



Self-management support in primary care: Enactments, disruptions, and conversational consequences



Patricia Thille ^{a,*}, Natalie Ward ^{b,c}, Grant Russell ^{d,e}

^a Department of Sociology, University of Calgary, 2500 University Dr. N.W., Calgary, AB T2N 1N4, Canada

^b Department of Sociology and Anthropology, University of Ottawa, 120 University, Social Sciences Building, Ottawa, ON K1N 6N5, Canada

^c Department of Anthropology, Mount Allison University, 144 Main St., Avarad-Dixon, Sackville, NB E4L 1A7, Canada

^d Southern Academic Primary Care Research Unit, School of Primary Health Care, Monash University, Building 1, 270 Ferntree Gully Road, Notting Hill, Victoria 3168, Australia

^e CT Lamont Primary Health Care Research Centre, Department of Family Medicine, University of Ottawa, 43 Bruyère Street, (375) Floor 3JB, Ottawa, ON K1N 5C8, Canada

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ABSTRACT

A common refrain in chronic disease management is that patients and clinicians need to enact new roles: patients as their own caregivers; clinicians as professional supporters of patient self-management activities. These roles are central to self-management support (SMS), an approach that emphasizes a clinical partnership, and promotes patient identification and achievement of realistic and short-term behavioral goals. With SMS, behavior change is the desired end, not the means to a desired biomedical end. Shifting SMS concepts into clinical practice has proven to be difficult and inconsistent, creating potential, unknown risks or harms to patients. We completed a discourse analysis of 16 clinical dialogues between diabetic patients and clinicians, collected during a study of six Ontario Family Health Teams, to explore the questions of risks and harms relating to SMS implementation. We observed varying degrees of incomplete implementation of SMS, as well as interactions that actively negated the core principles. Contrary to SMS principles, clinicians tended to emphasize behavioral changes as means to achieve biomedical ends, though to varying degrees. We present two appointments in detail, highlighting how linking behavior change closely with biomedical measures often elicited face-saving defenses from patients. The subsequent dialogue shifted attention away from problem solving and behavior change into active negotiation of responsibility and identity. Interactions that oriented more to SMS concepts elicited fewer defensive maneuvers from patients. Our analysis helps explicate one additional mechanism by which self-management talk threatens the clinical relationship, and highlights a promising method to mitigate this threat.

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1. Introduction

Patients and clinicians need to assume new roles for effective management of chronic disease: this is a common refrain when framing the solution to rising chronic disease prevalence and economic costs. Critics making this argument note that the acute care model is ill-suited to the needs of patients with chronic illnesses, and thus requires a re-alignment of health care services, facilitated by new, effective interventions (e.g. see oft-cited Wagner et al., 2001). People who self-manage well (i.e. problem-solve and implement changes) tend to have better health outcomes, in terms of symptom control, health services utilization, and disease activity

(Lorig and Holman, 2003). This result has fueled a line of inquiry into how best to facilitate patients' uptake of specific, health-enhancing, self-management habits.

Knowing that patient self-management of chronic conditions improves outcomes in populations is not the same as knowing how to support the shift (Lawn et al., 2010). Kate Lorig, an academic leader in this field, stresses that patients need education and long-term support to take on the extra work of self-management of chronic health conditions (Gilkey and Garcia, 2010; Lorig and Holman, 2003). Two different but complementary interventions to foster self-management have emerged: self-management education and self-management support (SMS). Self-management education focuses on self-management skill development, while SMS describes clinicians' reinforcement of self-management skills (Bodenheimer et al., 2002; Wagner et al., 2001). The evidence of

* Corresponding author.

E-mail address: pthille@ucalgary.ca (P. Thille).

effectiveness of SMS prompted inclusion in the internationally influential Chronic Care Model (Gilkey and Garcia, 2010; Improving Chronic Illness Care, 2011; Wagner et al., 2001).

Practicing SMS in clinical settings has proven to be challenging. Clinicians cite lack of time, competing demands, organization of care that silos different diseases, limited patient motivation (including the burden of self-management activities, or as a result of depression) as factors responsible for the implementation gap (Bower et al., 2011; Johnston et al., 2011). Perhaps more problematic, clinicians may not know what SMS is (Johnston et al., 2011), tend to over-rate the amount of SMS they provide (Carryer et al., 2010), assume SMS is new jargon for pre-existing approaches (Wagner et al., 2001), and describe their work as orienting to psychological concepts such as 'motivation', while applying idiosyncratic, experiential approaches to the work inconsistent with accepted principles of SMS (Macdonald et al., 2008). Lorig has raised concerns about framing patients as the problem, sometimes in the form of phrases like 'hard to reach' or 'unmotivated' (Gilkey and Garcia, 2010). Blakeman et al. (2010) found that routinized self-management interventions tended toward template usage, emphasizing a laundry list of health behaviors without supporting patients in the practices of self-management. The authors concluded that self-management talk stresses the clinical relationship, by highlighting patient behaviors deemed problematic.

