

A qualitative study of GPs' attitudes to self-management of chronic disease

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ABSTRACT

Background

Improving the quality of care for patients living with a chronic illness is a key policy goal. Alongside systems to ensure care is delivered according to evidence-based guidelines, an essential component of these new models of care is the facilitation of self-management. However, changes to the way professionals deliver care is complex, and it is important to understand the key drivers and barriers that may operate in the primary care setting.

Aim

To explore GPs' perspectives on their involvement in the facilitation of chronic disease self-management.

Design of study

Qualitative study.

Setting

General practices located in two primary care trusts in northern England.

Method

Data were collected through in-depth, semi-structured interviews with a purposive sample of GPs. During analysis, categories of response were organised into themes that relate to Howie's theoretical model for understanding general practice consultations: content, values, context.

Results

The GPs' responses highlighted tensions and trade-offs regarding their role in facilitating self-management. Although GPs valued increased patient involvement in their health care, this was in conflict with other values concerning professional responsibility. Furthermore, contextual factors also limited the degree to which they could assist in encouraging self-management.

Conclusions

Providing GPs with training in consultation skills is required in order to encourage the delivery of effective self-management. In addition, the context in which GPs work also needs to be modified for this to be achieved.

Keywords

chronic disease; family practice; self-care.

INTRODUCTION

Service reorganisation in the delivery of primary care is considered essential in order to improve the quality of care for people living with a chronic illness. It has become focused on the need to ensure that care is accessible, patient-centred, and provided according to evidence-based guidelines.¹⁻⁶ The recent NHS Improvement Plan emphasises that the delivery of interventions for people with long-term conditions should be tailored according to three levels of need:²

- Intensive case management. This entails community nurses and practitioners coordinating care with GPs and primary care teams, and is being introduced for patients with multiple complex needs.
- Chronic disease management. Structured chronic disease management for patients at some risk is predominantly being conducted within general practice, with the National Service Frameworks (NSFs) and the new General Medical Services (GMS) contract being mechanisms for ensuring that high-quality care is provided for patients at this middle level of need.^{2,3,7}
- Self-management. Alongside medical management, encouraging self-management is seen as an essential element of care for all patients with long-term conditions and is a particular focus

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How this fits in

General practice care for chronic diseases is being reorganised around chronic-disease management models. These require care that is provided according to evidence-based guidelines, and increases patient involvement and self-management skills. The research suggests that although GPs value increased patient involvement and increased self-management, there are significant barriers to the achievement of these outcomes. These barriers relate to the lack of effective consultation skills to facilitate patient involvement; conflict between values of professional responsibility and increased patient control; and contextual barriers, such as incentive schemes, that focus on biomedical care. All these barriers may need to be addressed in order to achieve effective levels of patient involvement and self-management.

of care for individuals at the third level of need, who have a chronic condition but who do not require more intensive disease management.^{2,8-10}

Encouraging self-management can be been defined as:

*'collaboratively helping patients and their families acquire the skills and confidence to manage their chronic illness, providing self-management tools, and routinely assessing problems and accomplishments.'*⁵

It encompasses processes that aim to increase patients' involvement and control of their health and

health care, and it refers to more than simply self-monitoring or the adjustment of medication. The Expert Patients Programme, which is a lay-led chronic disease self-management programme has been introduced in the UK and is seen as one mechanism for achieving this.^{1,11} In addition, although individuals gain skills from a range of experiences both within and outside the health system, their interaction with their GP also remains an important resource for encouraging self-management.^{12,13} However, although general practice is viewed as a relevant context in which to facilitate self-management, previous studies have indicated that this might not be straightforward.^{8,14,15}

With the introduction of new initiatives, including the new GMS contract and the Expert Patients Programme, a qualitative study was undertaken in order to explore issues concerning GP involvement in the facilitation of self-management for people living with a chronic illness. The study presented here forms part of a larger national study evaluating the implementation of the Expert Patients Programme. The article reports results relating to the GP's role in facilitating self-management.

METHOD

The study involved in-depth, semi-structured interviews with 16 GPs located in two primary care trusts (PCTs) in northern England. The PCTs involved were two out of the eight pilot sites participating in the national evaluation of the Expert Patients Programme and were chosen for this study due to their accessibility.

