

“Standing still in the street”: Experiences, knowledge and beliefs of patients with intermittent claudication—A qualitative study

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Objectives: To explore the experiences of individuals living with intermittent claudication (IC) owing to peripheral artery disease (PAD), their knowledge about the condition, and their thoughts about being asked to walk more and an intervention to promote walking.

Methods: We conducted five focus group sessions with 24 people (71% male; mean age, 71 years) diagnosed with IC with no prior lower extremity revascularization.

Results: Two overriding themes emerged: uncertainty and lack of support/empathy. Participants expressed uncertainty about PAD and IC, how risk factors work, and whether lifestyle change, particularly walking, would help. They also expressed dissatisfaction with and lack of empathy from the medical professionals encountered, with feelings of being dismissed and left on their own. There was enthusiasm for an education program to support their self-management of the disease.

Conclusions: Addressing the knowledge gaps and uncertainty around the disease process and walking will be critical to providing impetus to behavior change. A structured education approach to address these issues seems to be desirable and acceptable to those living with PAD.

Practice implications: Those working with PAD patients should provide clear and consistent information about the disease process and specific information on walking, as well as support to enable and manage behavior change. (J Vasc Nurs 2015;33:4-9)

Lower extremity peripheral artery disease (PAD) affects 202 million people globally and >10% of the population aged >70 years, with incidence that is rising.^{1,2} Some 50%-80% of patients with PAD are symptomatic and suffer from intermittent claudication (IC), which is a cramp-like leg pain that occurs during walking and is relieved by rest.³ IC reduces functional status, impairs quality of life, and results in substantial morbidity and mortality, both directly and through its strong association with systemic atherosclerosis.³ In addition to these clinical concerns, PAD treatment also generates substantial costs for the health care system.^{4,5}

A primary therapeutic goal for patients with IC is to regain lost physical function through exercise rehabilitation.⁶ Medically supervised exercise programs have demonstrated clinical efficacy with large improvements noted for claudication onset and peak walking times.⁷⁻⁹ Supervised exercise programs have been given a Class 1 recommendation by the American College of Cardiology and the American Heart Association¹⁰ and recently the UK's National Institute for Health and Care Excellence (NICE) issued guidance on the management of PAD recommending that a supervised exercise program be offered to all patients with IC.¹¹ Unfortunately, supervised exercise programs conducted within a formal health care setting are not widely available for patients with IC in the National Health Service,¹² and where they do exist they often have poor patient uptake and very high drop-out rates ($\leq 50\%$).¹³ Furthermore, supervised exercise programs may not improve daily walking activity away from the program.¹⁴ Given the lack of availability of supervised exercise programs within a health care system, basic walking advice is more commonly provided. This approach, however, has very limited efficacy, resulting in little change in walking behavior.^{15,16} An alternative approach could be home-based exercise programs that require individuals to self-manage their exercise. Such an approach has the potential to improve walking behavior in patients with IC at a much lower cost compared with institution-based, medically supervised exercise programs. In addition, home-based programs are also likely to be more acceptable to this patient group as a whole because the requirement to travel, with its associated costs, would be removed. However, the evidence for the efficacy of such programs is weak and mixed.¹⁷ Many of the studies have suffered

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from methodological flaws, most notably nonrandomized study designs and a lack of accurate quantification of the exercise volume performed. A further limitation of many previous home exercise programs is that they have been impractical and have failed to consider adequately patient knowledge and beliefs about their condition.¹⁸

