willing to undertake: "I won't change much", "I'll stop worrying", "I'll lose weight", "I've stopped smoking". What they do is a combination of what they want and what they see as most important.

As described in "Cues to Action" above, the family is a primary mechanism of interpersonal support. As a strategy, this overlaps with the cues to action with the family as supporter and interpretor of the BMM. The mechanism used in an interpersonal coping strategy places much of the responsibility on the family: "...it's her [wife's] job to keep me in line". This theme was often repeated by the patients. This feeling was also adopted by the spouses when interviewed, they felt that it was in fact <u>their</u> responsibility to get the patient better. This did not often go to the extent of placing the family in the "caretaker" role, especially if the patient was interested in getting better themselves.

Using these strategies as a measure, if the patient, after responding to the powerlessness, had decided that taking action was necessary, then the family was included as a support group. One man recognized the importance of diet and had asked for his wife's help.

She responded by adopting the recommended diet for herself as well; misery loves company. However, if the patient's response to the powerlessness was avoidance or denial (escape coping strategies), the task of getting the person well fell to the family. A husband used inappropriate behaviour to trigger this response in his wife. The wife volunteered the information of her attempts to try dissuade her husband from pursuing the activity, in this case, eating inappropriate food. That the husband enjoyed this interaction can only be assumed from his chuckling and obvious enjoyment at the story.

> [to wife] I guess you help him with what he's going through?
> Wife - Well, I try to..."don't do this, go for a walk"...
> Husband - ...I go for a walk sometines, by myself...
> Wife - ...It's also hard 'cause sometimes he likes his supper and he has dessert like always, and he has tea, and wants a couple of cookies,
> and pie, and ice cream!
> [husband responded to this with laughter]
> Husband - Well...smoking...
> Wife - ...But you don't want to gain too much weight!
> Husband - Well,...I'll work it off once I'm back to normal.

Dysfunction

Case eight:

> [the following fieldnotes were dictated following the interview]
> One thing I noticed before I went up and as I

was driving away from the interview was that he [the subject] was gardening. There was a hand lawnmower...and he was down, bending down, and cutting or edging with the hand clippers [during the interview the patient had admitted to cutting the lawn].

The patient is a 42 year old man, he has been married for 20 years and still has one child at home. He smoked for years but his stay in hospital scared him into quitting. He had no history of heart problems, but had previously recovered from serious accidents. He expressed the opinion that he was too young to have a heart attack: "People my age don't have heart attacks!" Perhaps this accounted for his high level of activity when interviewed at home fifteen days following the MI:

> [Sean] You say you've stopped smoking. Is there anything else they told you that you have to change?
> [Patient] Slow down for a good long time. And that's self-defeating anyways, because when I came home from the hospital I just didn't have the strength to do any...and its a slow excercise programme to get my strength back. It's going to take awhile. Nothing heavy, y'know, normal-be careful-slow down stuff. Don't mow lawns, don't lift things for awhile...And there should be no reoccurence. They've fixed it, and it should stay fixed.

This patient, in the course of the afternoon's interview, engaged in a contradiction between image and activity. His behaviour did not agree with his expressed beliefs, nor did it correspond with the rehabilitation programme's emphasis on a slow return of activity. His behaviour, in this case, is descriptive of his EM. His high level of activity is indicative of his perceived level of sickness.

It was felt that three types of dysfunction drawn from brief therapies (described in Chapter Three) would be found in the data. As can be seen from Table 1, the patient responses could only be categorized, for the most part, under two of the three dysfunction types.

A form of family epistemology based in maladaptive social interaction was expected. However, with only 15% (n=2) of the patients expressing problems, this expectation was not supported. Coupled with patient reliance upon interpersonal relations in 84% of cases, and the family seen as best in 69% (n=9), the results indicate the opposite of what was expected, that families seem to aid rather than hinder patients.

Of the two remaining forms of dysfunction, both the attempt at a wrong solution and a response to hierarchy are a response to the powerlessness involved in the cardiac experience. An attempt at a wrong solution was suggested by some (46%, n=6) of the patients. This form of dysfunction was indicated through patient rationalization of the programme in accordance with their own EM. Rationalization allows the patients to legitimate either their own activity, or why they cannot follow the hospital's recommendations. By rationalizing a wrong solution, the patient is expressing a problem in complying. Further reinforcement could amplify the

behaviour into non-compliance.

