

## SELF-CARE IN HEALTH

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### INTRODUCTION

Self-care in health in this paper refers to those activities individuals undertake in promoting their own health, preventing their own disease, limiting their own illness, and restoring their own health. These activities are undertaken without professional assistance, although individuals are informed by technical knowledge and skills derived from the pool of both professional and lay experience. This broad definition is consistent with definitions commonly applied to the term *self-care* [(C. Smith, unpublished paper; P. Crawshaw and B. Wong, unpublished paper; (1-3)]. The generic attribute of self-care is its nonprofessional, nonbureaucratic, nonindustrial character; its natural place in social life (4). Operational definitions of self-care have more narrowly reflected various emphases on the spiritual aspect of health and health care, wellness behavior, self-medication, healing potential, self-administered primary medical care, management of chronic disease, and protection in use of professional services (5-18). The concept of self-care also remains within the traditional health education literature as focused on risk reduction and disease prevention at the level of personal action (19). Self-care as a political concept involving individual skills in collective action on structural issues had its early expression in the consumer health movement of the last two decades. Currently, the collective action perspective on self-care is found largely within the broader frame of lay initiatives in health, particularly through neighborhood voluntary organizations (15) and mutual aid groups.

A typology of well-formed concepts of self-care is not to be found. Social research has yet to catch up to the varied social expressions of lay health care. The most useful contribution to be made by this review at this point, midstream in the growth of our awareness of self-care as a factor in health and health care, is (a) to synthesize the modest understanding we now have of self-care, recognizing the theoretical and methodological limits of available data; and (b) to identify what appear to be productive directions for research and public health policies and programs.

## SELF-CARE IN RECENT HISTORY

Before we begin to think about the subject of self-care in strictly contemporary terms, it would be well to emphasize its historical roots. Because it is a private, largely noneconomic activity, it has gone unnoticed by most students of the family and public health alike. Thus, its recent rediscovery could give the somewhat false impression that it is a new practice. But actually, the current popular interest in self-care and self-help is in many ways similar to what it was in mid-nineteenth century America, both politically and economically.

Popular interest in self-provided health care in the nineteenth century was closely tied to the other social and political movements that began during the Jacksonian period. It was rooted in the traditional American values of self-reliant individualism, anti-elitism, popular democracy, common sense, and even nationalism (20–22). But it also sprang from fundamentally optimistic beliefs about health and the causes of disease. With the proper diet, fresh air, and exercise, the health reformers and some of the domestic manuals counseled, men and women could prevent disease from occurring in the first place. Historians have argued that nineteenth century interest in health reform was a clear response to the social uncertainties of the time, chief among which were changes in women's work role within the family (23). Thus the confluence of changing women's roles, feminism, and a general interest in health matters in the nineteenth century, and similar configurations today suggest that these are socially logical responses to common problems.

In any case, the 1970s and 1980s have been another period of public interest in health, and self-reliance in health care matters has again been a major theme in the debate.

## THE EXTENT OF SELF-CARE TODAY

A surge of development in health care in Western Europe and North America following World War II was in response to substantial deficits in professional resources. The establishment of the National Health Service in

Britain in 1948 and rising concern in North America regarding issues of access to medical care and improving quality of services served to reinforce the perception that professional health care was synonymous with health care generally. But access to a broad data base made possible systematic studies of utilization patterns, and these in turn began to define the several components of the health care resource, both lay and professional.

In an effort to define the role of the general practitioner in primary and secondary prevention, J. M. Last (24) documented the extent of untreated morbidity in England and Wales. His study made clear that for virtually every category of disease, what the medical practitioner saw was only "the tip of the iceberg." This conclusion agreed with an earlier study by Horder & Horder (25) undertaken on a London population. Here it was found that less than one third of illnesses experienced were cared for by health professionals. In an international comparison study of medical care utilization, White et al (26) found a similar distribution of symptoms involving lay and professional care. From interview data, it was found that an average of 82.7% of all conditions causing "great discomfort" over a two week recall period did not involve consultation with physicians.

