

The pivotal role of cardiac self-care in treatment timing

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Abstract

In Western nations, cardiovascular disease (CVD) is the leading cause of death and disability, and myocardial infarction (MI or heart attack) is responsible for the most significant proportion of these deaths. Over the past decades, however, mortality rates from CVD in general and MI specifically have been decreasing due in large part to the proliferation of time-dependent therapies. As their description suggests, the use of such effective therapies is associated with early hospital presentation, thus reducing treatment time has significant benefits. Previous research most often has focused on sociodemographic or clinical factors influential in treatment timing, while the activities that individuals undertake during the critical hours prior to presentation for formal medical treatment remain insufficiently examined. Since self-care activities provide a window into how cardiac symptom sufferers conceptualize and act on their distress and, subsequently, how these conceptualizations shape treatment timing, we sought a more complete understanding of the relationship between self-care behaviours and treatment timing. Employing a complementary design, we examined data from 2972 survivors participating in the MI Onset study in the United States and 35 survivors from the MI Illness Narrative Study. Results indicate that cardiac self-care played a defining role in time to treatment, while other factors (i.e., sociodemographic and clinical factors) did not. Specifically, taking over-the-counter medications (i.e., analgesics and antacids) was associated with a longer treatment time. A closer look at who was likely to pursue these strategies and their reasons behind so doing leads us to conclude that (1) social location and self-identity; (2) previous health experiences, including personal health history and prior use of self-care strategies and; (3) social interaction play important roles in cardiac self-care responses which, in turn, shape treatment timing.

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Introduction

Cardiovascular disease, the leading cause of death and disability among women and men age 55+ years in the industrialized world, accounted for 48.6% of the total

deaths in Western nations in 2000 (Aboderin et al., 2001). With a yearly prevalence rate of 270,000 and 7.6 million in the UK and US, respectively, myocardial infarction (MI or heart attack) constitutes the leading cause of morbidity, disability, and death within the CVD classification (American Heart Association, 2002; British Heart Foundation (BHF), 2003). Given the great toll that MIs take on health and functioning, over the past 4 decades, scientists have devoted considerable

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attention to the development of therapeutic interventions. The result of such efforts has been tremendous strides in medical treatments, including the development of lifesaving medications and procedures. In large part due to these highly effective therapies, between 1988 and 1998 heart disease-related mortality declined for women by 52%, 45%, 45%, and 38% and for men by 49%, 45%, 45%, and 39% in Australia, Denmark, Norway, and the UK, respectively (BHF, 2003).

A limitation to the use of most of these therapies is the time-dependent nature of their administration. Despite consistent associations between rapid time to formal medical treatment and survival (GUSTO, 1993; Rawles, 1997), most individuals experiencing cardiac symptoms wait an average of four hours before hospital arrival (Burnett, Blumenthal, Mark, Leimberger, & Califf, 1995; Dracup et al., 1995; Leslie, Urie, Hooper, & Morrison, 2000; Yarzebski, Goldberg, Gore, & Alpert, 1994), and most of the delay is due to patient-associated factors (Gilbert & Clancy, 2003). Over the past several decades, interventions have demonstrated little efficacy in reducing the period between symptom onset and calling for formal medical assistance (Goldberg, Yarzebski, Lessard, & Gore, 2000).

Determinants of time to treatment

Acknowledging the vital role of appropriate and timely treatment seeking, researchers have examined sociodemographic and clinical factors and, to a lesser degree, psychosocial determinants of treatment decision-making (Clark, 2001; Dracup & Moser, 1997). Longer times to treatment have been associated with being female, older, and non-white (Arntz, Stern, & Willich, 1996; Wilkinson et al., 2002), while the effect of educational differences and social class continues to be debated (Yarzebski et al., 1994). Structural factors, including a lack of transportation and inadequate health insurance coverage, have been associated with longer time to treatment (Tod, Read, Lacey, & Abbott, 2001).

Researchers also have examined the associations between clinical factors and time to treatment, generally finding that previous MI or other CVD diagnosis, and/or having diabetes leads to longer treatment time (Dracup et al., 1995; Yarzebski et al., 1994). These results have led to speculation that symptom interpretation/confusion prolongs treatment time, a finding that may account for the longer time elapses among older adults, women, and non-whites who frequently have multiple chronic diseases or atypical presentation, respectively (Arntz et al., 1996). Indeed, our previous work, which employed a different sample and aimed to illuminate emic perspectives on treatment timing among women only, concluded that the convergent experiences of symptom confusion, competing social

demands, negative health care encounters, and structural barriers delimit women's health decisions, ultimately prolonging time to treatment (Schoenberg, Peters, & Drew, 2003).

Psychosocial factors relevant to time to treatment include social interaction and psychological reaction to symptoms. Consultations with family members, particularly spouses, and physicians generally have been associated with a prolonged time to treatment, while consultations with unrelated people appear to shorten treatment timing (Burnett et al., 1995; Dracup & Moser, 1997). Disbelief or denial have been implicated in longer time to treatment (Johnson & King, 1995; Meischke, Ho, Eisenberg, Schaeffer, & Larsen, 1995), as have fear of upsetting a loved one by informing them about symptoms or embarrassing oneself by making formal medical arrangements (Schoenberg et al., 2003; Tod et al., 2001).

Self-care behaviours

We currently lack extensive data on another component of the time to treatment issue—the behaviours or self-care activities individuals engage in prior to seeking formal medical treatment (Arntz et al., 1996; Clark, 2001; Dracup & Moser, 1997). Research suggests that self-care, the predominant form of health activities and the process whereby individuals act on their own behalf to prevent and detect disease and to promote and restore health (Dean, 1988), plays a vital role in MI health outcomes (Flavell, 1994). Moreover, while it is difficult or impossible to alter sociodemographic or clinical attributes, modifying self-care behaviour, though challenging, is at least feasible. A well-grounded understanding of actions taken by cardiac symptom sufferers during “the elusive prehospitalisation phase” (Clark, 2001, p. 441) provides health care professionals with appropriate and useful information to present to those at highest risk of cardiac events.

The modest amount of research that has addressed self-care responses to cardiac symptoms has revealed that most self-care activities prolong time to formal medical treatment (Alonzo, 1986; Dracup et al., 1995; Ruston, Clayton, & Calnan, 1998). While this research represents an advancement of our understanding of the steps symptom sufferers take to control these sensations, we remain deficit in our understanding of who engages in these patterns and the reasons underlying such self-care approaches (Clark, 2001). To address the dearth of research of self-care during a cardiac event, we pursued four questions: (1) what type of self-care activities do people undertake when experiencing cardiac symptoms; (2) what are the individual characteristics associated with these self-care behaviours; (3) what is the relationship among these self-care activities, individual

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