A purposive sample of GPs was selected from data available from lists held by both PCTs. In order to ensure that a wide range of characteristics was sampled, the process included selecting GPs according to sex, practice size, and contractual status (GMS and Personal Medical Services [PMS]). Within this sampling frame, GPs who were known by PCT staff to have either an interest in the Expert Patients Programme or a particular interest in developing chronic disease management in general practice were also invited to participate. This was in order to access views of GPs who may have had more experience of patients attending the Expert Patients Programme. Table 1 details the characteristics of GPs invited to participate.

An inductive-deductive methodological approach to data collection and analysis was undertaken.¹⁶ Semi-structured face-to-face interviews were conducted between May and July 2004 and lasted between 20 and 65 minutes (median duration 43 minutes). An interview guide provided a flexible framework for questioning and areas covered included GPs' knowledge of, and role in:

Table 1. Characteristics of participating GPs (n = 16).

	Participating GPs ^a n (%)
Median age in years (range)	49 (34-65)
Male	9 (56)
Female	7 (44)
Practice size	
Single-handed	3 (19)
2-3 GPs	8 (50)
>3 GPs	5 (31)
Contractual status	
GMS	9 (56)
PMS	7 (44)
Known interest in the Expert Patients Programme	1 (6)
Known interest in developing chronic-disease management in general practice	5 (31)

^aAt the time of sampling, 70% of the study population (combined total of 189 GPs located in the two PCTs) was male. Practice sizes included: single-handed, 26%; 2-3 GPs, 43%; and >3 GPs 31%. Of the study population, 40% provided services through Personal Medical Services (PMS) arrangements. GMS = general medical services.

- the facilitation of self-management;
- perceived barriers to the facilitation of self-management;
- attitudes towards the new GMS contract; and
- knowledge and attitudes towards the Expert Patients Programme (Supplementary Table 1).

Efforts were made to use open ‘what’ and ‘how’ questions,¹⁷ rather than potentially constraining ‘why’ types of questions. All the interviews were conducted by the first author and participants were made aware of the researcher’s identity as both a GP and a researcher. Follow-up questions were used to expand responses and reduce the risk of ‘shared conceptual blindness.’ This refers to the inability to effectively research the ‘taken for granted understandings that underpin everyday life’ because the researcher and participants are ‘bound together by a powerful set of common experiences.’¹⁸ The interviews were audiotaped and professionally transcribed.

Open coding was used to analyse the transcripts and, through comparison of these codes, categories were identified.^{16,19} These categories were reached independently by the authors and then agreed through discussion. Written memos and regular generation of word-processing files were undertaken in order to help provide a structure to data analysis. During analysis, categories that emerged were found

to resonate with Howie’s theoretical model for understanding general practice consultations (Figure 1).²⁰⁻²³ As a result, the categories were organised into Howie’s three themes:

- the content of the consultation;
- underpinning GP values; and
- the context in which care is provided.