The above studies, as powerful as they are in revealing the vast proportion of all illness episodes cared for exclusively by the layperson, very likely are substantial underestimates of lay self-care. The interview method used in these studies relied on respondent recall, which has been observed to be increasingly unreliable as a source of morbidity data after a two week period. Even within that period it can be expected that the more serious, painful, or disabling conditions would dominate in memory. Minor upsets, like tension headache, indigestion, cold, backache and other commonplace, short duration discomfort may not be remembered and thus not reported. A more sensitive method for collecting illness experience is the home health diary (27-29). Typically, respondents are asked to record on a daily basis for several weeks anything "wrong" with them and what, if anything, they did about it: such as self-treatment, or seeing a doctor.

Using the health diary method, Demers et al (30) analyzed all health problems recorded by study participants over a three week period. Results indicated that nearly 95% of the problems recorded did not involve professional medical care. Banks et al (31) incorporated a health diary as one of several sources for data on factors influencing demand for primary medical care in a group of British women between the ages of 20 and 44 years. The results showed that only 1 in every 37 symptom episodes was brought forward, solely on the patient's initiative, for medical consultation. The authors of this study identified clear differences between self-cared-for symptoms (headache, changes in energy) and those brought to the general practitioner (bladder, skin, genital). Some symptoms were more evenly divided in terms of self-care and professional care (emotional, abdominal,

pain in lower limb). Overall there is the strong impression that the women in this study were in agreement on what was appropriate to self-treat and what was not.

In addition to retrospective interview surveys and prospective health diary studies using nonpatient populations, there are two studies that describe the self-care behavior of patients prior to seeking professional help. Elliott-Binns (32) in Britain and Pedersen (33) in Denmark interviewed samples of patients registered on their general practice rosters. The Elliott-Binns study found that 96% of the patients interviewed said they had received advice or treatment for the condition prior to contacting the doctor. This finding suggests the point that the range of self-care practice must include, in addition to specific self-treatment behavior, those activities associated with seeking and evaluating information. Further, these two studies help clarify self-care as not always or necessarily sufficient, but as a factor in nearly all illness episodes, including those that ultimately receive professional care.

In any event, research on self-care in both the US and abroad has mushroomed. There are a number of bibliographies available (34–36; WHO, Div. Fam. H. 1982, unpublished report; G. H. DeFriese, 1982, unpublished draft) and the Index Medicus now lists self-care as a separate category, complete with subheadings.

### *What Kinds of Illness-Related Actions Constitute Self-Care?*

Initial descriptive self-care research has concerned the kinds of action undertaken in response to illness, including self-diagnosis and options for treatment or no treatment. Wadsworth et al in England looked specifically at who made the diagnoses for the complaints in their sample. They found that for the ten most frequent complaints, accounting for 98% of all complaints, the majority of respondents said they had diagnosed the condition themselves (37). In this country, a national survey of health beliefs and practices found that 12% of their total sample relied heavily on self-diagnosis, and that over 25% who said they suffered from arthritis, rheumatism, or a similar chronic ailment had never had it diagnosed by a doctor (38). One might think that self-diagnosis would lead to further self-treatment only in the case in which the individual felt himself to have a minor or self-limiting illness. But, even in the case of some fairly serious chronic diseases, people do not necessarily seek medical diagnosis or treatment. J. M. Last estimates that for every case of tuberculosis, cancer, anemia, diabetes, urinary infection, glaucoma, hypertension, bronchitis, arthritis, epilepsy, and psychiatric disorder known to a physician in general practice, there are 50 to 100% more in the population at large. Although some of these diseases are probably undetected by sufferer as well, the author notes,

“Some of these potential patients [sic] may be people living with a disability which has been recognized, and for which they have not sought treatment in the year of the inquiry” (24).

