What is the practice and understanding of podiatrists towards patient-centred consultations regarding diabetic foot care?

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Key words

- Behaviour change techniques
- Diabetic foot
- Patient-led care

Article points

1. Behaviour change techniques (BCTs) have the potential to improve foot self-care behaviours and reduce diabetic foot complications, but there are few studies looking at the use of BCTs in a podiatry setting.
2. Conflict in the answers of respondents suggests a lack of understanding of BCTs by UK podiatrists.
3. An increased emphasis on health psychology/behaviour change training for podiatrists at both undergraduate and postgraduate level, which can be applied in a diabetic foot care setting, is advised.

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Background: Patient education is an integral part of diabetes management, yet research shows that increased knowledge alone does not translate into behaviour change. Behaviour change techniques (BCTs) have the potential to increase foot self-care and reduce the incidence of diabetic foot disease. Aims: The aim of this study was to explore the practice and understanding of podiatrists towards patient-centred support versus prescriptive instruction in consultations regarding diabetic foot care. Methods: The study was a cross-sectional design with a web-based questionnaire distributed to members of the College of Podiatry in the UK. Descriptive statistics, conceptual content analysis and the Pearson product-moment correlation coefficient were used to analyse the data. Results: Most respondents reported using BCTs in their consultations "often" or "very often" and that they "strongly agree" or "agree" that their consultations were patient-led, yet most were categorised as having a partial or poor understanding of these terms. Three themes emerged regarding barriers and facilitators, including 'Skills and confidence', 'Patients do not want to take control' and 'The system'. No correlation was found between any of the variables investigated. Conclusion: Conflict in the answers of respondents suggests a lack of understanding of BCTs. A need for institutional changes and organisational support was highlighted by the respondents.

Diabetic foot disease can have a detrimental impact on an individual's quality of life and has serious financial implications for the National Health Service (NHS) (Kerr et al, 2019). It is, therefore, imperative that individuals with diabetes mellitus (DM) are encouraged and adequately supported to manage their own foot health and carry out daily foot self-care practices to prevent problems occurring (NHS England, 2014).

In the current COVID-19 pandemic, this has been more important than ever, as foot health service provision in the UK has been temporarily reduced in a bid to limit non-essential face to face contact, and many podiatrists redeployed to other services. The remit of podiatry services has been to avoid hospital admissions, preventing added pressure on intensive care unit capacity and saving limbs (Rogers et al, 2020).

Patient education is an integral part of the management of DM, as a means of promoting foot self-care, increasing adherence to foot self-care behaviours and, ultimately, preventing diabetic foot complications. However, research suggests that increased knowledge alone rarely translates into positive behaviour change (Dorresteijn, 2014), suggesting a different approach is required. Behaviour change techniques (BCTs) have the potential to improve foot self-care behaviours and reduce diabetic foot complications. According to Michie and Johnston (2013), a behaviour change technique can be defined as "an observable, replicable, and irreducible component of an intervention designed to alter or redirect causal

processes that regulate behaviour; that is, a technique is proposed to be an 'active ingredient, e.g. feedback, self-monitoring, reinforcement'". BCTs can be used alone or in conjunction with other BCTs as part of a behaviour change intervention (BCI) and can be a valuable part of patient-centred care.

Patient-centred care is a standard of practice that involves a respect for the patient as a person and their point of view. It is a move away from the paternalistic model of the healthcare professional-patient relationship where the healthcare professional made decisions about the patient's health and the patient complied, and a move towards mutual participation and shared decision-making (Pelzang, 2010). However, it is important to note that not all BCTs are patient-centred and, for the purpose of this paper, when BCTs are mentioned, this is referring to patient-centred BCTs only.

A search of the existing literature showed that BCIs are currently successfully being used in the management of type 2 DM, to reduce HbA_{1C} and body weight (Cradock et al, 2017). However, there are few studies looking at the use of BCTs in a podiatry setting, and those that do exist differ in aims, delivery and duration of intervention, outcome measures, and outcomes, highlighting a gap in the literature and a need for further robust research on the subject.

Aims

The aim of this study was to explore the practice and understanding of podiatrists regarding BCTs and patient-centred support versus prescriptive instruction in consultations regarding diabetic foot care.

