

Self-care — has DIY gone too far?

Self-care, 'the care taken by individuals towards their own health and wellbeing',¹ has always been commonplace. People have always made decisions about whether to attempt to manage their own symptoms, seek advice from lay networks, or go to a professional, be that a 'bloodletter', apothecary or herbalist. And self-care has continued to be a usual first step since the emergence of modern health care: for example, parents use thermometers to decide if their child needs a day off school, women use home tests for pregnancy, and Porteous *et al* report in this issue that members of the public prefer self-care to manage symptoms of minor illness.² All these activities seem appropriate: patients and clinicians would probably agree that it is not desirable for waiting rooms to be filled with people requiring paracetamol or a sticking plaster.

More recently, healthcare providers have actively aimed to promote greater reliance on self-care by providing information and support for health problems. In the UK, this has been through NHS Direct, an increased emphasis on supporting self-care during professional training, and the development of the Expert Patient Programme.^{3,4} There are many drivers for this: an increase in the number of demanding patients has been reported;⁵ communication, partnership and health promotion are preferred by members of the public;⁶ and advances in technology have enabled the development of quicker, more portable devices and tests that are suitable for home use. Furthermore, increased public engagement, improved life expectancy and technological advances are all likely to impact on the costs of providing comprehensive health services,⁷ leading to a need to explore innovative methods of care that could lead to cost savings.

Activities that come under the heading of self-care have expanded to encompass a wide range of preventive, diagnostic and treatment activities, from smoking cessation, through pharmacists checking

blood pressure, to self-monitoring and self-management programmes.⁸ Alongside this, the role of primary care professionals in helping people to know when and how to look after their own health has grown, for example educating and assisting people to self-monitor chronic diseases, such as self-monitoring of peak expiratory flow rate or symptoms by people with asthma.⁹

A more recent development is that many, potentially sophisticated, self-care activities can now be initiated by the individual without input or assistance from a health professional. A consequence, or perhaps the cause, of this is that many diagnostic self-tests are being marketed to members of the public. Self-tests for more than 20 different conditions can be bought in pharmacies or over the internet, including tests related to cancers (for example, tests for faecal occult blood and prostate specific antigen), chronic conditions (for example, tests related to diabetes and cardiovascular disease), and infections (for example, tests for urinary and sexually transmitted infections).¹⁰ Some self-tests provide almost immediate results, or the sample is sent to a laboratory and results are returned within days. People who buy self-tests do not need to discuss when they have the test, why they have decided to have the test, or the results of the test with anyone.

There are likely to be many benefits in the public becoming more involved in their own care. Self-management programmes for diabetes and hypertension appear to lead to clinically important improvements,¹¹ and convenience and anonymity is guaranteed for diagnostic tests carried out at home. Self-care has also been described as having the potential to reduce demand on primary and secondary care,¹ with associated resource savings. Nevertheless, self-care encompasses a group of very diverse activities and postulated or proven benefits for one activity, disease area or group of people, may not be generalisable to another activity, disease area or population. Inevitably, most evaluations concentrate

on self-care activities that take place with professional knowledge, input and supervision. There is a paucity of evidence relating to the level of use, or the perceived and actual harms and benefits, of activities initiated and used by the public without professional input, such as the use of diagnostic self-tests.

Before national screening programmes are introduced, potential harms (for example, false-positive results and consequent false anxiety) are weighed against potential benefits (for example, reduction in morbidity). For individuals using self-tests, there will have been no independent assessment of the whole clinical picture and whether a test is appropriate, and it is possible that the harms may outweigh the benefits. For example, there is an increased likelihood of false-positive results among people at low risk of the condition being tested. People with the greatest healthcare needs, most obviously the elderly or deprived, are less likely to have access to the internet,¹² but the widespread internet advertising of self-tests may mean that people who need the test least are most likely to purchase it, for example young men purchasing prostate specific antigen tests.

It is not only false-positive and false-negative results that may have adverse outcomes: people who get a true positive self-test result could think that they have a disease inappropriately because the whole clinical picture has not been considered, or those with a true negative self-test result may delay consulting when their symptoms are actually due to another condition. Such potential harms highlight the need for clear and adequate information accompanying self-tests. When testing is done in a conventional medical setting, the health professional assists the individual to consider how potential harms and benefits of a test apply to them, to decide whether a test is relevant and appropriate, to interpret the result in the context of the whole clinical picture, and to then decide upon the next steps. People who perform diagnostic

tests at home must do all this with only the aid of written information or, at best, a telephone hotline.