The second type of dysfunction, a response to an incongruent hierarchy, was exhibited by 53% (n=7) of the subjects. Patient responses operated upon two constraints: those imposed by the staff and constraints of the condition itself. Hospital schedules involving visitation, meals, medication, activity, emphasized the powerlessness of the patient in the treatment situation. The other response was to the very real disabling effects of the condition, which limits activity, creating frustration in the patient, and again emphasizes powerlessness in the face of the problem.

As seen in Table 1, the impact of the condition on the patient is great. The table shows that most patients expressed both benefits and costs arising from the cardiac experience. Of note, however, is that the benefits to be gained from the programme are mainly physical, for example, excercise for a return to health. This response was seen in almost 60% of those patients expressing benefits in the programme. Of equal value and expression are the emotional costs, the frustration and depression associated with the condition. Responses to internal cues to action show this physical/emotional distinction, the distinction I have termed as that between disease and illness. The programme responds to

the technical aspects of the condition but has yet to address the illness problems expressed by the patients. As can be seen in the following, patient compliance with the Cardiac Teaching Programme itself is good.

TABLE II - Patient Compliance with Cardiac Teaching Programme

A	B	C	D
no smoking	8	0	1
diet	2	7	NA
excercise	8	4	1
control of stress *	2	7	NA

A - Activities emphasized by the Cardiac Teaching Programme
B - Number of patients expressing compliance
C - Number of patients expressing compliance, but with difficulty
D - Number of patients observed non-complying by behaviour

* "stress" is an intangible response and therefore hard to define. Three criteria used here are expressed frustration, depression and problems arising from the condition.

Table 2 shows patient compliance with the main points of the Cardiac Teaching Programme. As seen, patients express overall compliance with the programme. However, the patients also express difficulty in complying with the recommendations of diet and control of stress. By emphasizing those behaviours with a "good return" (see Chapter Five), the programme focuses on the technical aspects of the condition. As has been described, the knowledge of the disease is fine, but there remains another facet with which the progamme must deal, that of the illness derived from the cardiac experience. Table 2 shows good compliance with the programme, as far as it goes. The research in hand shows that patients are more concerned with the illness problems that are not covered by the programme. Furthermore, this study suggests a possible basis for non-compliance found within the interaction of the BMM an the patient's EM.

SUMMARY

The coping strategies, cues to action, response to benefits and costs and so on, are all combined into the response the patient makes. The purpose of breaking down responses into the various categories is to suggest an uncomplicated way at arriving at the concerns of the patient, their concern over illness problems. The

pattern of open-ended descriptive questions allows patients to describe their concerns as they want to, and in a manner they choose. It is hoped this will lessen the barriers that can exist due to the power structure inherent in the treatment situation.

This study does not cover all concerns of the patients. The description above highlights some of the more pressing points. Not only are the patients concerned over what the illness will create in terms of problems in their lives, they also use this information to determine how much of the programme is viable in terms of their own recovery; it affects how compliant they will be. The following chapter will describe a basis for looking at why patients rationalize the information to suit themselves, and perhaps what can be done about it.

CHAPTER SEVEN

CONCLUSION

The preceding chapters described many different models, theories and strategies used to study problems in clinical settings. If the essence of this study were to be derived, it would simply be a study of acculturation. It has been a study of illness problems through the veils of different theories and aspects of communication.

THE PATIENT IN ADAPTATION

Eisenberg (1977) described many of the illness problems associated with patient status as based on a "disvalued state of being". Much of the information elicited during fieldwork validates the notion that adaptation to anything has a cost. One way of viewing this is the disease/illness distinction. Patients must adapt to their condition, but adaptation is less effective if the perceived cost of change is too high. Patients all exhibited what can be described as a good disease knowledge (they knew much of the specific etiology concerning what happened), but it was their illness concepts that determined what part of the programme they were willing to accept.

> I think the nurses were well informed. In both areas that I was

> in. Those girls seem to know a lot, and were quite willing to listen, and I could sense, that they didn't want to cross a line of trying to tell me, or get into areas...I would have suspected they wouldn't have anyway, when it comes to discussing findings, and charts and stuff. Generally speaking, they gave me a lot of information, I know. I've been in for X-rays, and I went in for this nuclear, radioactive, particle photography, or whatever you want to call it. So I said to the guy, "am I gonna make it through the night?" and "oh, yeah, yeah", smile, and I says, "well, how's it look?", and "oh, I'm sure that your doctor, when he gets a chance to look at all these, will tell you". I'm sure this guy who did the tests, can look at it and know, himself, whether it was good or bad. I mean that's part of their training. And I'm sure he did the correct thing in not telling me, but that's the type of information that you'd kinda like to get.

