Capacity, Responsibility and Willingness: A qualitative study of patient and practitioner views of self-management in multimorbidity

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Background

• Multimorbidity defined as the presence of 2+ long-term health conditions in the same individual

• Self-management considered critical to effective care

• Multimorbidity may be a barrier:
  – increased burden placed on limited resources of time and energy
  – competing demands of different conditions and/or treatments.

• Uncertain how best to engage people with multimorbidity in self-management
Aims

- To explore patient and practitioner views on factors influencing engagement in self-management in the context of multimorbidity
Method - Patient recruitment

- 20 patients purposively sampled by:
  - Deprivation score (taken from postcodes)
  - Number and type of long-term conditions
  - Age
  - Gender

1500 questionnaires mailed out
539 (36%) returned
222 (15%) agreed to interview
20 patients selected for interview
Method-
Practitioner recruitment

• 20 practitioners recruited: Initially from 4 target practices (n = 15); remainder via snowball sampling

• Attempt to purposively sample for:
  • Deprivation score (IMD of practice postcode)
  • Number years experience
  • Role (e.g. Practice nurse / salaried GP / partner etc)
  • Gender
Results

• Three major themes were identified:
  ❖ Capacity
  ❖ Responsibility
  ❖ Willingness
Capacity

- Resources required – time / money / social & emotional support / logistics
- More difficult with multimorbidity / deprivation

“I speculate that with several conditions people are too busy just trying to survive. Getting up in the morning out of bed if they can, having a plateful almost a meal full of tablets every day, and just about coping on the edge of everyday life.” DR 1 (M, GP Partner)

“Obviously, with low socioeconomic background.....you may not have the facilities, you know, to do certain things. Often self care depends in some part on, you know, things like access to telephones, access to internet..” DR 10 (M, GP Trainee)
Responsibility

• Patients had mixed views about whose responsibility it was to manage their health.
• Practitioners were generally of the opinion that all patients were capable of some form of self-care unless in the case of severe disablement but that ability was restricted by social norms:

“I think it’s my responsibility to manage it, to a certain degree and in as far as I can” P5 (F, 58yrs, DM and CHD)

“I think it’s the doctors concern, not mine. I mean I’ll do everything the doctor tells me.” P19 (M, 66yrs, COPD and CHD)

“...there’s always something that somebody can possibly do, unless they’re very, very disabled by a condition to help themselves a little bit” PN2 (F, Practice Nurse)
Willingness

• Motivation to engage in self-management dependent on future expectations for health
• Practitioners frustrated by patients lack of willingness

“...as you get older like I want to be fitter in myself and then you sort of like, these little conditions they stop you doing things and then your motivation, if you’re feeling down and you’re depressed then your motivation’s not there” P15 (M, 52yrs, DM, OA, Dep)

“It does make you a bit angry, you know, when something could have been avoided and then they could make some lifestyle changes, but, not willing to do it, you know, not placing enough of a premium on their own health” DR12 (M, GP partner)

“...they don’t have the skills to change, often because it’s inset, it’s inset in a long term habitual abuse of their bodies, it will be family history.” DR6 (F, GP partner)
Self-care Model:

- Firstly, capacity. Patients must have the ability to self-care before contemplating their desire to do so.
- Secondly, patients must believe it is their responsibility to self-care in order to have the drive to do so.
- Finally, the patient with the willingness to self-care in addition to these other factors will be most likely to achieve it.

**Capacity**
- + Finances
- + Social support
- - Treatment burden

**Responsibility**
- +/- Accepted social norms

**Willingness**
- + Positive outcome expectancy
- - Depression

**Self-management**
Conclusions

• Three main factors were identified as influencing patient engagement in self-management: *capacity*, *responsibility* and *willingness*.

• Capacity was perceived to be reduced in the face of multimorbidity.

• Capacity was a necessary but not sufficient precursor for self-management.

• These themes form the basis of an exploratory model that has yet to be tested.

• May provide a useful foundation for the development of interventions to enhance patient engagement in self-management in the context of multimorbidity.
Implications for practice

• The model requires further testing but the results at this stage can alert clinicians to the notion that there are social, economical and psychological barriers to self-management in multimorbidity.

• Improving capacity/resources alone may not lead to better self-management

• These are important impediments that may not necessarily be related to illness burden or severity; or to age or gender.

• Previous research has shown that some GPs are reluctant to discuss self-management due to concerns about alienating patients and disrupting the consultation. It may help to provide practitioners with a framework to address potential barriers to self-management in partnership with patients.
Thank you

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