Following self-diagnosis, the first available self-treatment option is to do nothing. In the Wadsworth et al study, only 5% of the people interviewed reported no complaints at all for the previous two weeks. Of the remaining 95% who did report at least one complaint, 19% had taken no action (37). Dunnell & Cartwright’s study, which was primarily concerned with medicine-taking, found that no medicine, either prescribed or nonprescribed, was taken for 47% of the complaints reported, though this does not take into account other actions (39). Knapp & Knapp found, in their study of self-medication, that only 7% of the illness situations received no doctor contacts or self-medication remedy of any kind, though 63% received a response within four hours of onset. Thus, a sizeable proportion of people, 30%, adopted a “wait and see” attitude before deciding that the situation was serious enough to warrant a response, be it self-medication or other treatment (40). Dean (K. Dean, 1980, University of Copenhagen, unpublished manuscript), in an interview study of self-care for common illnesses among a Danish population, found that “taking no action” was unevenly distributed among various presenting symptoms. Chest pains most often invoked no action, whereas symptoms of depression and influenza were nearly always treated with home remedies, other forms of medication, or a medical consultation. Differences in the rate of nonresponse to recognized symptoms in these studies may be attributable to differences in study design, goals, and methods. Knapp & Knapp, whose stated goal was to study self-medication behavior, commented that this goal may have influenced their respondents: “Perhaps drug use itself helped define incidents for diary recording” (40).

Of the possible forms of self-treatment, self-medication has been by far the most frequently studied. Wadsworth et al found that 38% of their sample had taken an analgesic in the two weeks prior to the interview; this was the most frequently used medicine. Twenty percent had used a skin medicine, 13% had used lower-respiratory medicines, and 12% had used antacids. Uses of nonprescribed medicines outnumbered prescribed medicines by two to one (37).

Dunnell & Cartwright found self-medication to be the most frequently reported response to symptoms, surpassing consulting a physician, doing nothing, and using other treatment methods. More than half of the adults in their sample, 55%, had used some medicine during the twenty-four hours prior to the interview. The people with the most symptoms tended to take the most medicine: adults who reported one symptom had taken an average of 1.1 medicines, whereas those who had had six or more symptoms took

an average of 4. Some symptoms were more likely to be responded to with medication than others: 94% of fevers, 83% of headaches, 81% of cases of indigestion, and 78% of sore throats were treated with medication. By comparing the use of prescription and nonprescription medicines with the number of symptoms present, they argue that self-medication does serve as an alternative to consultation with the doctor. Adults who had taken two or more medicines had lower consultation rates than those who had taken one, and those who had taken one had lower rates than those taking none. With children, however, medicines were used to supplement doctor consultations. Furthermore, these medicines were taken frequently and sometimes for long periods of time. Two-fifths of the adults in the study had taken some medicine every day in the weeks before the interview. Only 1% of the households in the sample had no medicines at all, and 10% had twenty or more. The average number was 10.3. More households had nonprescription than prescription medicines, and the most commonly found were analgesics (39).

This supports the findings of an earlier study in England by Jefferys et al. About two thirds of individuals in the study sample had taken a nonprescribed medication during a four week period, in contrast to a quarter of this sample who had taken a prescribed medication (41). Jones (42), collecting data from the records of all pharmacies and physicians serving an entire community in England over a two week period, found that nonprescribed medications were acquired twice as often as prescribed medications. Given that prescribed medicines at the time those studies were undertaken were free or heavily subsidized by the British National Health Service, the evident popularity of nonprescribed medicines is somewhat surprising. In this regard, Rea et al (43), studying the prevalence of skin disease and the use of medical care, found that 21% of those observed to have skin conditions severe enough to warrant professional care chose nonprescribed self treatment. These authors speculated that the public must prefer to pay for less effective drugs rather than “go through the time-consuming machinery of obtaining [free] professional medical advice.”

In their longitudinal study of 278 US families, Knapp & Knapp obtained information on 3300 illnesses or injuries, and on 3800 drug purchases. At the start of their study, the average household had 5.3 prescribed and 17.2 nonprescribed drugs, and during the period of the study, acquired 13.7 more of both. Prescribed drugs were used in 30% of the illnesses, nonprescribed drugs in 70%. Eleven percent of the illnesses were treated with both (40).