Much of the information can be described as part of the deviation amplifying feedback described earlier. If the information given the patients is perceived as negative, it will narrowly define the type of response the patient should exhibit. And it does. The patients believed that because they had an MI, they were supposed to be sick, and that they would likely die of an MI.

> Just knowing I'm high risk, and that one day it could hit me, and [pause] so what? y'know. My biggest concern, then, is will the rest of the family be able to cope? And mostly they will, I think. My wife, I don't think she'll cope very well, if it happens. It could, maybe it won't.

In this the patients do express their symptoms as a form of communication. Although the HCP will tell them things about their condition and are perceived of as very thorough in what they do, "there are still things I need to know"(patient's emphasis):

> I'm looking for answers that maybe nobody has, y'know? "What are my limits?", and "to what extent can I test them" after the healing process, which I need to give close to six weeks for, I believe, and how can I test it?...and well, I don't know, all they can do is give me stats, eh?

In this way one of the most important dysfunctions ascribed to the patients is their attempt at a wrong solution (see Table 1). Much of this has already been described as centred around the manner in which the patient rationalizes the programme to fit that with which they are the most comfortable. This can be seen in the following two examples:

> Example one:
>
> [Sean] Is it important to follow the programme...
> [Patient] Right down the middle? Nah. It should be important but I can't do that....If you have to, you have to. They want me to, But I could never do that. Could you?
>
> Example two:
>
> [Patient] But I know from my experience that once you get back into the routine of living again, your normal life and your work situation, and so on, a lot of these things are soon forgotten. You know

> you just can't remember them. I imagine that the same thing will happen again. You know my mind has been refreshed as far as ways of relaxing and ways of trying to get rid of stress and all that sort of thing, and I can practise that now, but I imagine that once I get back to the regular routine as far as the work situation and everything else is concerned, that a lot of those things will have been forgotten. It just isn't possible to live a normal type of life and keep all those things in mind.

Often their behaviour indicates this rationalization and wrong attempt at a solution. This goes beyond the patients expressed compliance with the programme's recommendations (see Table 2). Some patients admitted that they were doing more than they were supposed to, but that it was all right for them to do so, mostly because it was in accordance with their belief system. The emphasis on normal life being one precipitating factor in heart disease leads the patient to the conclusion that his problem is normal and his non-compliance becomes validated.

The general trend among the younger (in their 40s) patients was that 'I'm still young, so I don't have to worry':

> [patient] That's the last thing...that I was ready for a heart attack.
> [wife] The first couple of days after it..."this isn't me, this couldn't really have happened to me"...He went through that. But not

> the depression, just saying "can you believe this is happening to us?"...
> [patient] I've had a heart attack?!!
> [laughter]
> [wife] ...we've been through a lot in the 20 years we've been married, you go through a fair amount of ups and downs, but...
> [patient] ...people my age don't have heart attacks...and in my own mind I'd have thought a heart attack was different than what I had.

There are many corollaries wrapped up in this statement that I feel are important. Many of these have been discussed already under the section dealing with the patient's view of the programme. There appear to be age-related responses by which we can classify the impact of the programme on the patient's life. If young, one will recover, mainly because it should not have happened in the first place. It only happens to the old. If one is older, one may or may not be expected to recover, but it is all just part of life. The focus in these distinctions is that suffering, and perhaps dying, from a heart attack is seen as a <u>normal</u> part of the course of one's life. If it is something that is expected to occur in life, then the patient assumes they do not have any control over it, and therefore cannot do much about it.

This feeling of powerlessness is a function of the second major form of dysfunction described in Chapter Six, the response to an incongruent hierarchy. This feeling that they are unable to do anything about what

happens to them is heightened and emphasized to them during their stay in the hospital.

> [Patient - English is the patient's second language accounting for the dialect in the following]
> The main ward, where you met me. You could talk to different guys but the other [CCU], the other...SHEESH! All by yourself. Seven days there? Hooked to a bunch of hoses and wire and you just lay there, that' all you do. If you need a nurse you ring the buzzer, wait 'n wait 'n wait 'n wait.
> [Sean] What was it like?
> [patient] You a very independent guy there is. In the hospital you know it impossible for you to go to the toilet, stuff like that. Ask for this, ask for that!
> [Sean] Do you wish you were in more control...
> [patient] Right! If you go for a walk you have to take a nurse with you. I like to go for a walk by myself. Get it over with...You gotta wait for this, you gotta wait for that. I HATE IT! Everything is...you know, certain times! You wait for your pill, you wait for you breakfast, you wait for nurses to take you for a walk, then you wait for lunch again, then you gotta go for a nap, then you wait for the nurse for another walk again.