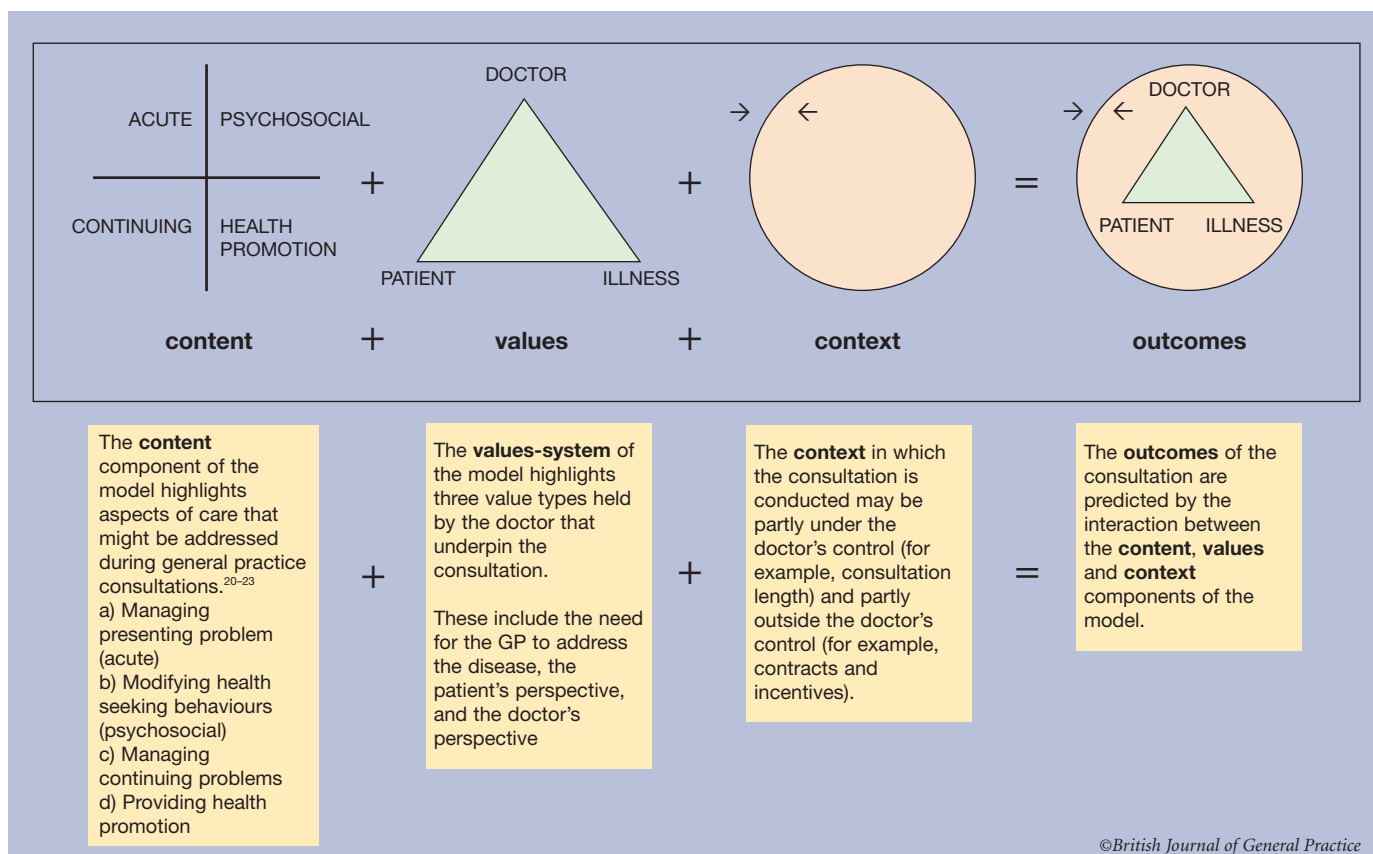
RESULTS

How do GPs facilitate self-management?

The content of GP consultations

There was a range of responses regarding strategies reported by GPs when describing their attempts to increase patient involvement in their health care. Some of the responses reflected the key dimensions of patient-centred consulting.²⁴ These included the need to understand the patient’s own ideas, concerns, and expectations (viewing ‘patient-as-person’).²⁴ Skills required to achieve this included creating a space for listening and asking open questions. Helping patients to understand their condition including underlying risks and management was seen as paramount. It was felt that the process of understanding can take time to develop and continuity of care was reported as enabling trust between all parties to develop (‘the therapeutic alliance’).²⁴

Figure 1. Howie’s theoretical model for understanding general practice consultations.



'Cos most of them have been with me years and years and the new ones will be coming to see me for years and years, and you do have time, you don't have to throw it all at them the first time. You can build on it.' (GP 1.)

'... but I've been seeing her for a long time, so I know her that well that I have given her a lever ... come and tell me whether she's done well with that or not.' (GP 4.)

Responders described the importance of offering ongoing support, including the need to provide encouragement and reinforcement of advice. Although only one GP had recommended the Expert Patients Programme to patients in her practice, a few GPs indicated that their role in facilitating self-management included referring patients to local community resources (for example, cardiac and chronic obstructive pulmonary disease rehabilitation programmes).

Several GPs indicated that written self-management plans were being used in the management of patients with asthma and diabetes. They were seen as providing a structure that gives the patient confidence to manipulate treatment themselves ('sharing power and responsibility').²⁴ GP 2 noted that, '... they are managing at home without coming to see us and get confidence from doing that.'. Written plans such as these were also seen as a tool to write down targets and areas of uncertainty, so helping with the formulation of questions to bring to the consultation:

'... I think the other thing's having the management plan in it so they, you know, it's clearly documented, they can see that, you know, they should have this done on a yearly basis, they should have that done on a 6-monthly basis, and being told that they have some responsibility for that. That, I think that seems to be helpful ...' (GP 5.)

In addition to self-management technologies, tools used by GPs to help patients increase their understanding of their condition included providing written information, videos, drawing pictures as well as using risk calculators, and explaining results from practice-based investigations (for example, a spirometry report).