Limited implementation of SMS raises ethical concerns. Redman (2007, 2010) argues that poorly delivered SMS may generate patient confusion, anxiety, reduced confidence, and stunted skill development. Examples of poor implementation include providers who: do not shift from expecting compliance to enabling independent judgment and freedom to act on it; give vague or inconsistent information; imply that patients are responsible for biomedical outcomes rather than only behavior change. Any of these may result in poorer disease control (Redman, 2010).

Starting from this foundation, we explore how SMS is conceptualized in the key, highly referenced articles by Dr. Kate Lorig, before contrasting with varied enactments of diabetes SMS in Ontario primary care organizations called Family Health Teams. We use Lorig's work because of the influence and spread of the model she developed. We illustrate patterns of discursive resistance and acceptance in patient–clinician interactions, and situate these in the discussion outlined above regarding the benefits, risks, and harms possible.

2. Methodology & methods

We conducted a discourse analysis of SMS implementation to illuminate variations in clinical approaches to self-management dialogue in a purposive sample of Ontario's inter-professional, primary care Family Health Teams (FHTs). One of Ontario's latest primary care reforms, FHTs are a practice model where family physicians work with a number of other professionals (e.g. nurses, nurse practitioners, dietitians, pharmacists) in either academic, community, or physician-governed organizations. This change of 'in-house' clinical resources reflects a desire to provide collaborative, comprehensive, accessible, and coordinated services, with particular emphasis on chronic disease management, disease prevention, and health promotion (Ministry of Health and Long-Term Care, 2009).

At its most basic, discourse analysis requires understanding that individual attempts at self-expression are fashioned from existing, shared communicative resources that are learned socially. "Individuals, when they speak, do not create their own language, but they use terms which are culturally, historically and ideologically available" (Billig, 2001, p. 217). Communication happens in a given time and place to accomplish some act (e.g. ask permission,

disagree, or give commands) (Potter and Wetherell, 2001). Communicators mobilize various resources, such as words/syntax, discourses, or common procedures, to construct a response (Potter, 1996). Discourse analyses help illustrate communication resources used, and highlight the consequences of using different resources in specific contexts. This analytic framework applies to both written word and interactive communication.

We focused on two resources with particular strength in illuminating core concepts in SMS. First are *interpretive repertoires*: relatively bounded, consistent units of language available to a range of communicators within a shared culture (Wetherell and Potter, 1988). As speakers selectively introduce repertoires to a dialogue, they propose and apply an interpretive lens to a situation, to which others are invited/expected to orient. That is, speakers propose a way to understand a situation (orienting to that which is already sensed to be present), and depend on others to recognize and take up what is proposed (Wetherell, 2001). Second, lenses proposed to frame a situation may also invoke particular *subject positions* for the persons involved (Davies and Harre, 1990). Speakers introduce culturally-available, recognizable character types through which to interpret the actions of those involved in the given situation (Davies and Harre, 1990). Speakers use these inter-related resources to promote one version of the world while disqualifying others, managing their own interests (Holstein and Gubrium, 1994). For example, to say that an artistic performance was excellent implies that the speaker has the authority to judge said performance against a standard. In this study, we explore the interpretative repertoires and related subject positions built up by Lorig compared to those in clinical dialogues to offer a sense of where consistencies and inconsistencies exist. Also, we apply specific conversation analytic insights to the clinical dialogues to identify moments of acceptance or resistance to speaker-proposed repertoires and positions.

2.1. Examining self-management related discourses in clinical practice

The data for this analysis comes from a larger project through which our research team sought to study the changes in clinical and administrative routines involved in becoming a Family Health Team (FHT). Using a purposeful sampling strategy to maximize variation, six FHTs agreed to have a non-participant observer onsite for short, intensive periods of study (maximum: 25 days over 15 months, during 2007–2009) and interviews with FHT staff and patients. Twelve audio-recordings and four fieldnotes of individual appointments with patients with diabetes or pre-diabetes (all but one with diabetes mellitus) from four FHTs were available for this analysis. Several involve two clinicians seeing a patient sequentially. The clinicians involved included a registered nurse or registered practical nurse ($n = 7$), nurse practitioner ($n = 2$), registered dietitian ($n = 4$) and physicians ($n = 7$). We selected diabetes care for two reasons: it has a strong self-management component and is prevalent, thus observed frequently.

The overarching project received approval from the Ottawa Hospital Research Ethics Board. Consent processes were multiple; once FHT leaders consented, clinicians and staff were approached to be interviewed and/or observed. Patients of consenting clinicians provided written consent before being observed. See Russell et al. (2012) for a detailed description of the larger study methods. The original study was funded by the Ontario Ministry of Health and Long-Term Care; this secondary analysis was unfunded.

2.2. Data analysis

We focus on patterns of subject positions and related interpretative repertoires in use in Lorig's published descriptions, as well as

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