



An Examination of the Self-Care Concept Uncovers a New Direction for Healthcare Reform

Dianne McCormack, RN, MSc
Professor of Nursing,
University of New Brunswick, Saint John

Abstract

The concept of self-care is multidimensional, with many defining elements. This paper describes the origin of this comprehensive concept. It examines the response of the nursing discipline to citizen self-care initiatives and the subsequent effects this response has had on the development of nursing knowledge. The evolution of self-care as a core concept within Canadian health policy is presented; the potential readiness for citizens to accept self-care as an aspect of healthcare delivery is explored, identifying potential benefits and obstacles. The paper concludes with a proposed self-care approach to healthcare reform in Canada and the subsequent influence this approach may have on the discipline of nursing. The congruency between a self-care healthcare delivery system and the theoretical foundations and perspective of healthcare delivery held by the nursing discipline is discussed. The role nurses might assume in shaping a self-care healthcare delivery system is delineated.

Self-care is not a new idea. Since the beginning of humankind, people have taken action to ensure personal safety and have developed strategies to address illness and other health challenges (Haug et al. 1989; Levin 1976; Padula 1992; Saunders 1994; Woods 1989). Primitive societies developed healing rituals that sometimes involved the consumption of special foods to promote the health of particular individuals or entire communities (Hill and Smith 1985). Women assisted one another in childbirth and shared the acquired knowledge with the next generation. Implementing self-care strategies to address day-to-day concerns about health is normal and usual (Bohart and Tallman 1996; DeFries et al. 1989; Levin 1981; Punamaki and Ascham 1994).

Individuals select self-care behaviours in order to maintain an acceptable level of health or well-being, to prevent illness or injury and to promote health. These self-care behaviours contribute to one's ability to perform a variety of tasks, ranging from ensuring survival to attaining self-actualization. Families accept responsibilities for facilitating the self-care of their members and take on self-care activities for other members who, owing to maturation, illness or other life events, are unable to complete the necessary task themselves. Community leaders support resources that enable individuals and families to carry out self-care tasks important to them. Clients at the individual, family and community levels have different self-care needs and expectations.

Different beliefs (Keller et al. 1989) and individual characteristics or conditioning factors (Chang 1980; Connelly 1993; Edwardson and Dean 1999; Horsburgh 1999; McCaleb 1995) influence the self-care behaviours selected or processes used to achieve a particular level of health. As well, the type or level of client (individual, family or community) influences choice of self-care activities.

Multiple descriptors of self-care result in varied definitions within and across disciplines (DeFries et al. 1989; Health Canada 1997; Punamaki and Aschan 1994; Rew 1990), and multiple variables are included in the self-care construct (Anderson 2001; Chang 1980; Horsburgh 1999; Keller et al. 1989; Punamaki and Aschan 1994; Wang and Laffrey 2001). According to Gantz (1990: 2), "self-care has been described as a movement, concept, framework, model, theory, process, or phenomenon." She reported that a panel of 15 experts in self-care were unsuccessful in their attempts to reach a consensual definition. However, 80 descriptors of self-care and 56 barriers were identified. Four characteristics of self-care that were acceptable to all members from the disciplines represented were recognized. These characteristics suggested that the self-care concept is situation- and culture-specific; involves the capacity to act and to make choices; is influenced by knowledge, skills, values, motivation, locus of control and efficacy; and focuses on aspects of healthcare under individual control (as opposed to social policy and legislation) (Gantz 1990: 2).

The concept of self-care is multidimensional and comprehensive, with many defining elements. In order for the concept to have relevance, a social and cultural context is required (DeFries et al. 1989; Mendias et al. 2001; Munchow 1993). Philosophical and foundational differences espoused by different disciplines within the healthcare sector add to the many perspectives of self-care. The origin of this concept will be described, the influence that the discipline of nursing has had on self-care initiatives will be examined and the subsequent effect of this influence in healthcare delivery will be explored. This paper concludes with a proposed self-care approach to health delivery and a subsequent position for the discipline of nursing. But first, here is a brief review of the events that triggered the trend towards self-care.

Inception of Self-Care as a Concept

Despite the idea that it is inherent in humanity, self-care became second-grade care during the scientific era. Nursing and medical schools had proliferated, making education and specialization within the disciplines available. Technological advances strengthened the power and control of healthcare providers (Saunders 1994). An interest in self-care was sparked when support groups developed to meet identified needs that had not been addressed by societal institutions such as the healthcare system. These support groups affirmed citizens' efforts to participate in self-care initiatives. This new focus on self-care, which resulted in the self-help/mutual aid movement, can trace its beginning to the founding of Alcoholics Anonymous in 1935 (Romedor 1989).