Self-medication may be the best studied, but it is not the only form of home treatment. Home treatments may range from physical devices, such as band-aids or canes, to herbal remedies, to electric heating pads, to certain

foods, i.e. chicken soup. Wadsworth et al found that 27% of their respondents used "other medicines and means," which included herbal preparations, ear trumpets, copper bracelets, and self-cauterization (37). In Alpert et al's study, 19% of the total symptoms received treatment with home remedies, which included rest, rubbing, gargling, bandaging, etc (44). In a third study, home remedies (noncommercial) made up 15% of all advice given about symptoms (32). But this area of self-care research has received modest attention; discrepancies in the amount of usage could be accounted for either by differences in study design or by real differences in the cultures studied.

### *How Well is Self-Care Performed?*

Research in the "quality of self-care" is fraught with at least as many problems as is research in the quality of medical care. However, whereas the latter may at times ignore the patient's criteria for the evaluation of care, this would be impossible to do in evaluating self-care. Dunnell & Cartwright note that self-medication may have symbolic functions as well as pharmacological ones; that the experience of asserting control over the situation may have self-fulfilling healing effects. Two-thirds of the medicines taken by the adults were said to have helped. Further, the nonprescribed drugs were felt to be at least as efficacious as the prescribed ones. Only 4% said the medicines did not help them at all, and less than one in 15 reported side effects (39). Another attempt to evaluate self-care was that of Elliott-Binns, a British physician who asked patients coming to his practice to describe and evaluate the lay advice that had been given to them about their ailment. Ninety-five percent of this advice was judged by the author to be either helpful or harmless (32).

### *Who Uses Self-Care?*

Are there some people or groups in society more likely to undertake self-care behaviors than others?

The variable of age is strongly related to health status. The older the people, the more likely they are to have a chronic illness, and hence more complaints. Wadsworth et al found that for each type of complaint the proportions of people consulting the doctor rose with patient age, implying that younger people with the same complaint were more likely to treat themselves (37). Dunnell & Cartwright found that the proportion of people taking medicine rose with age. However, when the source of the medicine is accounted for, the proportion of people using nonprescribed medicines remains constant with age; the increase is composed solely of increases in the use of prescription drugs (39). It appears that self-medication behaviors do not change drastically as adults become older. Elliott-Binns found that

the soundness of advice given did not vary among advice givers aged 21–60, but that advice given by people younger and older than that tended not to be as good (32). The US survey of health beliefs and practices found no difference in age between those who practice self-diagnosis and self-medication and those who do not (38).

The available data on sex are contradictory. According to Wadsworth et al, significantly more women than men had consulted a doctor for a diagnosis of mental, digestive, and rheumatic disorders, suggesting that men were less likely to have the problem, or more likely to diagnose these complaints themselves. But women had more total complaints than men, which could explain this difference. At the same time, women took more medicines than men, not only because they had more complaints, but also because they were more likely to take medicine for any given complaint (37). In the Dunnell & Cartwright study as well, women reported more complaints than men and took more medicine at all age groups. They took more of both prescribed and nonprescribed medicines than men did. The authors suggest that this may be because women do the family shopping, including buying medicines, and they also spend more time at home where the drugs are kept (39). Elliott-Binns found that women were more likely to offer practical advice on health matters than men, who most often suggested going to the doctor. However, the quality of women's advice varied: wives were thought to give the best advice, mothers-in-law the worst (32). Knapp & Knapp also found that wives were most likely to purchase drugs: only 20% of the husbands in their sample considered themselves the primary drug purchaser (40). Finally, the national US survey found that more women than men took vitamins, but that "questionable" self-medication was more likely to be done by men (38).

