Lay evaluation of health and healthy lifestyles: evidence from three studies

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SUMMARY. The maintenance of good health in the well population is an important goal of modern general practice. This often takes the form of encouraging patients to lead healthier lives, particularly where diet, exercise, alcohol and smoking are concerned. The fact that many people appear not to follow 'healthy lifestyle' advice suggests that more needs to be known about how relatively simple health promotion messages are understood and evaluated by the lay public. In this paper, findings from three independent qualitative social research projects in Scotland and Wales are analysed together. As qualitative social research is usually carried out with small numbers of informants, the work reported here represents an unusual opportunity for a large amount of interview and observational data to be analysed. The findings indicate that lay evaluation processes use subtle ideas of balance to weigh up the desirability of behaviour change, and that the practice of 'trading-off' positive and negative aspects of health-related behaviour is widespread. Conclusions for health promotion in the general practice setting are drawn. In particular it is suggested that the local knowledge held by the primary care team, and the opportunities for one-to-one interaction which exist in the general practice setting, are extremely important resources, given the highly personal nature of public evaluations of lifestyle change.

Keywords: attitude to health; patient health beliefs; lifestyle; qualitative research.

Introduction

MODERN medicine has always maintained an interest in the preservation of health and the avoidance of disease, in parallel with the diagnosis and treatment of sickness. Recent decades have, however, seen a considerable expansion in the resources devoted to preventive medicine and the development of health education and health promotion as important professional fields in their own right. General practitioners, traditionally familiar with their patients as they pass from health to illness (and often back again) are now contractually obliged to extend their interest to the well population by developing various health promotion activities within their practices.[1]

The encouragement of 'healthy lifestyles' is an important component of preventive medicine policy. This somewhat amorphous concept is generally recognized as being centred on three areas of personal behaviour: food intake (high fibre, low fat), participation in physical exercise, and a reduction or cessastion of drug use (principally alcohol and tobacco, but also various illegal drugs). The overall goal of health promotion and health education in the 'lifestyle' field is to bring about a situation in which as much of the population as possible adopts behaviours within nationally defined guidelines.

In practice this goal has proved difficult to attain; and it has become commonplace to recognize that social and cultural issues loom large in the personal adoption (or not) of 'healthy behaviour'. Consequently, social research has come to represent an important resource for behavioural preventive medicine. Recent assessments of the field highlight the potiential role of non-medical research, and in particular the importance of understanding patients' perspectives on health and illness. Kelly and Charlton maintain that: 'The social sciences can contribute to our understanding of both individual and group behaviour in ways which are directly relevant to health promotion.'[2] Pill explained this further: '[An] exploration of the patient's viewpoint and a greater understanding of perceived barriers to change and the factors associated with successful implementation can help health professionals to intervene more sensitively.'[3]

This paper draws on the findings of three social research projects and analyses some of the ways in which lay people define and make sense of health and illness and their associated behaviours. In particular, the paper analyses the popular culture surrounding ideas about 'healthy lifestyles' and lay evaluations of the relative worth of associated behaviours.

Three research projects

The ways in which health concerns and lay evaluations are interwoven with other social constraints or opportunities in daily life have been studied in three separate research projects in Edinburgh, Glasgow[4] and south Wales. In Edinburgh a multi-interview qualitative study was carried out with members of 28 families randomly selected from a general practice list to provide a research population representing social class ABC1 households each with two children under 12 years old. Men, women and children in these families were interviewed about their everyday health beliefs and behaviours during a two year fieldwork period.[5] In Glasgow a qualitative interview study researched the health beliefs of 70 men, each randomly selected from a Medical Research Council register of residents of the City of Glasgow. The sample was designed to represent men in different occupational classes and an age range of 30–49 years.[6] In south Wales, semi-structured interviews and ethnographic observations were carried out with a total of 160 adults randomly sampled from the electoral register in three different wards. The south Wales sample was designed to cover men and women aged 18–70 years, across a range of four occupational classes.[7] While the central theme of all this work was prevention of coronary heart disease, interviews covered many aspects of health and the development of illness.

In each of the studies, the principal data collection instrument was at least one in-depth semi-structured interview carried out with each informant singly and in private.[8,9] Each research project aimed to make use of less structured interactions with indi-

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vidual informants and naturally occurring groups and, as is customary in ethnographic investigations, informal conversations with informants were also treated as valuable data.[10] In each case, the transcripts of tape-recorded interviews and contemporaneous notes were used to document research activities and provide textual material for analysis. As the goal of qualitative research is to site or 'ground'[11] the understanding of thought and behaviour within specific social or cultural contexts, data produced by the research methods outlined above were analysed 'inductively',[10,11] to generate analytical categories which flow from the informants rather than from the researcher(s). Thus, each study aimed to interpret the structure of thoughts and behaviours in the light of the social worlds inhabited by the informants themselves.[11]

Analyses carried out independently by each of the three researchers have revealed considerable overlap between the studies in the ways in which lay people make sense of health and locate ideas about healthy lifestyles within the complex process of deciding on courses of action in everyday life. The common results are discussed here.