Other social movements, such as ParticipAction, wellness and women's movements, created the societal context for the emergence of self-care initiatives (Badgley 1994; Kickbusch 1989). The women's movement embraced "autonomy, self-determination, and independence in both health and illness" (DeFries et al. 1989; Health Canada 1997: 4; Kickbusch 1989) and extended self-care beyond formal and informal support groups to include personal self-care initiatives once again. When the focus of self-care returned to individuals, self-help literature abounded. Citizens were expressing a desire not only to survive adversities but also to thrive. Self-care became a dimension of health (Punamaki and Aschan 1994).

An interest in autonomy, more available and accessible information, dissatisfaction with the formal healthcare setting, a shift from acute to chronic illness care and an increased number of older citizens motivated participation in self-care (Chewning and Sleath 1996; Edwardson and Dean 1999; Health Canada 1997; Lachman 1996; Levin 1976, 1981; Padula 1992; Saunders 1994). Punamaki and Aschan (1994) claimed that in many illnesses, recovery or management of chronic symptoms depended on client adoption of health practices. Some proponents of self-care hoped that increased self-care activities would decrease the need for expensive healthcare services (Edwardson and Dean 1999; Health Canada 1997; Levin 1976, 1981).

Various social movements and the proliferation of self-care activities also influenced the various disciplines directly and indirectly involved in healthcare delivery. Although the disciplines of medicine, psychology, health education, sociology, public health and even business administration and insurance experienced, and to some degree were influenced by, the return of self-care initiatives (Gantz 1990), nurses used the interest in self-care to develop and promote the work of their discipline.

The Discipline of Nursing

The discipline of nursing is directed by multiple conceptual frameworks and theories contained within its boundaries that are determined by the metaparadigm

concepts of health, nursing, person and environment (Fawcett 1984, 2000; Flaskerud and Halloran 1980; Jennings 1987). All nursing actions are directed towards attaining, maintaining and promoting health (Schlotfeldt 1972). The intention of nurses is to influence the client's health experience in illness or health situations. Nursing actions are directed towards the client, the environmental context or both.

Within this context, different strategies are used to identify appropriate nursing actions. Often, a problem-solving process called the nursing process is used (Furlong 1996; Gantz 1990; Jewell 1994), but other approaches that build on client strengths are being used and tested (Allen 1977; Mitchell 1997; Wright and Leahey 2000). In all situations, data are collected to determine the needs of the client, to understand the environmental context and, when appropriate, to interpret the expectations of medical protocols.

Because people are unique, each client presents with different abilities to cope in diverse self-care situations. Nurses are curious about self-care that maintains and promotes healthy living, growth and development and recovery from or self-management of situations evolving from experiences of illness and injury (Orem 1995). Nurses are interested in all variables that clients identify as exerting an influence on their health. The self-care goals of the client determine nursing actions (Chang 1980; Gantz 1990).

Within the nursing discipline, Dorothea Orem began to link self-care with nursing practice as early as 1959 (Orem 1995). By 1971, her Self-Care Deficit Theory had been developed, providing the nursing discipline with a conceptual framework to guide practice and to build self-care knowledge through research (Hartweg 1991). Orem described self-care as those continuous actions initiated and performed by mature adults in order to maintain life, health and well-being (Comley 1994; Holzemer 1992; Orem 1995; Rourke 1991; Soderhamn 2000).

The delineation of three self-care requisites – universal, developmental and health deviation – are used to categorize the different demands for self-care that a person may experience (Comley 1994; Hartweg 1991; Horsburgh 1999; Orem 1995; Padula 1992; Rourke 1991; Whelan 1984; Woods 1989). Universal self-care encompasses the requisites created by life processes and needed by all humans, including such factors as water, air, food, rest, protection, interaction with others and so on. Developmental self-care requisites include both maturational needs adjusted for developmental stage and situational needs that stem from life events that, if left unattended, will impede human development. Health deviation requisites are derived from illness or injury experiences that develop from genetic and constitutional conditions and human structural and functional deviations, or are derived from medical diagnoses. This last category includes medical self-care or tasks

delegated to client but directed by healthcare providers. These tasks include self-monitoring of symptoms with more defined expectations when a client is experiencing a chronic disease; self-assessment so that physicians are consulted in a timely fashion and as required; self-treatment of minor illnesses and injuries; and self-vigilance in prevention efforts related to screening protocols and annual physical examinations, and in accessing healthcare resources within the community. This total set of activities is simply referred to as medical self-care (Gantz 1990; Padula 1992; Stearns et al. 2000).