It is difficult to draw any safe conclusions from these findings. Although it looks as though women, by and large, are more likely to practice self-medication and to advise others to do so, women may also be more willing to see a physician for their complaints. And both of these differences may ultimately be due to women's higher complaint levels. However, these higher rates may be an artifact of the research design. In all of the studies that used health diaries, health events were recorded by the wife or mother for every member of the family, the likely effect of which would be an over-reporting of these women's complaints. Elliott-Binns suggests that although times may be changing, medical care in the family has always been "the prerogative of women" and, for the time being at least, it apparently still is (45). Although one goal of the women's movement has been to equalize role responsibilities within the family, the women's movement also has focused considerable interest in issues relating to women's health, with a strong self-help, self-care orientation. These two potentially conflicting



trends might cancel out each other's effect, with women continuing to play a more important role in self-care than men.

Marital status and family size and structure are also important variables in describing self-care activity, though once again, the available research does not allow us to draw any strong conclusions (46). Wadsworth et al found that for certain disorders, divorcees and widows were more likely to consult a physician than were married women (37). In Elliott-Binns' study, married patients were significantly more likely to use self-treatment than single people (32). And in Dunnell & Cartwright's study, the number of medicines found in the home rose with increasing family size, although the number of items per person fell steadily. They interpret their findings to mean that as the number of people in a family increases, so does the sharing of medicines. In fact they found that 20% of nonprescribed drugs and 6% of prescribed drugs had been used by a family member other than the one for whom they had originally been obtained (39). One might take these data to indicate that self-care activities will increase with family size, not only in frequency, but also proportionately, and that those who live alone will be more likely to consult a physician than to treat themselves. Clearly, coping styles and their effectiveness may vary by culture, family demographics, family decision-making, the nature of the illness (and its perceived implications), the persona of the ill member, the family's previous illness experience, family access to technical knowledge, and the availability of extended kin and friendship support resources (13-14, 47-52). This is another area for future research, and it is somewhat surprising that these correlations have not already been more fully explored.

Finally, the variable of social class should be mentioned. After sex and age, social class has been the most frequently measured variable with regard to self-care behaviors, and the results, both in Britain and America, have been remarkably consistent. Wadsworth et al and Dunnell & Cartwright both found social class to be of little value in explaining their findings with regard to physician consultation rates. Wadsworth et al conclude, "Sound explanations of this difference are not to be found in simple and readily available descriptive variables concerning social position, but are most likely to lie in the more complex areas of social interaction and role." They argue that marital and employment status are much better predictors of physician consultation (37). The National Analysts survey found self-diagnosis and self-medication not to be related to any demographic variables, a finding they report with evident dismay: "It appears that those who engage in self-diagnosis, as examined in this study, are not very different from people in general." One might even say, they *are* people in general (38).

*Public Interest in Self-Care*

We can only speculate with regard to factors and forces that may be related to growing public interest in self-care. Given the cultural and social specificity of the factors proposed, the discussion is limited to those factors relevant to North America and, in some respects, to Western Europe.

**EPIDEMIOLOGICAL FACTORS** The shift in disease patterns from acute to chronic disease makes self-care both a logistical necessity and an appropriate strategy (1).

**PERSONAL RESPONSIBILITY FOR HEALTH** Research on the association of life-style factors with both morbidity (53) and mortality (54) has focused public interest on personal initiatives to prevent disease and promote health.

**NEW HEALTH WORKERS AND CONSUMERS** The bureaucratization of medicine has opened prospects for a variety of medical tasks to be performed by persons with less professional training and suggests the feasibility and legitimacy of extending the lay medical role. Consciousness of the limits and hazards of professional care (4, 55–61) also has grown.

**ALTERNATIVE THERAPIES** Non-allopathic systems of health care have become readily accessible and are attractive from the standpoint of their compatibility with a wide range of cultural values and ideologies (62–64).