Despite a lack of theoretical and empirical evidence supporting the benefits of merely giving advice,^{25,26} in circumstances where effective management of a patient's condition was difficult to achieve, several GPs reported that advice giving and reinforcing the message were the main techniques they used:

'Obviously talking to them, you know ... a multidisciplinary approach, where they see a number of professionals who are reinforcing advice ... will help to a degree, and if they're followed up regularly that gives us an opportunity to reinforce things. If they do develop complications then it's easier for us to pick it up early and try and scare them into following the advice (laughs) and lifestyle changes that we've been offering them.' (GP 11.)

A few GPs highlighted the need to identify underlying social and psychological reasons ('biopsychosocial perspective').²⁴ Other methods for managing these situations included being non-judgmental, involving other professionals, and reflecting their frustrations back to the patient (viewing 'doctor-as-person').²⁴

GP values: do they facilitate or inhibit self-management?

Rather than using the term self-management, GPs tended to refer to valuing the development of a partnership approach to chronic disease management. All the GPs reported valuing increased patient involvement in the management of their health.

'It's absolutely essential because somebody who's got diabetes knows more about it than I do, really. I can help them with the biochemistry parameters, but they're living with the disease ... and it's a partnership that we have. "You do your bit and I do my bit and between us we'll aim to get you right." And I try and build on that as my model rather than me saying, "Yes, I'm the doctor, take this tablet and don't worry about it," which I don't think helps anybody.' (GP 1.)

Responders suggested that, although GPs can manage the medical aspects of a chronic condition, patients needed to have an active role in making lifestyle changes in order to reduce the development of complications.

Views on the extent to which patients should take responsibility ranged from sharing information but leaving the decisions to patients, to most GPs expressing concerns about giving patients too much responsibility without sufficient support or guidance. The GPs' responses indicated that they felt a sense of responsibility for ensuring that high-quality care is achieved. Although they valued a shift towards increased patient involvement, their comments suggested that this was not necessarily straightforward and that it can take confidence to be able to share some of the control and responsibility with the patient:

'... I think we still are a particular paternalistic profession and I think it takes a lot of confidence to hand over care to a patient. It's much easier to take control, isn't it?' (GP 2.)

'... whereas before we would take responsibility for managing somebody's diabetes for example, now — and rightly so — we need to really devolve that responsibility to them but with, with guidance. So I think there's a danger of putting too much responsibility on the patient to make clinical decisions about their condition without adequate support. Many of them are very well capable of doing it, I'm very happy for them to do that but you need to identify ... the ones that can't, cos it can be very stressful. There are a lot of patients that want to be told what to do and, whereas that's not trendy now, that's how it is, so I think our role's ... really changing from what it was and I think it's ... in some ways it's a difficult one because we need to assess the individuals, you can't just do a blanket change of policy.' (GP 5.)

GPs' own sense of responsibility was reflected in professional concerns being expressed that without guidance and follow up, patients might lose enthusiasm, might use medication inappropriately, may not recognise warning signs, or may obtain incorrect information from other sources. Despite self-management plans being advocated by some GPs, concern was also expressed that they might result in patients becoming overconfident and avoid seeking help when necessary:

'That's the danger, isn't it, it gets put in a drawer and they don't know where it is, and they think, oh, I'm alright, or maybe they stop using their steroids and use their long acting β_2 agonists, you know, that's dangerous. I think it's important that even though you have an expert patient ... helping himself, it's important that you're monitoring them all the time too.' (GP 14.)

'... might be better if they had some input and some follow up. Obviously there's a lot of talk nowadays about over-the-counter dispensing of statins and antibiotics even and other things. Now, obviously if patients are knowledgeable about their condition and they're aware of potential complications and so on, then no, I don't see any problems with that. But ... I tend to find a large majority, particularly of our patients, aren't, and therefore if they were under the pretence of [being able to] just go and buy some stuff, if maybe they're feeling their

cholesterol's a bit high, and that would cure everything, and they carry on using that and you know, they develop complications as a result of that, then obviously there are serious issues ...' (GP 11.)

Responses suggested that GPs themselves need to feel in control in order to fulfill their professional responsibility and this was also reflected in tensions regarding their attitudes towards the Expert Patients Programme. Although only a few responders reported any awareness or understanding of the programme, the GPs tended to refer to valuing the idea of patients gaining knowledge and sharing experiences with other patients. Several GPs indicated that they themselves did not have the experiential knowledge to share with patients:

'... Now maybe another patient will get the information across much better than we do because they'll perhaps talk, if you like, in patient terms rather than in doctor terms. And say, "Well it feels like this," which I can't say cos I've never felt it. I can say, "Well in the book it says it feel like this," but it isn't the same. It's like when you first have your children, you read it all in the book but it, it's not really the same in reality. And I think, you know, there's nothing to beat personal experience really. And we can't have had experience of every chronic disease. And that's, so that's, where I see the Expert Patients fitting in.' (GP 6.)