When nurses develop therapeutic relationships or enter into therapeutic conversations with clients, the intention is to collaborate with them and to facilitate client efforts to achieve health (Gantz 1990; Gottlieb and Rowat 1987; Jewell 1994). Clients set the agenda. Nurses act as consultants and guide them in their efforts. Successful collaboration results in a partnership that respects equality, reciprocity, mutual understanding and informing (Jewell 1994; MacIntosh and McCormack 2001; Stewart et al. 1995).

This collaborative approach to care was confirmed by a qualitative study designed to determine how a self-care philosophy was implemented in one hospital unit (Furlong 1996). In that work environment, a process of negotiation was used to determine the expectations of the client, the client's family and the nurse. Because each client required particular self-care activities, the care was individualized. After developing a relationship with the client, nurses adopted an approach to self-care that matched the client's receptiveness. Client participation in self-care depended on which activities the client felt able or willing to do, and client choice. The ward philosophy was explained using three concrete aspects of self-care:

to enable patients to maintain a feeling of control ... [to] be given the opportunity to do as much for themselves as they were able or wanted to do ... to enable the patient to practise activities that they would need to perform for themselves after discharge, whilst in the comparative safety of the hospital environment. (Furlong 1996: 89–90)

Within the nursing discipline, active client participation is an antecedent to self-care. Because self-care involves the actions of the client, it cannot occur without participation. Both concepts, participation and self-care, indicate involvement. However, the degree of involvement in self-care might dictate whether the participation is active or passive. The boundaries or limits set on participation within institutions and other healthcare environments are real (Anderson 2001; Furlong 1996). In active participation, an egalitarian approach is adopted, and power within the relationship is equalized (Chang 1980; MacIntosh and McCormack 2000, 2001; Stewart et al. 1995). Passive participation is entrenched through the adoption of a

paternalistic approach to care (Chang 1980) or the setting of boundaries such as those imposed by medical self-care.

Self-Care and Canadian Public Policy

In Canada, the publication of the Lalonde Report (Lalonde 1974), which was soon acknowledged as a document of global significance, facilitated a major transition in the conceptualization of health (Glouberman 2000; Legowski and MacKay 2000; MacKay 2000; O'Neill and Pederson 1994). In that report, health was conceptualized as self-determination, with a mortality causality shift from infectious to noninfectious diseases. This document further declared that health was greater than both healthcare and advances made in medical science (MacKay 2000, 2001). The direction proposed by this paradigm shift opened opportunities for the development of new models to direct healthcare delivery systems. The idea that health could be self-determined through lifestyle choices created space for self-care initiatives.

In 1986, a health policy document, championed by federal Minister of Health, Jake Epp, recognized self-care as one of three mechanisms to address identified health challenges. Self-care, “or the decisions and actions individuals take in the interest of their own health” (Epp 1986: 7), was placed in a central position within a national framework for health promotion. However, self-care was associated with two other mechanisms: mutual aid and healthy environments. These latter mechanisms created a social and environmental context for self-care. This health promotion framework is credited with using a bottom-up approach to address health inequities (Legowski and MacKay 2000), implying citizen involvement.

When population health initiatives and the determinants-of-health model replaced health promotion in 1994, self-care lost its central place in health policy but was subsumed under individual factors of personal health practices and coping skills (Health Canada 1997). However, discussion about, and support for, the concept of self-care remained prominent because in that same year Health Canada initiated the Self-Help Project. One of the mandates issued to this project involved conducting an exploratory study in order to determine “how nurses and physicians stimulate and support self-care” (Health Canada 1997: 1).

The results of that exploratory study not only acknowledged the ongoing efforts of nurses and physicians to support self-care initiatives but also proposed a future direction for self-care (Health Canada 1997). A conceptual framework for supporting self-care initiatives emerged from the practices of nurses and physicians. The five interacting components are situated within the context of the conceptual definition for the study, which described self-care as “the decisions and actions taken by someone who is facing a health problem in order to cope with it and improve his or her level of health” (Health Canada 1997: 1). Elements or strategies to guide practice

were delineated for each of the five interacting components of the conceptual framework: supporting the person; sharing knowledge; facilitating learning and personal development; helping the person build support networks; and providing a supportive environment (Health Canada 1997: 49).