The Department of Health's enthusiasm for self-care may be based on the premise that visits to health services, including primary care, will reduce as a result. There is some evidence to support this, for example self-monitoring of hypertension led to reduced consultations for blood pressure measurement.¹³ Over three-quarters of the public say, however, that they would be far more confident about taking care of their own health if they had guidance and support from an NHS professional.¹² As this role is likely to fall to primary care, primary care professionals will need to be enabled to give guidance and support if potential benefits are to be realised.

Some may see patient-initiated self-care and self-testing as a threat to their professional role — some patients do not disclose their self-care to their doctors, and a possible extension of the current situation might be that primary care becomes redundant for those patients who can test, treat and refer themselves. It could also be viewed as an important opportunity to strengthen the patient-professional partnership and health outcomes by encouraging people to appropriately use and share their experiences of self-initiated self-care and self-testing. A recent study of GPs' perspectives on their involvement in the facilitation of chronic disease self-management suggested that increasing patient involvement and control is valued, but that it is not necessarily prioritised because it conflicts with other issues, for example professional responsibility and accountability and contextual factors, such as consultation length.¹⁴

We need to ensure that the public have enough information to make informed choices about when and how to care for themselves and when they should share information about self-care with their primary care team. Primary care doctors and nurses also need access to enough good quality information about available self-care activities to be able to ask questions and then advise patients appropriately, and any barriers to them doing so need to be addressed: they need to be able to adapt themselves to consultations with patients who are even more proactive and informed, but also, at the other end of the spectrum, with patients who are unable or unwilling to take a more active role. The clinical and academic communities will certainly have a role to play in listening to the public about why, how and when they self-care or self-test, and in generating and then providing the public and professionals with the information to make sensible self-care choices.

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REFERENCES

1. Department of Health. *Self-care — a real choice. Self-care support — a practical option.* London: The Stationery Office, 2005.
2. Porteous T, Ryan M, Bond CM, Hannaford P. Preferences for self-care or consulting a health professional for minor illness: a discrete choice

experiment. *Br J Gen Pract* 2006; **56**: 911–917.

3. Department of Health. *The NHS Plan: a plan for investment, a plan for reform.* London: The Stationery Office, 2000.
4. Expert Patients Programme. *About expert patients.* <http://www.expertpatients.nhs.uk/public/default.aspx?load=ArticleViewer&ArticleId=436> (accessed 14 Nov 2006).
5. Weiss MC, Fitzpatrick R, Scott DK, Goldacre MJ. Pressures on the general practitioner and decisions to prescribe. *Fam Pract* 1996; **13**: 432–438.
6. Little P, Everitt H, Williamson I, et al. Preferences of patients for patient centred approach to consultation in primary care: observational study. *BMJ* 2001; **322**: 468–472.
7. Wanless D. *Securing our future health: taking a long-term view. Final report.* London: HM Treasury, 2002.
8. Bodenheimer T, Lorig K, Holman H, Grumbach K. Patient self-management of chronic disease in primary care. *JAMA* 2002; **288**(19): 2469–2475.
9. Pinnock H. Respiratory medicine. *Br J Gen Pract* 2004; **54**: 539–545.
10. Ryan A, Wilson S, Greenfield S, et al. Range of self-tests available to buy in the United Kingdom: an internet survey. *J Public Health* 2006; doi: doi:10.1093/pubmed/fdl051.
11. Chodosh J, Morton SC, Mojica W, et al. Meta-analysis: chronic disease self-management programs for older adults. *Ann Intern Med* 2005; **143**(6): 427–438.
12. Department of Health. *Public attitudes to self-care. Baseline survey.* London: The Stationery Office, 2005.
13. McManus RJ, Mant J, Roalfe A, et al. Targets and self monitoring in hypertension: randomised controlled trial and cost effectiveness analysis. *BMJ* 2005; **331**(7515): 493.
14. Blakeman T, Macdonald W, Bower P, et al. A qualitative study of GPs' attitudes to self-management of chronic disease. *Br J Gen Pract* 2006; **56**: 407–414.

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Chronic kidney disease: a new priority for primary care

Chronic kidney disease is a long-term condition that has been the focus of important recent initiatives. Although only a small minority of individuals with this condition will develop end-stage renal

disease, the presence of even minor renal impairment is an independent risk factor for all cause mortality and cardiovascular disease.¹ The number of patients treated with end-stage renal failure is increasing

dramatically in the UK. Projections for hospital-based haemodialysis indicate an annual growth rate of 6–8%; a steady state is not predicted for at least 20 years.² Currently one-third of people reach