However, although they tended to value a lay-led approach to chronic disease self-management programmes, some of the responses indicated that in order to have confidence in referring patients to programmes, such as the Expert Patients Programme, GPs needed to know that information given in such programmes was appropriate. In addition, the majority of GPs felt that there should be some professional input and this included the need to ensure that the medical aspects of care were not neglected:

'... there obviously has to be some professional input to make sure that what is being said is appropriate and not being made up as it goes along, as sometimes can happen ...' (GP 3.)

'I don't know what they would be learning, that's the problem. I mean, what is one hoping to teach if they self-refer to the Expert Patient Programme? What are they hoping to learn? Is it just about their condition or is about how to handle their condition? And if they were told the

things that we tell them here about their condition and that motivates them to be better patients, that's great, I don't mind, you can do that, that's fine by me. I don't want people to end up confused though.' (GP 14.)

What contextual factors impact on GPs' ability to facilitate self-management?

Responders highlighted a variety of contextual factors that seemed to be impacting on their ability to facilitate self-management. The majority of GPs identified limited consultation time as being a factor, with longer appointments being required in order to help manage more complex problems:

'... you need to spend time with them, I think that's very important. You need to be available when they want to ask questions ... as a GP you don't have the time, you have 10-minute appointments ... Nurses however, have half an hour. So I think, I think it's important that you do spend time, and with all the extra things you've got to do it's not easy to find that.' (GP 14.)

Poor knowledge of community and voluntary services was also seen as problematic when trying to provide appropriate patient care.

GPs provided responses suggesting that although valued, strategies for increasing patient involvement in their care were not necessarily prioritised. Despite 'empowering' patients being a key standard in NSFs,³ it was stated that these aspects of care were not prioritised during discussions with colleagues:

'...the patient autonomy bits of the service frameworks don't seem to have occupied our conversation much.' (GP 8.)

In addition, interpretation of policies regarding access to a primary care professional within 24 hours was reported to have made it difficult for patients to 'plan and fit their diseases around the rest of their lives.'

Except for two GPs who conducted diabetes clinics, nurses were seen as being predominantly responsible for the running of structured chronic disease management clinics for patients whose conditions were stable. GPs mostly reported being responsible for managing acute illnesses and more complex chronic medical problems. In terms of encouraging self-management, compared with opportunistic appointments with GPs, designated nurse-led clinics were seen to provide more time and ensured that the consultation remained focused. Appointments with GPs, it was felt, did not allow for this:

'Patients often come to a consultation that is designed specifically for that particular issue, as opposed to a GP consultation of 10 minutes which tends to be an opportunistic thing, they come because they are going to talk to you about their sore throat and ... [because] your GMS things are flashing in the corner you do remember that they're also an IHD [ischemic heart disease] patient and there might be something you need to deal with there. Now, that isn't the setting, I guess, for talking about or exploring how they're managing, what's it stopping them doing, all the other things that I'm sure that they would like to talk [about] and we'd probably ... like them to tell us if we had more than 5-10 minutes, but we haven't.' (GP 2.)

Although the GPs' responses indicated that they valued the role of the practice nurse in helping to manage patients with chronic conditions, some responders expressed concerns that care was becoming fragmented, threatening their own ability to make sense of the patient's needs and develop a partnership relationship:

'... how do you provide that traditional family medicine role of the ongoing care of people but devolve it to other people but still retain that personal contact ...' (GP 9.)

Some GPs felt that the new GMS contract would reward practices for ensuring that biomedical aspects of care are addressed. Although one GP suggested that it would lead to an increase in the amount of nursing time and as a result 'information transfer', others did not feel that it was concerned with increasing patient involvement and control. There were concerns that with the new contract, care will become prioritised according to disease status and that consultations will become focused on data collection, with increased attention being paid to the computer screen thereby disrupting the conversation:

'I think we're really too focused on points and I think we'll be more preoccupied with filling the boxes on the computer and I'm not sure that's not gonna help patients manage their own health at all ... The new contract was a good thing but, in practice what happens is, as I say, we're kind of preoccupied with [the] ticking of the boxes and we're looking at, at you know, levels rather than necessarily spending time explaining to patients ...' (GP 5.)