In an effort to raise awareness of the newly developed conceptual framework and to begin the dialogue about the utility of the framework in practice, Health Canada organized two invitational workshops for nurse and physician educators (Health Canada 1998). The central outcome of these workshops identified four barriers to supporting self-care in the practice of nurses and physicians and four key areas for action. Because results of the exploratory study were validated and extended, the readiness for nurses and doctors to dialogue about self-care practices was established. However, for real change to occur, the dialogue needs to continue and a champion in health policy must be identified so that the momentum for self-care is accelerated and integrated into healthcare reform.

A Self-Care Approach to Healthcare Delivery

In Canada, citizens have “both a right and an obligation to take charge of their personal health and to take part in decisions made on their behalf” (National Forum on Health 1997a: 32). Yet, barriers to active participation often inhibit Canadians from exercising their right to participation. As in other healthcare delivery systems, barriers range from intrinsic to extrinsic factors. In some situations, clients who have been socialized to assume the traditional “sick role” often feel inadequate and are reluctant to assume an active role in their own healthcare decisions (Baker and Stern 1993; Furlong 1996). In other situations, extrinsic factors in the environment hinder the active client participation. For some, family and work responsibilities create obstacles to self-care practices (Mendias et al. 2001). As mentioned earlier, the adoption by professionals of a paternalistic rather than an egalitarian approach to healthcare interactions has the potential to create controlling environments that encourage passive participation, if any at all (Punamaki and Aschan 1994; Rourke 1991). In Canada, the 250-year history of operating under a regulatory philosophy needs to be overcome (Badgley 1994).

Although client participation is necessary in self-help initiatives, readiness to accept change also contributes to one’s commitment to participate. In healthcare delivery, clients as passive participants have been rewarded with positive labels such as the “good,” or cooperative, patient. Health professionals have benefited from maintaining the power to control the interventions used and the decisions made. And in Canada, clients and professionals have benefited from a publicly funded healthcare system that ensures universality, portability, comprehensiveness, accessibility and public administration (Begin 1984). All medical and most hospital care in Canada is publicly insured. Furthermore, there is absolutely no doubt that Canadians value

and support these core principles of medicare (National Forum 1997a, b; Rachlis et al. 2001).

In the past decade, healthcare reform driven by fiscal restraints has resulted in hospital closures, reduced numbers of beds and reduced professional staffing. These activities and others have created concern for the stability and viability of the Canadian healthcare system. In recent months, the framework for healthcare reform in Alberta concretizes the idea of a shared public and private system (Premier's Advisory Council 2001). Because of these escalating events within the Canadian healthcare system and the constant reform of healthcare resources, citizens are preoccupied with maintaining the principles of medicare. Consequently, nonmedical health policy changes without adequate attention to detail, reflective thought and criticism are likely to be rejected or ignored by citizens. Therefore, in order to gain a commitment for a self-care healthcare delivery system in Canada one must build on the principles of medicare. A building approach to healthcare delivery is likely to be seen as a welcome change from the previous approach of reducing and downsizing. Self-care becomes an additional principle in medicare.

Citizens have expressed interest in alternative and complementary approaches to the traditional curative model of care (National Forum on Health 1997b). This particular proposal involves an additional criterion that builds on the inherent human response of self-care and protects the medical or curative healthcare system. Also, this proposal might be inviting to the majority of citizens who are interested in being active, rather than passive, partners in healthcare delivery (Health Canada 1997; National Forum on Health 1997b).

A Canadian conceptual framework for supporting self-care initiatives has been developed and is ready for testing. Because the framework evolved from guided research interviews with both nurses and doctors, differences between these disciplines in approaches to care might be equalized. Collegiality between these two dominant health professions presents an opportunity for collaboration and partnership. But what are the potential benefits and obstacles of a healthcare delivery system grounded in self-care?

Potential Benefits of a Self-Care Delivery System

Exercising the right to be an active participant in health continues to be an important value to Canadians. Although the medicare principle of public administration provides an opportunity for some input from a few Canadians, citizens are interested in discovering other meaningful ways of participating in healthcare decision-making at community and regional levels (National Forum on Health 1997b). In a self-care delivery system, clients are the influential decision makers, and their participation in medical and health self-care initiatives is expected. For those

citizens who wish to be an equal partner in care, health professionals will be consultants, guides or both (Health Canada 1997).