Results

Weighing up the evidence

One major theme was that lay understandings of evidence about health and illness drew on a wide variety of perceived influences. Respondents in all three studies saw these influences or causes as including not only individual 'lifestyle' behaviour, but also heredity; social, political and economic factors; the wider natural or man-made environment; and luck, chance or fate.[12] Respondents engaged in complex processes of weighing up the contribution made by each of these factors both to health and illness in general and to individual episodes of morbidity or death. Furthermore, causation was seen as multi-dimensional, and therefore weighing up the evidence about health and illness was inseparable from social and cultural experience. For example a woman explained her severe asthma as follows:

> 'Well I think it's quite a combination of things. I think obviously, part of it's hereditary obviously if my cousin has got it ...[and]... a lot of it was brought on by stress in my marriage as well you know. I think if I hadn't been in a marriage to the person I was married to, probably I might have escaped. Or might not have had it so severe.' (Woman, 55 years, south Wales)

The three studies also indicated that there were important differences in how evidence about health was evaluated by lay people, compared with health professionals and scientists. In popular culture factors affecting health were experienced as a whole, and, depending on individual circumstances, might be drawn upon as equivalently weighted explanations of health and illness. In, contrast, health professionals and scientists are concerned to attach very different relative weights to these factors, often dependent on their own particular profession or line of enquiry. Moreover, in lay evaluations, particular items of knowledge could be used or discounted depending on the immediate question to be answered. Such pragmatism could be discordant with the 'facts' or 'programmes' which health scientists or professionals may wish to promulgate. One woman echoed the views of many respondents when she said about food and health:

> 'I mean with this dieting and everything now well you don't know which way you are going. You jump this way or you jump that way for this and that, but if you eat moderately of a little of everything and then I, we personally think you're just as well off. Because we all need fats and things as much as we don't need it. Its no good for one thing but then you need it for other things.' (Woman, 39 years, south Wales)

For the lay person, individual circumstances or pressing specific questions to health and illness affected the processes of weighing up the evidence. This may appear very different from the approach of general principles adopted by health professionals. For example, respondents regularly discounted the current scientific evidence about the harmful effects on individuals of say, drinking, smoking, 'unhealthy' eating or lack of exercise in favour of a more multidimensional model of structurally based health effects such as poverty, overwork or unemployment, environmental hazards and living conditions.

Not only did different constructions of health often appear together, but specific links were made between them by the respondents, as one man said:

> 'There are circumstances which would tend to make folk ill. Taking the world's problems and things like that ... I suppose there are some people who are caught in what you would call the poverty trap. No matter what they do, it is like climbing a muddy slope, you never get any further. Quite often a depression type thing could lead to many other illnesses.' (Man, 46 years, Glasgow)

Here, the respondent linked aspects of the environment to mental state and then to physical illness.

Not only were there differences in the actual evidence which was seen as relevant by lay people, but also the way in which scientific evidence is evaluated, developed and transmitted by professionals could be alien to the lay public. Contradictory and conflicting knowledge resulted in a degree of scepticism about scientific knowledge in general.[7] While disproving the null hypothesis is integral to the development of scientific knowledge, lay processes of evaluation required less changeable 'certainties'. As one responent pointed out:

> 'As a child I was always brought up, well you should drink milk and you should eat eggs and you should eat butter otherwise you're not going to be healthy. Well today you're not supposed to do none of them are you? So really who is right?' (Woman, 61 years, south Wales)

The three studies showed that the multidimensional model of lay evaluation also included the idea of 'weighing up' evidence or examining processes of health and illness with reference to everyday observation. Frankel and colleagues liken this activity to scientific epidemiology, in so far as it involves linking ill health to its surrounding circumstances to support or challenge 'theories' of disease causation.[13] This 'lay epidemiology' operates closely with the notion of 'candidacy' for particular illnesses: the existence of idealized images of the kinds of people who 'ought' to experience particular ailments. The fact that people who are sick in real life are often not classic candidates, and the allied fact that people who are candidates often remain well, provide a rich field for discussion, humour and the general cultural manipulation of illness and its possible behavioural causes.