Currently, there are few data on how individuals with IC view their condition. The evidence reviewed by NICE¹¹ suggested that patients with PAD often lack understanding of the causes of PAD and often do not believe that lifestyle interventions such as increased walking will make a difference to the outcomes of their disease, meaning that there is little incentive to change behavior. Other work, not included in the NICE review, also supports this contention. For example, Galea et al¹⁹ reported that uncertainty about PAD and a lack of knowledge about the benefits of walking, particularly with respect to pain, represented a cognitive barrier to actually walking. Similarly, Barbosa et al²⁰ reported that the most common barriers to physical activity in PAD patients were related to the pain experienced when walking. However, much of this evidence comes from PAD patients who have been referred for operative intervention, and therefore may not reflect the understanding and beliefs of the majority of PAD patients being managed conservatively (eg, through lifestyle behavior interventions). NICE¹¹ recommended further research to explore more deeply patients' attitudes, beliefs, and knowledge about PAD and the types of physical activity and behavior change interventions that might result in improved outcomes for patients with IC. Such research is also recommended as a critical step within the development phase of complex interventions.²¹

The aim of the current research was to inform the development of a pragmatic self-management intervention for promoting walking in patients with IC in the United Kingdom. The approach proposed for the intervention was structured education, modelled on the self-management programs used in diabetes care.^{22,23} This approach encourages patients to participate in an interactive way in their learning about their medical condition and associated risk behaviors, usually through nondidactic educational workshops that include group discussions, experiential learning and practice, self-monitoring, and goal setting to promote self-efficacy and self-managed behavior change.²² The current study sought to ascertain individuals' experience of living with PAD, their knowledge about the condition, and their thoughts about physical activity and intervention programs, particularly structured education.

METHODS

Design

This study adopted a qualitative approach, and utilized a focus group methodology to explore patients' perceptions.

Sample

Twenty-four patients with IC owing to PAD were recruited via screening vascular clinic letters at a hospital in the midlands in the United Kingdom. Participants took part in one of five focus groups. The groups were 71% male and 100% White British, with a mean age of 71 years (SD = 8) and a median duration of claudication symptoms of 17.5 months (range, 3-180 months).

TABLE 1

TOPIC GUIDE FOR FOCUS GROUPS

Outline topic areas

- Experiences of living with PAD/IC
- Attitudes and beliefs about PAD/IC
- Educational needs of people with PAD/IC
- Attitudes and beliefs about physical activity/exercise
- Levers and barriers for exercise behavior change
- Opinions of behavior change interventions, particularly structured education

IC = intermittent claudication; PAD = peripheral artery disease.

Inclusion criteria were age ≥ 18 years, an ability to understand and speak English to a sufficient standard to allow participation in a focus group session, and stable IC for ≥ 3 months accompanied by an ankle-to-brachial systolic blood pressure ratio of ≤ 0.90 in their most symptomatic leg at rest. Exclusion criteria were an absence of PAD, asymptomatic PAD, critical limb ischemia, previous lower limb revascularization, and the presence of contraindications to exercise or comorbidities that limited walking to a greater extent than the IC (eg, severe arthritis). Written, informed consent was obtained before patients entered the study.

All focus group sessions were undertaken and audio recorded by two researchers. The topic guide is presented in Table 1. Participants were asked to complete a brief questionnaire before the focus group discussion on physical activity, which assessed their level of interest, readiness, and confidence in making a change to their walking behavior (0%–100%), the importance they place on making a change (0%–100%), the main barriers they have to being physically active, and any potential solutions to these barriers. This questionnaire was used to prompt participants' thoughts about their own physical activity behavior. Sessions lasted between 60 and 75 minutes and were conducted over a 3-month period between May and August 2013. The audio recordings were transcribed verbatim by an independent source and checked for accuracy by one researcher. After five focus groups, there was consensus agreement between the interviewers that no new information was emerging; therefore, further groups were not required.

Data analysis

A thematic analysis was employed to analyze the focus group data. This involved reading and rereading the transcripts to become familiar with their content, the identification of themes within the data, using the themes to code the interviews, identification and development of higher order themes and linkages, and interpretation of findings. All interviews were coded using the NVivo qualitative data indexing package (NVIVO 10) with two of the research team identifying the initial thematic structure. Themes were indexed and charted with accompanying quotes. A third researcher then independently read the transcripts and reviewed the identified thematic framework. Consensus and agreement was reached on key subthemes.

RESULTS

The data presented herein illustrate the main themes arising from the analysis with overriding themes of uncertainty and

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