Methods

Ethical approval was obtained from Coventry University. The study was a cross-sectional design with an anonymous, self-administered, web-based questionnaire distributed via email to all members of the College of Podiatry with the Health and Care Professions Council (HCPC) registration working in the UK. A link was also posted on relevant Facebook groups UK Podiatry and footindiabetes. Descriptive statistics were used to analyse data regarding the current practices of the participants. The questions investigating the participants' knowledge were analysed using conceptual content analysis to categorise participants as having "good understanding", "partial understanding", "unsure", "poor understanding", "no understanding". Questions that investigated barriers and facilitators were analysed using thematic analysis. The Pearson product-moment correlation coefficient was used to determine the strength of relationships between the reported use of patient-centred language and the reported use of prescriptive language, the association between respondents reporting that their consultations were patient-led and the reported use of patient-centred language, and to identify whether the duration of qualification influenced the responses of participants to provide insight as to whether the use of BCTs and a patient-led approach has changed over time.

Results

A total of seventy-eight podiatrists completed the questionnaire. Most respondents were female, between 31 and 60 years of age, and had been qualified for either 1–5 years or more than 20 years. Not all the respondents completed every question. Most respondents reported using BCTs in their consultations "often" or "very often" (82%) (*Figure 1*) and that they "strongly agree" or "agree" that their consultations are patient-led (81%).

Most respondents (43%) agreed that they use patient-centred language in their consultations, yet contradictorily, the majority (51%) also agreed that they use directive language in their consultations. Seventy percent of respondents reported being confident in negotiating behaviour change with their patients and only 14% reported being not at all confident. Over 60% of respondents reported not being taught about health psychology and the psychology of self-care in their undergraduate BSc podiatry degree.

With regards to understanding, 49% of respondents were categorised as having a partial understanding of the term 'behaviour change techniques' and 53% were categorised as having a partial understanding of the term "patient-led consultation" where they showed some understanding of the concepts but also

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included inconsistencies or some incorrect or ambiguous answers. For both questions, most respondents were categorised as having a partial or poor understanding of the terms. Only 14% of respondents were deemed as having a good understanding of the term "behaviour change techniques", and 18% were deemed as having a good understanding of the term "patient-led consultation" (*Figure 2*). No correlation was found between any of the variables investigated. Three themes emerged from the thematic analysis regarding barriers and facilitators to support behaviour change.

Theme 1. Skills and confidence

This theme captured how confident respondents felt about using behaviour change techniques in their consultations and whether they felt that they had the skills to do so. A lack of appropriate training and skills was reported by many respondents as being a barrier to implementing a patient-led consultation style in their practice, with some citing "Not knowing how to do it" and "Lack of training" as reasons. Confidence was also an issue, with respondents citing "Low confidence" or "Knowledge that I am doing it right" as a barrier. Most respondents felt that training would help increase their ability to negotiate positive behaviour change with their patients, with some citing specific behaviour change training, such as "Motivational interviewing training" and "Health coaching training". Both undergraduate and postgraduate training was suggested as a possible facilitator.

Theme 2. Patients do not want to take control

Respondents felt that their patients do not want to take control of their own health or foot care and that this was a barrier to them using a patient-led consultation style. This was illustrated by responses including "Patient belief that they do not need to participate in own care", and "Patients do not want to take control of their health". Some respondents felt that a lack of patient compliance was a barrier to their use of a patient-led consultation style, and that many patients "just want us to make it better".

Theme 3. The system

Broad institutional factors seemed to impact on the clinicians' ability to implement a less directive approach in their consultation style. Time was an important issue, with most respondents citing "Time" or "Time constraints" as a barrier to implementing a patient-led consultation style in their practice, and "More time" as a facilitator. Lack of continuity with patients also seemed to be a concern, with "Lack of follow up from the next podiatrist", as well as a "Lack of ongoing support" being cited. Some respondents felt that "A better working relationship with other health practitioners" would be helpful, particularly those who work in psychology.

Discussion

Most respondents reported using behaviour change techniques in their consultations "often" or "very often" and that they "strongly agree" or "agree" that their consultations are patient-led. However, most respondents were categorised as having a partial or poor understanding of the terms "behaviour change techniques" and "patient-led consultation". This conflict suggests a lack of understanding of the terms and may have led to respondents over-reporting their use of behaviour change techniques and a patient-led consultation style. The highest proportion of respondents agreed that they use patient-led language in their consultations, yet the highest proportion also agreed that they use directive language in their consultations, again showing a conflict in the data.

Moreover, a further conflict was shown as 87% of respondents reported being "confident" or "very confident" at negotiating behaviour change with their patients, yet "skills and confidence" was identified as an important theme regarding the barriers to implementing a patient-led consultation style in their practice and negotiating positive behaviour change with patients. It might be that the respondents were reporting accurately based on their poor understanding of the terms, resulting in the contradictory answers given. The results of the thematic analysis captured the idea that the respondents felt that there are systemic institutional issues such as lack of time and support to learn and then use behaviour change techniques, which, in turn, may result in clinicians not having the adequate skills, knowledge or confidence required to implement a patient-led consultation style in their practice.