It is in the hospital that the patients become aware of what is expected of them and take the initial decision on whether to comply or not. Therefore, we must look at the hospital for the initial impact of the condition on their lives.

Although they feel that the staff (meaning usually the nurses) are 'wonderful', they sense that the

power structure of the hospital is set up against them.

> You see all this is going through my mind at the same time, and that's what makes you think to yourself. But you can't...no doctor's going to go against another doctor, as far as I'm concerned. Doctor's ethics or something isn't it? [laughter]

Much of their identity as a patient within the system is derived from their response to the system itself. An example of this can be seen in the levels of activity the patient achieves taking on a form of ritualized status. The patients do respond with frustration and boredom to the hospital's scheduling of events. These are mainly the responses associated with the staff-generated activities.

Perhaps more important is the level of activity that the patient has attained. As described to me while visiting in the hospital, it serves to create a status and label for the patient. The activity levels (see appendix) indicate to the staff how far along the patient has progressed in their recovery.

To the patient the level of activity has two contradictory functions. At one the activity level indicates to them how well they are doing and that they are indeed getting better. The notion of 'levels' also highlights the fact that they are sick, and what their behaviour is to be according to what level. Some patients desire to progress quickly and are frustrated at

the constraints indicated by the level. Others may seem 'stuck' in one level, which creates frustration and anxiety and highlights their feeling of being sick.

There is also a spatial component that determines the impact of the condition. As has been described, the stay in the hospital usually lasts 12 days, with about one-half in the CCU, and the remainder on the ward. The CCU, as described in the section dealing with the setting, is at the end of the ward. It is in a new extension to the hospital and is separated from the main ward by a set of fire doors.

> Then I got moved to a ward, and I was there for six days. I didn't like that, at first, but once you get used to it...
> [Sean] What was wrong with it?
> Well, a room all to your own [in the CCU]. And those gals really make you feel good. I felt to be moved away from that, I would rather have come straight home. Get dumped in an unfamiliar place with new faces. Dark room, I wasn't near a window. And then you saw other people in worse condition or better, depending on what was in the room. That first day, boy, it hit me like a ton of bricks. That hey, y'know, you're a casualty, you're in a different category...

It is movement through these doors that focuses the condition for the patient. To the HCP, the move out to the ward means that the patient is out of danger, that they are well enough to be released from constant surveillance. To the patient, going out to the ward was

when they first realized the danger they were in. While they were in the CCU, they got great care; they really felt like they wanted to live. But once out on the ward, the perceived care diminishes. Not that they are not being well cared for, but as the patient described it: "that's when it hits you that you're a casualty, y'know".

It is here that the restrictions of the power structure take effect. Whereas in the CCU patients could have visitors 24 hours a day, in 4Royal it is only between 3 and 8 p.m. It is here that the time schedules became frustrating, and where boredom plays a major role. For most of the day, outside staff-generated activities, all there is for them is to read or watch television ("the boob tube", "the box") and wait until visiting hours arrive.

It is at this point that I feel the patient starts to emphasize distinctions between what I have termed disease and illness, without of course, using such analytical terms. How the condition will affect their life becomes their primary concern. This is the point at which the patient decides on the strategies he or she will use when they return home, and thereafter. It is here that the information given to the patient is 'pigeon-holed' into the patient's EM. This was a pivotal time for the patients and this is why the research

reported here may be important.

RECOMMENDATIONS

A study of clinically applied medical anthropology must live up to its title; it must be applied. The section following contains suggestions based upon the research that might be applied to offset some of the problems which have been identified.

Recommendations developed from this study are not intended to turn health care professionals into social scientists. Rather, awareness of the different cultural perspective of the patients gives the professional one more tool that may be used in the development of a successful rehabilitation programme.

These recommendations will fall into two forms: those that may be easily implemented and of a more general nature, which owe their place to the social hierarchy. These recommendations would be more difficult to effect because they involve culture at the level of basic assumptions.

General Suggestions

These suggestions deal with the role that the condition plays in the social identity of people so afflicted. Both deal with the general perception of

their condition held by the patients interviewed. Virtually all the patients felt that they did not have a heart attack because the popular mass media does not portray an attack as what they had, in fact, experienced. Furthermore, the attack was not supposed to come at their particular age, it was thought of as something that one has when one is "old".