In this information age, clients are better informed about health issues, and access to information is no longer controlled by health professionals. Participants in the National Forum on Health (1997b) pointed out that accurate and timely information is required in exercising choice. Because citizens are already seekers of information, being exposed to opportunities to develop and refine self-care competencies is likely to be viewed positively. However, the learner (the client) determines the self-care competency that needs to be developed (Levin 1978). For these clients, independence, empowerment, acquisition of new knowledge and skills and autonomy are intangible rewards for their efforts (DeFrieze et al. 1989; Furlong 1996; Health Canada 1997; Levin 1976; Warren 1998). These citizens are prepared to invest in effective self-care initiatives.

The cost-effectiveness of self-care (Health Canada 1997) is a welcome adjustment to an already burdened healthcare system. In a study conducted by Stearns and colleagues (2000), the results indicated a potential reduction in medicare expenses for older adults who engaged in specific exercises or hobbies, made general home modifications and practised medical self-care. This evidence validates the efficient and effective benefits of self-care activities.

Potential Obstacles to a Self-Care Delivery System

Each time citizens exercise a right, there is a responsibility attached. Although Canadians have been exposed to the idea of self-care since the publication of the Lalonde Report in 1974, some citizens may encounter difficulties in assuming that responsibility. In order to protect those citizens, a self-care delivery system will need to ensure that people who choose self-care strategies that may adversely influence their health will not be denied access to necessary curative care (Health Canada 1997; National Forum on Health 1997b). In a study that examined how homeless persons in Canada achieved health, lifestyle behaviours were identified as health-promoting, survival or hindering. Both health-promoting and survival behaviours reflected positive self-care initiatives, while hindering behaviours appeared to influence health adversely (McCormack and MacIntosh 2001). However, these same hindering behaviours may have been used as a behavioural coping mechanism and the most appropriate strategy for that day and that situation.

Most self-care information offered in public education programs has included skills that are low in potential risk for harm (DeFrieze et al. 1989; Levin 1978, 1981). However, information gained from public Internet sources such as PubMed may not be easy to comprehend. Health professionals will need to shift their role from presenters of information to interpreters of information. For some health profes-

sionals, this change in role will create a loss of control. Any concerns about loss of control are likely to be compounded when clients discover new knowledge from recent research that the professional has yet to read. In these situations, health professionals need to accept the role of co-learner. Although self-care is seen as an opportunity by many health professionals and clients, it will be viewed as a threat by others.

If self-care initiatives delay access to professional health services and subsequently result in more costly interventions, the tendency of healthcare professionals to assert more control over individuals will need monitoring. Conversely, the cost-saving benefit of self-care must not become such a burden for citizens that quality of life for the client or other family members is diminished. In other situations, the burden of self-care may present too many challenges for some individuals, who may need to relinquish self-care activities. To avoid the potential for victim blaming, this situation also warrants monitoring (Health Canada 1997).

Proposed Position for the Discipline of Nursing in a Self-Care Healthcare Delivery System

Self-care is a construct that is central to the discipline of nursing. A conceptual model offers a distinct and coherent approach to nursing practice from the perspective of self-care (Fawcett 2000; Orem 1995), and concepts foundational to the origins of modern nursing are strongly linked to self-care. Health, a metaparadigm concept of the discipline of nursing and the focus of nursing actions, is the intended outcome of nursing and self-care (Woods 1989). As well, the healthcare delivery system that nurses have supported for the last quarter of a century, primary healthcare, is conceptually connected with the idea of a self-care healthcare delivery system. Nurses need to support the integration of self-care as a central approach to healthcare delivery.

Theoretical Foundations of Self-care in the Nursing Discipline

Nightingale, the founder of modern nursing, was so convinced that self-care promoted health that she wrote a book, *Notes on Nursing: What It Is, and What It Is Not*, to guide women as they cared for their families (Schuyler 1992; Woods 1989). This book is evidence of the long-term association of the constructs self-care and nursing. Even today, Nightingale's approach to promote the self-care practices of families remains feasible.

