

# Putting our best foot forward in motivating foot self-care

Misalignment of the perspectives of people with diabetes and healthcare professionals may contribute to low adherence to foot self-care. Learning to align these could inform simple solutions which would be cost-effective ways to improve self-care and reduce amputations, according to a new UK, qualitative exploration of barriers and facilitators of diabetes foot self-care. People with diabetes felt they could be motivated by personal or vicarious experience of foot problems or fear of consequences of diabetes, and enabled by being well-informed, having good communication with healthcare professionals and having time and the physical ability to undertake foot self-care. Clinicians' perspectives were influenced by their beliefs about patient self-care, often believing that poor adherence is due to lack of motivation, which they try to improve with warnings and stark health messages that, in many cases, prove demotivating. Different healthcare professionals perceived different barriers to effective self-care, which the authors believe could contribute to mixed messages and uncertainty about where to seek assistance with foot problems.

People with diabetes have a 19%–34% lifetime risk of foot ulcer. Ulcers are the leading cause of non-traumatic lower limb amputations, yet they are largely preventable with good foot self-care. Five-year mortality rates following amputation are 45%–57% (NICE, 2019), much higher than with most cancers. Previous studies have identified that, unfortunately, people with diabetes often do not take care of their feet until foot ulcers develop, when amputation may already be inevitable. This UK, qualitative study (Hill et al, 2022) aimed to identify barriers and facilitators motivating foot self-care, to identify areas of consensus between the perspectives of people with diabetes and healthcare professionals (HCPs), and to identify ways to improve foot self-care. In-depth, semi-structured patient interviews (9) and HCP interviews (7) were undertaken, and interview findings discussed by two separate patient groups to identify areas of agreement and difference.

Concerns over the consequences of diabetes, informed by personal experience, vicarious experience watching others with complications, and clinician messages about seriousness were identified as increasing people with diabetes' motivation to self-care for their feet, while

absence of these meant that people did not see foot care as important. Being well-informed, communicating well with their HCPs and having the time and physical ability to tend to their feet, enabled self-care.

Areas of consensus between the people with diabetes and HCPs in the study are summarised in *Figure 1*. They included concerns around consequences of diabetes complications, importance of patient education and frustrations around aspects of NHS care delivery. Important tensions included mixed messaging from HCPs around who has responsibility for foot health, and confusion over who to contact should a foot problem develop. HCPs appeared to attribute lack of motivation to undertake foot self-care to lack of patient knowledge, and non-specialist HCPs tended to avoid foot-care discussions owing to perceptions of their own lack of knowledge.

Despite the limitations of the study (conducted in an affluent and largely white British population, small sample size and limited range of HCPs included), this paper helps us identify simple steps we can easily take to overcome some of the barriers to foot self-care, as well as raising important questions for discussion within our practice or service. For example, do



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**Citation:** Brown P (2022) Diabetes Distilled: Putting our best foot forward in motivating foot self-care. *Diabetes & Primary Care* 24: 201–2

### Further reading

**How to assess feet to prevent foot ulceration in people with diabetes**

A step-by-step guide to improving foot care for people with diabetes. Available at: <http://bit.ly/3gMSVEp>

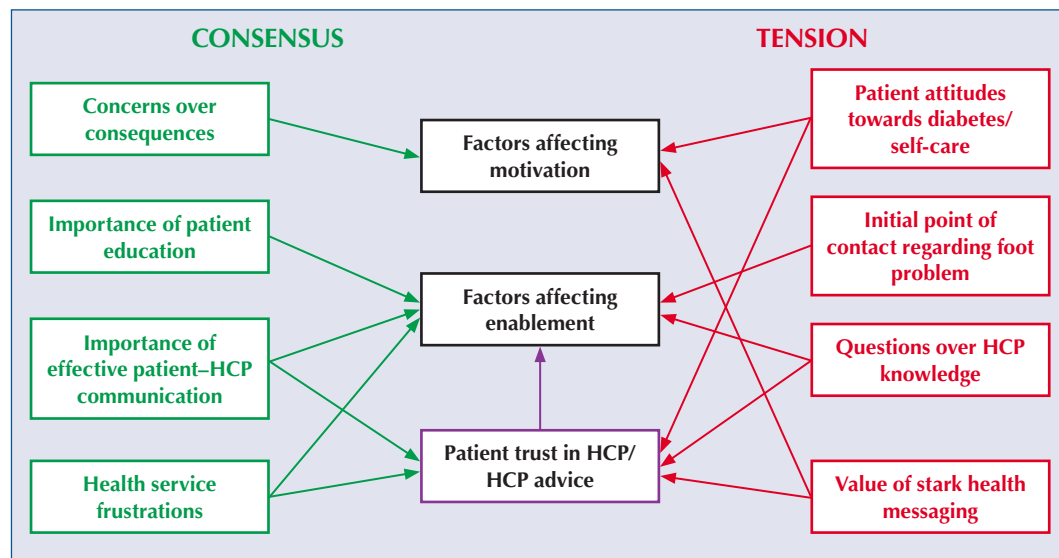


Figure 1. Areas of patient and healthcare professional (HCP) consensus/tension of perspective, and their relationships with barriers to and facilitators of good foot self-care behaviours. (Redrawn from Hill et al, 2022.)

all our team know when and how to access the specialist foot care team? Do people with diabetes clearly understand their own foot self-care role and to consult immediately if foot problems develop? And post pandemic, do our current access arrangements ensure people with diabetic foot problems can get same-day access to an appropriate clinician?

