

Variation in perceptions of risk between doctors and patients: risks look different when they are close to home

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SYNOPSIS

There are no simple ‘one size fits all’ instructions to guide health professionals in communicating with their patients about risks. Patients – as individuals, and as a group – may see risks very differently to the medical profession. Understanding that things have a certain perspective to health professionals, and that other things may be closer to home for the patient, could help the health professionals better ‘speak their patient’s language’ of risk. Helping patients get a balanced, multidimensional picture of their risks may not lead to the decisions the health professional expects, but should assist people to make decisions in accordance with their values and priorities.

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There is a large and growing literature about how to try and affect people’s perceptions and understanding of risk.¹ Despite this, people often forget just how differently individuals see risks (some of us are simply far more ‘risk averse’ than others). Your perceptions may quickly change if it is you, facing a real-life decision. Radical treatments that look unacceptably risky to a healthy person (such as bone marrow transplantation), can look very different to a person with advanced cancer who is running out of options. Yet, far too much of the evidence in this area is based on studies of people saying what they **think** they would do in a hypothetical situation. Extrapolating the recommendations of these studies into real life is risky.

Health professionals and patients often view risks differently. For example, doctors have expertise, but this also means that their view of health risks may be out of proportion. What is more, doctors are so used to adverse effects of medicines, or the indignities, inconvenience and discomfort of tests and procedures, that they can fail to appreciate what these mean to the average person. Perceptions of what is ‘trivial’ or ‘mild discomfort’ can be vastly different to people on opposite sides of the prescription pad (never mind the scalpel). For a doctor who wants a healthy person to take a drug to prevent a serious outcome (such as a stroke), the image of the person with a stroke may loom very large. For the patient, though, this outcome could be far more hypothetical. Meanwhile the risks and inconvenience of taking warfarin every day are immediate

and real. Sometimes, people are simply more willing to hope for luck with life’s many gambles, than take a chance on something that might turn out to be poison for them. Others see ‘doing nothing’ as inherently risky.

Some things hold true in certain circumstances, but not in others. For example, presenting data in the most dramatic way to evoke a desired reaction may work for someone scared of having a heart attack (‘This will halve your risk’), but may have no effect on a parent intending to circumcise their newborn. A dramatic presentation is also less likely to work well when people have a fair working knowledge of something. Risk framing, as it is called, may not work as effectively with menopause, as it does for stroke. Severity of the problem matters too – fear of cancer or a stroke may outweigh most benefits of a treatment.

Just how afraid people are of a particular outcome also matters. It is clearly easier to activate people’s desire to reduce risk when we are talking about cancer or HIV/AIDS, than it is to motivate people about measles. Too great an attempt by the health professions to use information to affect people’s behaviour can backfire as well. Lack of openness about risks of treatments (including childhood immunisation) leaves fertile ground for others to raise fears, sow distrust and blind people to the risk of doing nothing.

There may well be a saturation point that differs between the community and the health professions. When health is your business, it can be easier to keep track of all the information. Take dietary advice for pregnancy: by the time the awareness campaigns of everything from the dangers of soft cheese and the need for more folate have rolled their way through (and you have morning sickness anyway), it can all get just a bit too hard. The community, healthier than it has ever been, seems to have been made more afraid than ever before of risks. While a doctor can more easily adjust their perspective if something turns out not to be a real risk (a false positive from a test result or a grey zone answer – raised but not ‘high’ cholesterol, for example), it is not always so simple for the patient. Further, while doctors understand the concept of risk as it applies to screening tests, the rest of us often see a test as a diagnosis. People’s entire lives and health can be damaged by what a doctor thought was just a caution and explanation of risk, but which the patient sees as being labelled with a disease.^{2,3}

We need to develop a more balanced and sophisticated approach to the communication of risk, one that takes patients' fears and concerns more seriously. The goal really is balance and perspective, so that the patient can make a decision in keeping with their values and priorities. This requires presenting a multidimensional picture. There is no 'one size fits all' approach to communicating about risk.

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This article is the second in a series on risk. See also 'Perceptions of risk – a legal perspective' by J. McPhee in Vol. 25 No. 5, October 2002.

Patient support organisation

Asthma Australia

Asthma Australia is an association of all the Asthma Foundations throughout Australia. Asthma Australia aims to eliminate asthma as a major cause of ill health and disruption within the community. The Asthma Foundations provide asthma education, information, research, community advocacy and support to people with asthma and their carers.

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