The greatest contribution to understanding the construct of self-care in the nursing discipline was made by Orem. Her conceptual model continues to inform nursing knowledge development in self-care through empirical research (Anderson 2001; Horsburg 1999; McCaleb 1995; McCaleb and Edgil 1994; Warren 1998) and theoretical analyses (Rourke 1991; Taylor et al. 2000, 2001; Utz 1990). Additionally, two

other Canadian theoretical conceptions of nursing practice, the Calgary Family Assessment and Intervention Models and the McGill Model, build on client strengths, including self-care practices (Gottlieb and Ezer 1997; Wright and Leahey 2000). Canadian nurses have developed competencies in self-care knowledge development and can champion the formal integration of self-care into healthcare delivery or, at the very least, facilitate its acceptance.

Perspective of Healthcare Delivery Supported by the Nursing Discipline

The predominant healthcare delivery model that has been embraced by the discipline of nursing is that of primary healthcare. The tenets and underlying philosophy of this model conceptualized at the Alma-Ata Assembly in 1978 (World Health Organization [WHO] 1978) were adopted and continue to be supported by the International Council of Nurses (ICN) and its member nursing associations as an acceptable approach to healthcare delivery (ICN 1988). As a result, the Canadian Nurses Association and member provincial associations developed position statements confirming their commitment to this model. This model comprises five core principles or tenets: essential healthcare needs; acceptable, appropriate and affordable methods and technology; accessibility; full client participation; and intersectoral collaboration (WHO 1978). These principles are connected through universal rights for health, including the right that health is an individual and a societal responsibility (Holzemer 1992; WHO 1978).

Within the primary healthcare model, stakeholders need to learn a new way of interacting and sharing power (MacIntosh and McCormack 2000, 2001). As in self-care, active participation of citizens is not only encouraged but is also expected. In primary healthcare, active participation is the process used to achieve health; in self-care, active participation is a required antecedent to care. In both primary healthcare and self-care, clients drive the system and set the agenda. Healthcare providers are consultants and guides who enable clients to promote their health. Clients assume responsibility for their healthcare and are actively involved in all decisions pertaining to their health (MacIntosh and McCormack 2001).

The primary healthcare principles of accessibility and acceptable, appropriate and affordable methods and technology are strongly imbedded in the values of equality, efficiency, effectiveness and accountability held by Canadians (National Forum on Health 1997b) and interpreted within the medicare principles of universality, accessibility and portability. The primary healthcare principle of essential healthcare is reflected in the comprehensive principle of medicare, and an intersectoral perspective connects the determinants of health. Citizens, however, have expressed their reluctance to shift healthcare resources to determinants of health outside the health sector (National Forum on Health 1997b). Because the community crisis created in Walkerton, Ontario, highlighted the importance of intersectoral collaboration

(Glouberman 2001), the idea of developing an infrastructure that enables stakeholders from different sectors to work collaboratively to address concerns of a multidimensional nature needs to be re-examined. In brief, primary healthcare encompasses both curative care and self-care.

The Role of Nursing in Shaping a Self-Care Healthcare Delivery System

In a professional discipline such as nursing, knowledge development depends on societal needs. According to Donaldson and Crowley (1978), nurse scholars have the responsibility for integrating the needs of society into the structure of the discipline. Using knowledge gleaned from empirical studies, nurses are exercising their responsibility to society when they elect to advocate and lobby for a self-care healthcare delivery system.

The exploratory study conducted by Health Canada (1997) connected the two dominant disciplines in healthcare through the development of a self-care framework. Nurses can test this conceptual framework and expand the approach to include other health disciplines and clients, building on and demonstrating the strategies effective in supporting self-care practices as well as elucidating shared understanding of self-care knowledge. Although this approach to collaborative practice is gentle, it has the potential to penetrate differences while developing an egalitarian approach to self-care. Nurses need to adopt, model and facilitate an egalitarian approach to care in order to become part of the solution. The “turf protecting” must stop, and the energy must be directed towards partnership.

The role that nurses assume in shaping this self-care approach warrants a national discussion. Experts in self-care within the discipline need to dialogue. Further to this end, the general membership including researchers, educators and practitioners needs to respond and refine the ideas until nurses across the country can articulate the common vision. A common understanding of self-care, combined with a commitment from all nurses to support it, can result in tremendous power to move this agenda forward.

Conclusion

The theoretical foundations of the nursing discipline and the perspective of healthcare delivery embraced by nurses support the Canadian societal interest in, and need for, a healthcare delivery system based on self-care. The egalitarian approach to care necessary for a self-care healthcare delivery system offers an opportunity for equal partnership with citizens and colleagues from other disciplines. Expectations and roles for citizens and professionals in active and passive participation will be clarified and understood as knowledge about partnership develops.