The concept of lay epidemiology can be expanded to encompass health as well as illness. Here the epidemiological work becomes broadened out to take into account wider aspects of people's ways of living in order to assess 'what is healthy'. The studies showed that lay evaluation processes include examining what people 'look like', what is 'their attitude to life', how adequately they function in their work and personal life, how they cope with life's crises, how happy they are and so on. Thus, in

the lay system, healthiness was weighed up not just in physiological terms but in social, emotional and moral or spiritual terms. The health parallel of the lay epidemiology of illness was the assessment of someone who carries out all the 'approved' health related behaviours but who also, for example, neglects his/her family, becomes obsessional about his/her physical condition, or who somehow gets his/her life out of balance. For example, a man explained:

> 'Now one of my neighbours also seems to be a very healthy bloke, in one way, but I wouldn't have actually called him a healthy bloke because I don't think his mental attitude towards his family is healthy, but that, perhaps, is a different way of looking at it.' (Man, 38 years, Edinburgh)

Carrying out reasonable courses of action

The process of translating evidence into behaviour was also found to be heavily affected by social and cultural considerations. For example, many of the respondents were able to show not only that they knew that health damaging behaviours involved risks, but also that these involved benefits in terms of, for example, well being, social acceptability and pleasure. So-called risky behaviours could be 'life enhancing' even if they were not considered 'health enhancing'. This tension was evident for example in the pursuit of dangerous sports, as well as among those people enjoying so-called health damaging lifestyles. Moreover, as in the area of lay epidemiology, the process of evaluating risk took place in a much broader landscape since each behaviour was assessed in terms of its social and environmental context, not simply the physiological context.

Also, in must be appreciated that what constitutes a risk may be viewed differently at different points in the course of life. Plainly, it was much less risky in the overall scheme of things for an elderly person to continue drinking milk after the Chernobyl nuclear reactor disaster than it was for a child. In different ways lay people also weighed up the risks and benefits of reasonable courses of action in terms of age and physiology. For example, the young body was seen as able to withstand considerable physical neglect and not give evidence of any damage to health; parents of young children may be expected to risk their health by overwork or lack of sleep to cater for their children's needs.[14]

This lay process of weighing up risks and benefits was found to be intimately connected with assessment of potential consequences. The studies indicated that, no matter how sophisticated the respondents' appreciation of probability or understanding of long term consequences of health damaging behaviours, there was a strong tendency to weigh up costs and benefits by paying attention to short term rather than the long term consequences. The main problem with preventive medicine is that if it is working there is little to show for it. In the lay system, if you looked alright, felt alright, did not have a smoker's cough, did not suffer ill effects from being overweight, were able to function adequately at work and socially, then less pressure was experienced to change any particular behaviour. The short term health damaging effects of so-called health related behaviours were also commonly recognized. When deciding on reasonable courses of action the respondents took into account their observations that, for example, people may put on weight after stopping smoking, may have to have dietary supplements if they become vegetarian, or may injure themselves in the course of taking exercise.

In the lay evaluation process, therefore, health related behaviours were only one small part of daily living. Scientists and health professionals regularly miss this vital point when they focus attention on a single item of behaviour which may be health damaging, or that they wish to change. Any item of behaviour was seen to be part of a complex whole, and a whole which was seen by the respondents as having some kind of internal homoeostasis.[6] Thus, when respondents talked about their everyday lives, moderation and balancing out the 'good' and the 'bad' in health related behaviour were dominant themes in all three studies. For example, many respondents expressed concern about 'going overboard' in terms of excesses of unhealthy or healthy behaviours. Interestingly such views are also reflected in a national survey of health and lifestyles in the United Kingdom.[15]

Such notions of balance and inter-connectedness have often figured prominently in sociological accounts of popular health culture.[16,17] It is because of the relationship between one area of life and another that the health behaviour of some patients can appear irrational to primary health care workers. For example, balance and health were connected by the respondents in terms of general way of life. This meant that one part of life, or one area of behaviour, should not become dominant at the expense of others. In the lay evaluation process happiness, contentment and lack of pressure were all held to be both the cause and the outcome of a 'healthy' way of life, illustrated by the following man's trade-off between health and a greater commitment to, and thus extra stress in, his occupation:

> 'I am not really involved in my work that much. I would not let myself get in a state. I would stop what I was doing and take a couple of days off. I have seen too many people in my work under strain and having a heart attack. One of my old bosses died at 47 with a heart attack. He was told to stop work but he did not do that. I work for money, I don't work for the joy of working for my company.' (Man, 34 years, Glasgow)

Few people, however, felt they achieved this satisfactory balance and explained at some length disjunctions between, for example, work and family commitments, personal satisfaction and social obligations. As one man replied:

