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

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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.

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...
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 such management thwarts 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 talk among patients in the practices of self-management. The authors concluded that self-management talk stresses the clinical relationship, by highlighting patient behaviors deemed problematic.

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