**AVAILABILITY OF SELF-CARE INFORMATION AND TECHNOLOGY** There is a substantial and growing self-care literature, both allopathic and non-allopathic (62). Also available are texts on medical consumerism, particularly focusing on how to seek and use health professional resources in a productive and self-protective way (16–17, 65, 66). Pursuing self-care interests has been enhanced further by medical technology designed for lay use, including health monitoring for bladder infection, strep throat, pregnancy, bowel cancer, and high blood pressure (67). Home computers, terminals, and cable television programming presage a new complex of resources for lay self-care development.

**IMPACT OF BROAD SOCIAL MOVEMENTS** The consumer participation, civil rights, and women's health movements have contributed to the democratization of employment, housing, education, and health care. The latter presents a difficult challenge because of its tradition of elite professional control (68). The women's health movement, in challenging the medical

autocracy by seeking women's control over their own bodies, left a legacy of individual and collective programs designed to promote self-care among all groups of people, particularly those at high risk for illness or at high risk for the negative effects of professional care.

With regard to economic factors, studies in Western Europe and North America report comparable levels of self-care practice among countries with diverse health care systems and payment mechanisms. Financial factors are apparently not as important in motivating self-care as are a person's belief in the efficacy of self-treatment, convenience, and desire to self-manage. However, the cumulative economic impact of increased levels of self-care is of interest to economists (69) and health service planners (70). There is a link between lay self-care competence and the viability of primary professional care (71). Even modest shifts in the overall level of self-care can have powerful health economic effects (72).

## ORGANIZED APPROACHES TO SELF-CARE DEVELOPMENT

Formalizing self-care education, as distinct from other forms of health education, began with the "activated patient program" organized by Sehner in 1970 (9). This program has since become a prototype for myriad self-care education programs throughout the United States. The Course for Activated Patients (as it is now called) is designed for adults, but is not specific to cultural or demographic factors. Subjects covered by the course include (among others) lifestyle behavior, self-monitoring (e.g. blood pressure), use/abuse of medications, management of common illnesses and minor injuries, patient rights, the physician-patient relationship, and nutrition. Content is allopathically oriented. Instruction involves lectures, discussions, demonstrations, and role playing. More elaborate packaged programs are now available that offer wider content options, more variety in educational methods and evaluation techniques. The major advantages of such packaged programs are that they are easily accessible (although some have a one-time high purchase price); start-up time for user groups is short, requiring little or no preparation of materials or decisions about methods; efficient scheduling of program cycles is possible; and they have the ability to accommodate large numbers of learner clients at once. Also, uniform methods of evaluation allow for continuous program monitoring and comparisons among similar programs elsewhere.

There are, however, several limitations to packaged programs (73). Perhaps the most serious criticism is that these programs do not necessarily reflect, in either content or methods, the preferences, values, or learning styles of clients. The result may be more than inefficient or even inappropri-

ate learning; professional control of educational content is essentially discordant with a definition of health empowerment that includes problem-posing skills as a central goal (74), relating to the clients' life situation (75), and honoring the extent and substantial health competence of lay people (76). Self-care education programs also have been organized with the needs of particular groups in mind [e.g. rural populations (77), the elderly (78–79), university students, poor and minority populations (L. S. Levin, Yale University study, in progress), and children (80, 81)]. There are, in addition, a vast array of self-care programs for women sponsored by women's health groups (82).

Available literature on organized self-care education is meager. We know little about the extent of such programs, the characteristics of sponsors, participants, content, methods employed, ideology, or effectiveness. No standard nomenclature exists for them; they are not bound together as an association; they have no central clearinghouse or official publication. As of this writing, a national survey of self-care education programs is underway as the first step toward a careful delineation of self-care programs [G. H. DeFriese, University of North Carolina, unpublished study; (83)]. This study could provide frames of reference for inquiries that are both program (efficacy) and policy (equity of access) productive.