The stereotypical mass-media heart attack is the 360 degree spin, clutch at the chest, and collapse while dramatic music plays over. This image was not consistent with the experiences of the patients, and, as such, the attack was not recognized until, in some cases, death was imminent.

This problem is related to the behaviour that the culture associates with the illness, creating an expectation in the individual that was not fulfilled by the reality of the cardiac episode. The popular belief decrees that the condition will be manifested in a manner which it simply is not. More significant is that the culturally defined illness is deemed a normal part of life in our society; it is something to be expected with age. Our culture does not define the illness for what it is, a disease that does afflict some individuals but which should not be expected or accepted. The condition is so widely accepted that it has become not a disease but a fact of life, in the literal sense. Heart disease

has been defined as condition afflicting virtually everyone as they age. Therefore, a change must be made in the popular conception of both the heart attack and of coronary disease.

The cultural norm of the heart attack must be shifted away from the complacency and wide acceptance it now enjoys or rehabilitation and prevention will be compromised. The individual's beliefs will be shaped by the norms, and it is the beliefs with which one must deal in the treatment situation. Change the norms, in this case the acceptability of the condition, and the beliefs will follow suit. Changing norms, however, is a difficult proposition; they are the norm.

The most effective manner of changing norms is through public education and media attention. This has been successfully accomplished elsewhere (Mitic and Perkins, 1984, Puska, et al., 1979). Though operating in a dialectic, this is not circular, for it is the individual who suffers the condition, and it is the individual who enters the treatment situation. Therefore, it is with the individual's beliefs that the problem must be countered.

Specific Suggestions

It can been seen that the patients in the rehabilitation programme are satisfied with the technical

knowledge about the disease but are dissatisfied with the treatment of what I have termed the illness. The following suggestions are the ones that are felt to be the most easily initiated and will deal directly with the patients' illness concerns.

The patients have fear, frustration and confusion about their future course of action. The information offered by the rehabilitation programme would be more effective if it dealt with the patients' concerns, those of the illness problems, or the problems that the condition creates in their lives. The technical or disease knowledge is fine, but the patients feel they need to know more--more specifics about their lives and their futures. The patients need to know what they can expect from the condition. This is difficult for the professional to deal with because the professional and the programme are less concerned with the idiosyncratic features of the various patients lives.

An emphasis on the illness presupposes a close understanding of the patient's lifestyle and beliefs. This close understanding is perhaps overly optimistic given the very real time constraints placed upon the staff. The staff can only act while the patient is in their care. However, the information suggested could prepare the patient for possibilities of what they may experience once they return home. Is this going to make

me an invalid? Is the active part of my life over? I stress that the impact of the condition on the patient is more effectively approached from the direction of the illness and not the disease.

Many of the illness concerns are centred around the future. As has been seen, this fear of the future begins with a shift in the hospital ward itself. Once the move to the ward has been made, the impact of the condition starts: "That's where it hits you that you're a casualty, y'know?". The move is made because the patient is essentially out of critical danger, but the move actually emphasizes the danger from the patient's perspective.

Part of the problem involved in the move from the CCU to 4Royal has been described as the impact of a more structured routine. The change in visiting regulations and the increase in the nurse/patient ratio have been already described as emphasizing the impact of the condition for the patient. Because time spent is perceived as care given, a reduction in the nurse/patient ratio would de-emphasize the impact of the condition following the move. Allowing for more interaction between patient and professional will alleviate problems of social distancing associated with reliance on audio-visual and written forms of information.

This suggestion is problematic in that an

increase in staff is required that is not feasible given the limitations of budgetary constraints. However, cultural responses in health care have been shown to be cost effective in the literature (Weidman, 1982: 236-237). In this case, by establishing effective therapy initially, the potential recidivism by the patient is lessened.

Increased interaction should also occur with long-term follow-up of the patient following discharge. Contacting patients at intervals (for example three months, six months, one year) would allow the professional to determine the effectiveness of the programme by examination of the patients' incorporation of information into their EM and influence on behavioural change. Ongoing internal monitoring of the programme would help ensure its responsiveness to patient concerns. The suggestion of greater time spent in patient education emphasizes the importance of not just disease treatment but of illness management as well.