Legitimizing self-care as an equal principle in medicare creates new possibilities, such as the adoption of noncurative care as well as curative care. Dissemination of research findings to both professional and lay audiences opens opportunities for sharing information while facilitating self-care initiatives. Commitment and energy must be directed to the task of moving the self-care agenda forward.

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Commentary

Operationalizing Self-Care Within the Healthcare System

Souraya Sidani, RN, PhD
Associate Professor, Faculty of Nursing
University of Toronto, Ontario

The benefits of self-care make it a concept of critical importance for designing health and nursing care offered across the healthcare sectors (i.e., primary, acute and long-term). However, a clear definition of self-care should be determined prior to adopting it as a core concept underpinning care. It is viewed as a process that is initiated independently by the individual or in collaboration with healthcare professionals (HCPs), in response to a perceived need or demand, to achieve the goals of promoting, maintaining or enhancing health. The self-care process encompasses self-observation or monitoring, perception and identification of changes in functioning, judgment as to the meaning and severity of these changes, assessment of options for actions and selection, and performance of appropriate actions. This process involves active client participation in health-related decisions and in implementation of healthcare (Henry and Holzemer 1997; Sidani 2003). The individual's engagement in the self-care process is influenced by several factors (Gantz 1990; Sidani 2003).

This perspective on self-care has implications for the design and delivery of nursing care. At the abstract level, the

adoption of self-care in practice demands a shift from a paternalistic approach to care that is directed by the HCP to a participatory approach to care that is patient-centred. This shift is taking place in the healthcare system (e.g., Beaver et al. 1996), but is championed primarily by nursing. The participatory approach entails changes in the role of the client and the HCP. The role of the client becomes that of an equal partner, with responsibility for expressing his or her perspective, needs and preferences; taking an active part in health- and treatment-related decision-making; and engaging in appropriate actions and behaviours. Thus, clients are the initiators of healthcare, the providers of their own care and the evaluators of their health and their care (Watt 2000). The role of the nurse becomes that of a facilitator or coach. Nurses are responsible for:

1. Understanding the client as a unique person and elucidating the client's needs and preferences. Nurses recognize that clients have individual characteristics and specific needs, demands and preferences that shape their health, knowledge of and reaction to their condition, and choice of

treatments and self-care behaviours (Closs and Cheater 1999; Mead and Bower 2000). Nurses conduct a comprehensive assessment of clients' physical, psychological and socio-cultural condition, as well as preference for health condition and willingness to participate in self-care. They assist clients in identifying their priorities and individual goals. Nurses need to be aware that patients vary in the extent to which they want to assume an active role in self-care and decision-making (Beaver et al. 1996); therefore, they have to assess client preference for participation in care.

2. Responding flexibly to clients' priorities, needs and preferences. This implies that nurses base care-related decisions on clients' needs, values and preferences (Closs and Cheater 1999). Nurses inquire about interventions or self-care activities that clients have used to address their needs and have found to be effective, and inform them of others that are available and have demonstrated effectiveness. Nurses discuss the nature of each intervention or self-care activity, its dose, benefits and side effects, and elicit clients' acceptance of and preference for a particular intervention. They assist clients in adapting the intervention or self-care activity to fit their unique situation (i.e., abilities, resources, environment), needs and preferences, and provide them with the necessary physical, psychosocial and educational support to perform the intervention or self-care activity. Nurses encourage clients to monitor

their implementation of the intervention, to identify any difficulties in carrying it out and to evaluate its effectiveness. They use clients' feedback to revise care accordingly.

3. Providing education to clients in an interactive format, in which nurses engage in a two-way discussion with clients. Nurses listen to what clients have to say about their understanding of their condition, knowledge of conventional medical treatments and alternative complementary therapies, and ways or strategies for taking care of themselves. They clarify any misconceptions and offer additional information about clients' condition and care.

Understanding the client as a unique person, responding flexibly to client needs and preferences and providing interactive education arise in the context of mutual respect and a trusting relationship. Nurses respect clients' right to self-determination or autonomy. They honour clients' decisions and take them into consideration when planning and delivering care. Nurses value, encourage and support clients' active participation in care. While some aspects of a self-care framework have been used to guide nursing practice, the feasibility and utility of its full implementation across healthcare settings are yet to be determined.

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