No distinct differences were found in the

responses of GPs who were known by PCT staff to have a particular interest in chronic disease management compared with other participating GPs. There was variation across all the participants in the extent to which they reported contextual factors impacting on their ability to facilitate self-management. This ranged from one GP, who conducted a regular diabetes clinic and who did not report any difficulties, to some GPs who described several barriers discussed earlier in this section. However, no other distinct differences were found in the responses of GPs who were known by PCT staff to have a particular interest in chronic disease management compared with other participating GPs.

DISCUSSION

Summary of main findings

A central theme to emerge from the study is the conflict between different values, and between values and context. The findings suggest that although increasing patient involvement and control of their health appears to be valued, it is not necessarily prioritised. This is because it clashes with other important values of professional responsibility and accountability as well as with contextual factors that drive GP behaviour (for example, consultation length). The findings suggest that GPs themselves need to feel confident in order to be able to share some of the control with patients.

Comparison with existing literature

The findings from the study broadly resonate with Howie's model for understanding general practice consultations. This model suggests that GPs' ability to facilitate self-management is dependent on the relationship between the content of the consultation, the values prioritised by GPs, and the context in which chronic disease management is organised.^{20,21} Although training professionals in consultation skills is required in order to provide the necessary content of consultations, the findings support previous research, which suggests that this alone is unlikely to be sufficient.²⁷

The responses suggest that the context in which GPs work may limit their application of GP values towards facilitating self-management. Trade-offs appear to exist, with the contextual factors highlighted by the GPs suggesting that they may be more likely to prioritise the biomedical aspects of care at the expense of having space to explore the patient's perspective. This supports work by Charles-Jones *et al*, which suggests that the GP's identity may be more likely to shift towards that of a 'biomedical specialist'.²⁸

In addition, the findings support earlier work that the integration of community-based self-management programmes, such as the Expert Patients Programme, into mainstream health care is unlikely to be achieved without greater GP understanding and involvement during their implementation.²⁹

Strengths and limitations of the study

This study was conducted within the time frame of a Master's degree, which restricted the opportunity for further sampling for negative cases and limited the potential to explore in greater detail the relationship with professional outcomes (for example, stress, morale). For example, it may have been useful to interview salaried and locum GPs in order to explore their attitudes towards professional responsibility and their ability to encourage self-management. In addition, observational studies, as well as further qualitative interviews exploring patients' and practice nurses' attitudes to self-management of long-term conditions, may illuminate the impact of general practice consultations on self-management behaviour.

As participation in the study was voluntary, the GPs interviewed may have been more likely to have been interested in chronic disease self-management and may not be representative of the views of GPs nationally. Six out of 16 participants were known by PCT staff to have an interest in either the Expert Patient Programme or developing chronic disease management in general practice. Consequently, the findings potentially overemphasise the extent to which increasing patient involvement is valued. However, the study aimed to contribute to theory development rather than seek 'empirical generalisations'.¹⁶ Therefore, even among GPs who are more likely to prioritise self-management, the responses highlighted conflicting values that impact on their ability to increase patient involvement.

Implications for clinical practice and future research

The findings suggest that GPs value a shift towards a partnership or 'shared model' of care and they described various methods for achieving this.³⁰ These results indicate that training in shared decision-making skills may further assist with the sharing of control and address an important component in the facilitation of self-management.³¹

In addition to the patient-centred techniques mentioned by the GPs for working collaboratively with patients, a range of skills derived from several psychological and sociological models may also be necessary and applicable to the facilitation of self-

management in general practice.^{9,32} Rather than giving didactic advice, various strategies include drawing on lay experiential knowledge, exploring patient's ambivalence and readiness to change behaviour, as well as using short-term action plans in order to identify patient-defined goals and their confidence to achieve these goals.^{9,32}

Although responders valued increased patient involvement, the findings suggest that there will always be some difficulty for GPs between valuing their professional responsibility for the delivery of patient care and that of valuing increased patient involvement and sharing control in the management of their health. Training in relevant consultation skills is necessary to encourage self-management, but not sufficient. Such training may be ineffective if the context in which GPs work does not provide the necessary reinforcement. In order for GPs to have the confidence to share control with patients, structures that enable GPs to facilitate self-management need to be identified and integrated with mechanisms that ensure that the biomedical aspects of care are addressed.

Supplementary information

Supplementary information accompanies this article at: <http://www.rcgp.org.uk/Default.aspx?page=2482>

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Ethics committee

North-West Multicentre Research Ethics Committee (MREC 03/8/043)

Competing interests

The authors have stated that there are none

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