The future of the patient should be positively addressed. The move the CCU to 4Royal should be progressive, it should indicate an advance in status for the patient. Once on the ward, the routine for the patient has shifted. They are alone longer, with less to keep them occupied. The patients described the emphasis on their activity as an emphasis on the "don't do..." as

opposed to their concern over what they can do. It is widely recognized that the stay in the hospital is boring. Not many of the patients enjoyed watching television or listening to the radio for days on end.

There is reading material available to the patient, but I think this should go one step further. It should be suggested that the families of the patient provide material with a future orientation. If the person has a hobby, encourage future thinking about that hobby. If the family had been planning a trip, although postponed, the trip plans could be reviewed. While the patient goes on to recuperate at home they can continue to consider projects to pursue.

The hospital can provide this as well in the form of travel and leisure magazines. Magazines of a more general appeal, with sections covering travel, home improvement, gardening, cooking and so on, invite planning on the part of the reader.

A future orientation for the patients might alleviate the illness problems that were expressed by the patients. It is hoped that an increasing emphasis on the illness problems, and then offsetting these by instilling a future orientation will create an environment where the patient not just survives but is allowed to live again.

Beyond simply providing the patients with more staff generated activities and material to alleviate

boredom, the impact of the condition at this point must be addressed. The shift from the CCU to 4Royal marks a shift away from optimism on the part of the patients. To ensure that a future orientation is maintained by patients, information about resources and associations available as aids in social support should have more emphasis. Such organizations (for example the YMCA's programme) are established and capable of helping the patient in dealing with the illness. However, of the patients in this study only one was aware of such an organization and was actively pursuing this interest.

Organizations of this kind, whether formal or informal, allow for patient interaction with other people with similar cardiac experiences away from a medical setting. Patient-based groups, being less formal, allow for easing of illness problems patients develop from their cardiac experience.

A format by which this may be accomplished falls within the guidelines of an 'action anthropology' programme where one or two patients who have recovered initiate - perhaps with the assistance of the anthropologist - an independent group to serve as role models for current patients. Such voluntary organizations have been developed for other groups (parents who have lost children, the bereaved, and so on) who must also deal with illness problems. The fact that

our society has paid scant attention to the support and assistance of heart attack victims is indicative in itself of the belief that heart attacks are normal.

Despite the fact that heart disease remains the leading cause of death in our society, the culture holds only an inaccurate description of the event and the widely held belief that it is inevitable. Thus the problem becomes perpetuated at all levels. This kind of problem can only be dealt with by a change in basic beliefs and assumptions. The suggestions generated here are only meant to serve as a catalyst for such action.

SUMMARY

I hope that this research demonstrates the need for a behavioural science approach described by Weidman and Egeland (1973). As shown, the strategies developed by the patient may be a combination of the patient's perceptions, typical coping strategies, and may result in some form of dysfunction. This research delineated categories that allow for the interviewer to elicit the information needed to attain some comprehension of the patient's explanatory model. The scope of this research is far too small to be in any way definitive, but I feel that the information gathered indicates the validity of the use of these models in health-care research. Furthermore, I believe that this research shows the

validity, and utility, of assuming an anthropological aproach when using models and theories which necessitate dealing with people in clinical settings.

Models described here, and used during analysis, are just that, models. They work as a tools of analysis, but it is of more importance that they work for the patients. Research should be done not solely for its own sake. It is my concern that this research will benefit that group to which anthropology owes its existence: the people themselves.

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APPENDIX

PATIENT ACTIVITY CHART

(reduced 25%)

ROYAL JUBILEE HOSPITAL

Patient's Activity Card

Your progression from one level of activity to another will be ordered by your doctor.
A member of the Nursing Staff will check your pulse before and after each activity period.
Each new level includes the activities in the Level before it.

ACTIVITY PROGRAMME
Date

	Level 1	Bedrest	Includes: Feed Self - Use Bedside Commode - Wash hands and face - Stand to Void
	Level 2	Dangle	Up to 15 minutes T.I.D. as tolerated.
	Level 3	Up in Chair	3 x daily 1st time 15-30 min. - 2nd time 30-60 mins. - then as tolerated.
	Level 4	Shuffle	30 feet 3 x daily - May have bathroom priv. per wheelchair for B.M.
	Level 5	Walk	75 feet 3 x daily - Up in Room PRN - may wash at sink. - BRP if bathroom adjacent to room.
	Level 6	Walk	150 feet 3 x daily - Up in Hall PRN - BRP even if not adjacent to room.
	Level 7	Walk More Briskly	400 feet start Step climbing 3 x daily - First day no stairs.

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Author [redacted]

Robert William Sean Steele

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