

Clinician's Commentary on Figueiredo et al.¹

The prevalence of chronic diseases threatens to overwhelm Canada's health care system: Of total direct costs, 67% are being spent on patients with chronic conditions.² Canada is not alone in facing this challenge; 70% and 86% of the health care budgets of the United Kingdom and United States, respectively, are also spent on chronic disease services.³

As a method of driving down the costs of delivery, self-management support (SMS) has received considerable attention. To date, the role of primary care in supporting self-management has been emphasized.⁴ However, practice staff have opposed primary care as an appropriate setting for delivering SMS.⁵ Rehabilitation programmes, which focus on enhancing patients' ability to engage in everyday activities, may be more suitable. Implementing SMS in rehabilitation programmes has been given little consideration, and health care professionals (HCPs) specializing in rehabilitation often report feeling ill equipped to deliver SMS.⁶⁻⁸

In their *Physiotherapy Canada* article, Figueiredo and colleagues¹ confronted this gap in knowledge by offering SMS education to physiotherapy and occupational therapy students. Despite the knowledge gained, students remained hesitant to adopt SMS into their future practice, citing a desire to conform to the example set by their clinical educators. In reality, SMS is rarely integrated into clinical practice.

These findings indicate that a top-down, in addition to a bottom-up, approach might be necessary to encourage HCPs to incorporate SMS into the care of individuals with chronic diseases. It would seem that the factors contributing to HCPs' unwillingness to incorporate SMS into their daily practice is more complex than a lack of knowledge and skills alone. This commentary expands on some of the conceptions of SMS outlined by Figueiredo and colleagues¹ that may serve as a barrier to implementation.

EVIDENCE REGARDING THE EFFICACY OF SELF-MANAGEMENT SUPPORT FOR THOSE WITH CHRONIC DISEASES IS UNCONVINCING

Given the discrepancy in the literature, it seems likely that clinicians foster a lack of belief in the efficacy of SMS for those with chronic conditions.⁹⁻¹² The psychological theories of reasoned action and planned behaviour propose that a person's intention to perform a behaviour (in this case, to adopt SMS into clinical practice) is influenced by his or her beliefs about and evaluation of its efficacy. Long-term follow-up was associated with greater effectiveness of self-management in a review of the literature focusing on individuals with an acute exacerbation of chronic obstructive pulmonary disease.¹⁰ Yet, in clinical practice, long-term follow-up is rarely possible because of the pressures of treating large numbers of patients; this means that HCPs are often unaware of any positive effects of SMS. As a result, clinicians' motivation to continue incorporating SMS into their daily practice is likely diminished.

THE TIME REQUIRED TO DELIVER SELF-MANAGEMENT SUPPORT EFFECTIVELY IS NOT AVAILABLE

Evidence derived from a systematic review that examined self-management for people with chronic diseases has suggested

that only face-to-face contact is associated with an improvement in clinically relevant outcomes.⁹ Nevertheless, more time-efficient modes of delivering self-management, such as e-health (i.e., over the Web) and m-health (i.e., through mobile apps), have become increasingly popular.^{13,14} Although distance interventions play a role in improving patient access, they are not able to take into account patients' individual circumstances. Home visits may be necessary to contextualize SMS because the majority of self-management behaviour is performed away from the hospital setting.

SELF-MANAGEMENT SUPPORT MAY NOT BE APPROPRIATE FOR ALL OLDER ADULTS

HCPs no longer endorse a paternalistic model of care, and yet many older adults express a preference for passive care, driven by stoic attitudes. These individuals may react to SMS, which encourages patients to take responsibility for their own disease management, by feeling that their HCPs have dismissed or abandoned them, leading them to feel discontented with the health care service. These sorts of feeling may be particularly true for those patients whose condition can be ascribed to behavioural factors (e.g., smoking, lack of exercise, poor diet) and who harbour feelings of self-blame.^{15,16} It is important that these individuals' responsibility not be overemphasized but that SMS instead fosters working in partnership.

Adopting a more active model of care means that patients face an overwhelming amount of information about their disease and are required to make several choices. Often this occurs at a time of life when the ability to make decisions and to problem solve (two key self-management skills) is declining due to age-related changes.^{17,18} These abilities may be further affected by the presence of a chronic condition known to be associated with greater cognitive impairment.^{19,20} Perhaps expecting all older adults with chronic conditions to successfully self-manage is unrealistic; instead, HCPs ought to assess the appropriateness of offering SMS on an individual basis.

SELF-MANAGEMENT SUPPORT IS AT ODDS WITH A THERAPIST'S ROLE

The role of physical and occupational therapists is commonly conceptualized as focusing on the restoration of function.^{21,22} Physiotherapists, in particular, are described as attending to outcomes that are specific and measurable.²¹ In contrast, SMS outcomes of interest are difficult to assess, often relying on self-reported data (e.g., health care use, health-related quality of life).

A qualitative synthesis exploring clinicians' views on self-management emphasized a construct labelled "clinician control." Clinicians described their role in providing education and blamed patients' lack of motivation if patients did not adhere to their advice.²³ Being in a position of control was important to HCPs, and they appeared reluctant to relinquish control to patients.^{23,24} Perhaps SMS is considered to be a challenge to therapists' role security, undermining their skills and expertise. As a result, SMS may be viewed as an unattractive or less desirable mode of therapy available to clinicians.

CONCLUSION

Despite the fact that SMS provides an opportunity to deliver care in a more cost-effective way, it is time consuming to administer, as is the process of training HCPs to a level of competence. Delivering SMS in a time-efficient manner is not always achievable, and stakeholders and managers need to recognize this. Delivering SMS ought to be considered on an individual basis, taking into account an individual's capacity to self-manage and the likelihood of achieving a benefit, in terms of both patients' well-being and the costs to the health care system. Although SMS fits well into a rehabilitation context, it needs to be adopted at multiple levels of the health care system and by all individuals involved in the care of patients with chronic diseases. Until SMS becomes embedded in the culture of health care rather than being administered as an adjunct to existing therapy, its implementation is unlikely to be successful.

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