> 'I can't think of anybody leading a healthy life. I think I'm probably looking for somebody who is the epitome of taking a lot of exercise, eating the right kinds of food, probably working the right hours, getting the mix between work and family right, all these sort of things. I'm not sure I can think of anybody.' (Man, 35 years, Edinburgh)

Respondents also weighed up 'healthy' and 'unhealthy' items in an individual's behavioural repertoire. In the lay evaluation process it seemed not to be expected that any individual will have a 'healthy' existence in every respect. Sometimes, in fact, such an individual might be viewed with some suspicion or judged perhaps as not 'human'. Rather it was assumed that 'we always have our little weaknesses, lazinesses, preferences'. The usual descriptions of respondents' own health behaviours and those of other people involved balancing, for example, overeating against exercise, drinking against participation in sport, sedentary behaviour against staying slim. In lay evaluation systems, therefore, a common pattern seemed to be that respondents traded-off a 'good' behaviour for a 'bad' behaviour to balance out their overall health rather than being moderate or conformist over a wide range of behaviours. This was particularly evident in the area of eating behaviour. Here balance was a practical social accomplishment involving interspersing 'good' meals with 'bad' snacks/junk food; being aware of eating healthily after a spell of inattention to dietary requirements; and trade-offs between convenience and nutritionally good food.

Discussion

The data from the three studies presented here suggest that ideas of trade-off and balance are aspects of an active management of health related behaviour on the part of the research populations. The autonomy that the idea of management presupposes is, in itself, an important aspect of these findings. Because any one individual's understanding of his or her own life is essentially unique, it is vital to underline that a patient's construction of the desirability of behaviour change may not be readily predictable.

It has been shown how lay people, in their everyday health decision making, often draw on different frames of reference and relevance from those of medical practitioners, health educators and even health researchers. It is vital to pay attention to these lay processes since the abstraction of health relevant beliefs and behaviours from the social relationships, meanings and motives of which they are part can result in inaccurate understandings of why people behave as they do regarding their health.

Something which is often forgotten, but which general practitioners face every day in the course of encouraging patients to follow prescribed regimens, is that behaviours which may have relevance for health and illness are integral components of social and cultural processes. Even the most apparently simple cause and effect relationship between a health relevant behaviour and its purported outcome is subjected by each individual to a complex process of weighing up the evidence, weighing up the risks, and weighing up the short and long term consequences for him or herself. As part of this process individuals may take into account the scientific evidence about behaviours and health outcomes. However, this forms only one part of the lay process, and one which may be outweighed by other logical (but not necessarily scientific) forms of commonsense reasoning.

Furthermore, when analysing the lay evaluation process it is important to remember that behaviours which may have health implications are often carried out for reasons perhaps unconnected with a concern for health. For example, many sports players play for fun or to enhance social life, rather than for reasons directly related to physiological health. Many non-smokers hate the smell, taste or lingering taint on clothes and furniture that smoking causes and this may be entirely divorced from any concern with health. Furthermore, even if an awareness of potential health consequences does exist, this may be accorded a lower priority in the lay evaluation process than are other socially based considerations.

As has been described elsewhere, these outcomes are best understood by accepting an analytical distinction between behaviours considered scientifically rational and those which are reasonable.[14] The difference hinges on the acknowledgement of the part played by cultural factors in the lay evaluation process. Scientifically rational behaviours assume a pure, almost mathematical model of behaviour, which should cross all cultures. However, the concept of reasonable behaviour acknowledges variation in what are felt to be acceptable beliefs and practices between cultures or between different cultural groups within a complex society. It is important therefore to investigate behaviours relevant to health in terms of how reasonable, acceptable or apropriate they appear to the lay population.

The promotion and maintenance of good health among the well members of a general practice list is now a salient aspect of the workload of the primary care team. Health promotion, indeed, is currently a contractual obligation for British general practitioners and is likely to maintain such a position for many years. Because general practitioners and their teams are community-based and see members of local populations as individuals, they are in an excellent position to develop an understanding of the environmental, social and personal factors influencing their patients' thoughts about the maintenance of good health and the avoidance of illness. This essentially local knowledge is sometimes at odds with the current goals of health promotion, which tend to underplay environmental and collective issues and to focus more on personal health related behaviours in the overall context of centrally devised national targets.[18,19] This approach to health promotion may be in danger of failing to utilize the particular strengths and advantages of the general practice setting. These are that the primary care team has the ability to build up an essentially holistic understanding of both the health of individual patients and the health profile of their community. The one-to-one nature of consultations further enhances the potential for a constructive dialogue concerning the differences between medically defined priorities for preventive behaviour and the everyday exigencies of the real lives of patients.

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