With the more directive consultation style continuing, it is perceived that patients are then not taking responsibility for their own health/foot care and want the clinicians to take responsibility for this.

To be registered with the Health and Care Professions Council (HCPC), a podiatrist must meet the threshold standards of proficiency that have been set by the HCPC to ensure safe and effective practice. Standard 13.7 states that a podiatrist should "understand the key concepts of the knowledge base relevant to their profession" and must "understand, in the context of chiropody and podiatry: behavioural sciences" (Health and Care Professions Council, 2018).

In this study, over 60% of respondents reported not being taught about health psychology and the psychology of self-care in their undergraduate BSc podiatry degree. This could mean that either the respondents were not taught this in their undergraduate podiatry degree, or that they were taught it but were not able to recall being taught it, both of which suggest an increased focus on health psychology/behaviour change training and an emphasis on this approach may be required at undergraduate level to move this up the podiatrists' agenda and increase awareness. It should also be noted that NICE guidelines (NICE, 2019) recommend that patients should be given oral and written information regarding foot care advice and the importance of self-care, but do not currently give recommendations regarding the use of BCTs.

However, they do state that one of their research recommendations is to explore education and psycho-behavioural interventions for the prevention of diabetic foot complications and acknowledge that new interventions to target psychological and behavioural factors should be developed.

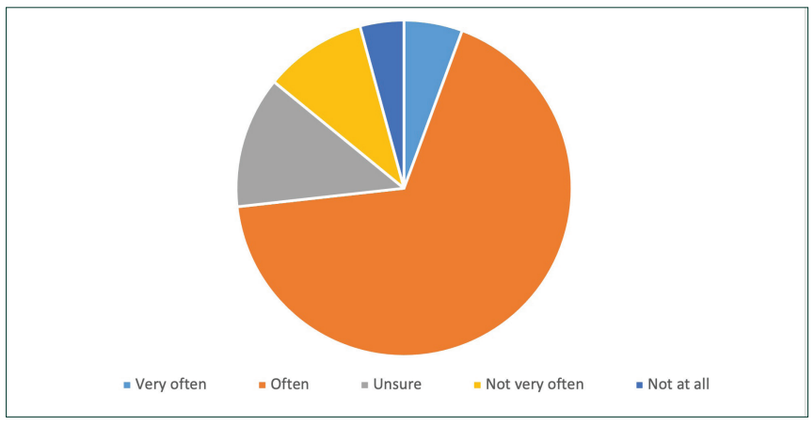

Figure 1: Frequency of use of BCTs (%).

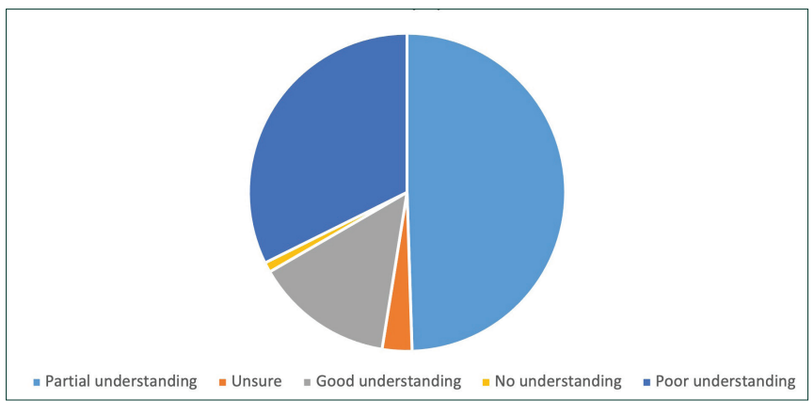

Figure 2: Understanding of the term 'Behaviour change techniques'.

Conclusion

This study explored the understanding and practice of podiatrists regarding BCTs and their consultation style using an online survey. Conflict in the answers of respondents suggests a lack of understanding of BCTs, which may have led to respondents over-reporting their use of BCTs and a patient-led consultation style. A need for institutional changes and organisational support was highlighted by the respondents, including extra time to undertake training to develop the adequate skills, knowledge and confidence and extra time in appointments to implement a patient-led consultation style in their practice.

Recommendations

- Consider an increased emphasis on health psychology/behaviour change training for podiatrists at both undergraduate and postgraduate level, which can be applied in a diabetic foot care setting. Review education standards and make appropriate revisions as required.
- Qualified podiatrists should be upskilled and given appropriate training to increase their understanding of BCTs and how to use them as part of a patient-centred approach to encourage appropriate foot self-care. ■

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