Take-home messages for clinicians include the importance of:

- Improving motivation by helping people develop their own, individual reasons to undertake foot self-care.
- Consistent messaging across all team members, including the roles of HCPs and people with diabetes in foot care.
- Clear education on when, where and how to ensure rapid clinician access, which will differ in different parts of the UK.
- Identifying and filling gaps in our own diabetic foot-care knowledge to increase our confidence in discussing foot self-care, rather than just examining feet.

Hill A, Ellis M and Gillison F (2022) Qualitative exploration of patient and healthcare professional perspectives on barriers and facilitators to foot self-care behaviors in diabetes. *BMJ Open Diab Res Care* 10: e003034

NICE (2019) *Diabetic foot problems: prevention and management* (NG19). NICE, London. Available at: [www.nice.org.uk/guidance/ng19](http://www.nice.org.uk/guidance/ng19) (accessed 29.11.22)

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## BMJ Open Diabetes Research & Care

### Qualitative exploration of patient and healthcare professional perspectives on barriers and facilitators to foot self-care behaviors in diabetes

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**Abstract** Diabetic foot ulcers contribute significantly to morbidity and mortality associated with diabetes, but are preventable with good foot self-care. This study sought to explore the perspectives of patients and healthcare professionals (HCPs) on barriers and/or facilitators to foot self-care behaviors in diabetes and areas of consensus and/or tension between patient and HCP perspectives.

**Research design and methods** This was a sequential, qualitative study that used a hermeneutic phenomenological approach. Phase 1 involved nine in-depth, semi-structured patient interviews. Phase 2 involved seven in-depth semi-structured interviews with HCPs (podiatrists, diabetes nurses, foot health practitioners (FHPs) and general practitioners (GPs)). In phase 3, findings from phases 1 and 2 were brought back to two patient interview groups (five patients in total) to validate and identify any areas of consensus and tension between HCP and patient perspectives.

**Results** Patient and HCP perspectives had several areas of alignment: concerns over consequences of diabetes complications; the importance of patient education and frustrations around aspects of health service delivery. There were also some notable tensions identified: mixed messaging from HCPs around whose responsibility patient foot health is; and who patients should initially consult following the development of a foot problem. Overall, patients expressed that motivation to undertake good foot self-care behaviors was generated from their lived experiences, and was enhanced when this aligned with the information they received from HCPs. HCPs appeared to attribute lack of patient motivation to lack of knowledge, which was not raised by patients.

**Conclusions** This study has identified points of misalignment between the views of patients and practitioners that may help to explain why adherence to foot self-care among patients with diabetes is low. Our results suggest that better outcomes may stem from HCPs focusing on supporting autonomous motivation for self-care and enhancing the rationale through reinforcing patients' own experience rather than focusing on increasing patient knowledge. Research focus on consistency of messaging by HCPs around the roles and responsibilities relating to foot health in diabetes, and the benefit of foot-specific training being provided to non-foot specialist HCPs may also help to improve uptake and adherence to foot self-care behaviors in diabetes.

**WHAT IS ALREADY KNOWN ON THIS TOPIC**

- Diabetic foot ulcers (DFUs) contribute significantly to morbidity and mortality associated with diabetes and are extremely costly to health services.
- Effective foot self-care behaviors are an important, low-cost approach to reducing the likelihood of DFU development; however, patient adherence to advice is low, and reasons for this remain unclear.
- Patients typically only adopt good foot self-care behaviors once DFUs have developed, which is often too late to prevent future occurrence of amputation.

**WHAT THIS STUDY ADDS**

- Patient motivation for foot self-care is generated through personal or vicarious experience and fear about the consequences of diabetes.
- Healthcare professionals (HCPs) often focus their time on factors that patients do not link to motivation, such as increasing patient knowledge.
- Non-foot specialist HCPs displayed an apparent insecurity around their own foot health knowledge which led them to avoid foot self-care discussions.
- There was discrepancy between patients and HCPs about who patients should seek out when a foot problem arises.

**HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY**

- HCPs should support more autonomous motivation for individuals in pursuit of self-care, including acknowledging barriers; recognizing patients' lived experiences and helping them to develop a personally meaningful rationale for undertaking necessary health behaviors.
- There should be increased focus on developing consistency of messaging by HCPs.
- This is both in terms of who the most appropriate HCP is to present developing foot problems to initially, as well as clarifying the roles and responsibilities of HCPs and patients around foot care.
- The benefit of foot-specific training being provided to non-foot specialist HCPs should be explored.

**INTRODUCTION**

For a person with diabetes, the lifetime incidence rate of a diabetic foot ulcer (DFU) is

BMJ Open Diab Res Care 2022;14:e003034. doi:10.1136/bmjopen-2022-003034