

Self-care — opting out or opting in?

AN issue which is causing concern to more and more doctors is how far to go in encouraging self-care for their patients. The promotion of health in the healthy is now government policy and is given at least lip-service by most doctors, while some have adopted it with missionary zeal. The question now is how to do it, rather than whether. Self-care in illness, however, raises different questions. Is it safe to pass on information to patients and expect them to take the right action? Is it ethical or legal to leave patients to monitor their own blood pressure even if they know they should seek help if required? Is it an abrogation of responsibility or is it what medical care is all about?

Underlying the traditional medical approach to self-care in illness is a set of assumptions about the importance of health and of doctors in helping people to be healthy. Levin, one of the foremost exponents of self-care, argues that the medical model assumes that health is life's highest goal; that non-compliance with medical advice and treatment is destructive behaviour; that trust is a key factor in healing; and that the role of the lay person in self-care is supplementary to the professional role.¹ In this view, patient education is geared to improving compliance with advice and the success of treatment is judged by clinical or health-related behavioural outcomes, such as finishing courses of medication, giving up smoking or uptake of prescribed services. Patients with chronic disease, such as diabetes or hypertension, are expected to take autonomous decisions, yet the implication is that doctors still have the responsibility to ensure that their patients are properly informed and to judge which patients are not capable of handling this degree of independence.

However, lay views of self-care in illness do not necessarily agree that continuing, or even initial, responsibility lies with the doctor. Two slightly different ideologies can be discerned.² First, there is the holistic or individualistic concept, which regards self-care in health and illness as simply one component of managing one's life-style and views professional care as a supplement to or occasionally a substitute for self-care. The lay person, not the doctor, is seen as the primary care practitioner,³ and health services as supporting and adapting to existing self-care practices. Moves by medical practitioners to pass knowledge and skills to patients are seen as entirely appropriate because health problems should be managed, as far as possible, by an individual as part of daily coping with living. Secondly, there is the social or interactive concept, which is less individualistic. This approach regards the development of self-care behaviours as a socialization process. The aim is competent participation in health care alongside professional care — a therapeutic alliance — and, for the individual, success is measured by the extent of self-control and assertiveness, as in psychiatric rehabilitation. In this view, self-care is seen as a primary outcome and measure of any health care process² and continuing paternalistic supervision is seen as a failure of the professions to interact appropriately with their 'patients'.

Thus both holistic and human rights ideologies support lay people having a greater responsibility for their own care than is customary within the national health care system in most European countries. However, it can be argued that the promotion by governments of health as 'everybody's business' represents a 'victim-blaming' ideology with party political and financial

motives.⁴ Autonomy and informed consent is only possible with an educated, participative public. Self-care is therefore less likely to be valued or be adopted by people with no financial or educational resources. There is also a danger that the move to self-care will distract attention from the environmental, financial and social improvements needed by such families as a first step towards reducing their much greater than average morbidity.² It is for this reason that the World Health Organization's approach of 'health for all by the year 2000'⁵ emphasizes small community developments towards social and economic independence, which are seen as the essential basis of health.

So, is it safe, legal or responsible for general practitioners to promote self-care? As in all things it depends — on the patient, the community and the doctor concerned. Obviously, self-care has little place in acute appendicitis. However, in minor illness or in chronic disease, if it is accepted that the patient has a right to choose to participate in care, and if this principle is honoured by competent transmission of information by the doctor, there are unlikely to be legal problems. The nub of the issue is for doctors to understand that the changing relationship which they observe with their more articulate patients carries with it a changing balance of responsibility as well as of information. At its extreme, the doctor's role becomes one of offering negotiated guidance when asked. As Levin says, we cannot on the one hand push for a change of behaviour and on the other deny self-control.⁶

The same principle applies at a community level. Primary health care professionals have special knowledge about the interaction of life-styles and health which, increasingly, community groups would like to share. For some problems, such as perinatal mortality or drug abuse, the community approach offers the only hope of early contact and the promotion of self-control offers the best hope of prevention. The best method by which the health care professions should participate in community self-care is by no means certain but it is clear that the time has come for doctors and nurses to opt *in* to the communities they serve.

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