There are clear philosophical differences among protagonists of organized self-care education. The kernel of the controversy is the distinction between health education and self-care education (18). Health education has its historical roots in medicine (84) and as a result is bound to a strategy of diagnosing needs, filling gaps in knowledge or skill, seeking compliance, and measuring success against professionally validated outcomes. This approach has carried over to many of the packaged courses as well as self-study books as represented in medical self-help guides and lay oriented, do-it-yourself texts that use clinical algorithms (e.g. 72). There also is an opinion that self-care education, whose goal may be to improve health and reduce costs, should focus precisely on those medical self-care practices that would have the greatest measurable, direct potential to do so (85). Another view of self-care education holds that achieving health is essentially a political struggle and efforts to improve health must address a broad shift in the locus of control from professional to layperson (2, 86). In this view, the central tasks of self-care education are to preserve and nurture a layperson's sense of competence in health, follow already established motivations for learning additional skills, strengthen problem-posing skills, create a mutual learning environment, avoid medicalizing social life, and measure the success of the educational program against client-derived criteria. Furthermore, this perspective on self-care education encourages consideration of structural aspects of health (environment, professionalism, politics, economy) as well as functional aspects (individual care skills).

## SELF-CARE ISSUES AND PROSPECTS

Professional care givers and social scientists have, until quite recently, chosen to ignore and sometimes condemn these unsanctioned health practices as useless and frequently hazardous. One federal study labeled lay health care as “rampant empiricism” (38); and the influential work of Parsons (87) judged the family to be largely incompetent as a health resource and, indeed, a prime source of pathology. But changes in the social environment noted above forced more precise consideration of the nature of lay self-care practices and implications for health status, the professional health care resource, and strategies for increasing the lay role in health. With more precision in framing the issues, however, there is apparently no lessening of polemic. Lay health care has become a subject both of scientific inquiry and political debate, often inextricably linked (88).

Self-care and self-help, as society engages these concepts and practices, cover a wide and diverse range of values, motives, and ideologies. Among practitioners of self-care are those seeking to avoid disease, promote health, apply self-healing, reduce iatrogenic risks, and generally regain control over health. Self-care is not a movement in the classical use of the term: there is no single ideological position adhered to, no charismatic leader, no agreed set of goals. As a result, critiques of self-care often fail to make explicit the definition of the aspect of self-care involved. A central issue appears to be the confusion of health promotion programs with self-care programs. Although clearly these are not wholly discrete terms, the former mainly emphasize changes in lifestyle habits (e.g. eating, exercising, smoking cessation), whereas the latter focus on developing behaviors associated with the effective and self-practiced use of health resources (e.g. self, family, community, professional). The “self-care debate” is, of course, more than a problem of definitional confusion; but such clarification could help move attention to the role of self-care and self-help in improving the quality of care and extending its benefits (89, 90). Below are several questions that seem to dominate the literature about the role of self-care.

### *How Safe is Self-Care and What is Its Legal Status?*

Existing levels of self-care are part of social life and constitute a fabric of beliefs and practices more profoundly cultural than medical. The bulk of lay self-care remains within the realm of coping with common symptoms of distress, self-limiting illnesses and injuries, and managing chronic conditions. Its modalities include home remedies, nonprescribed medications, and psychosocial support. Although the safety or value of specific self-care procedures may be challenged, as in the case of the prophylactic use of Vitamin C, there appears to be common acceptance of self-care contribu-

tions to both health and the viability of the professional care system (91). Concern about the safety of self-care and its legality appears more likely to arise around efforts to expand the venue of self-care practices. To date, the safety issue has been focused mainly on the quality of published self-care materials (92, 93) rather than on self-care education programs. From a legal standpoint, the status of self-care practices has not been fully established (94). Courts appear reluctant, however, to regulate intrafamily or friendly services, despite the broad sweep of statutes governing the practice of the healing arts. The legal status of organized self-care programs is equally vague and would depend on the character of the appropriate state statutes. However, even if such programs fell within the general scope of medical practice acts, self-care instructors could seek exceptions on statutory or constitutional grounds. Clearly a more fruitful solution to such possibilities is to revise relevant state health practice acts to conform to contemporary public expectations for access to self-care skills.

### *How Effective are Self-Care Practices?*

As Martini (95) emphasizes, there is a dearth of evaluative research on the effectiveness of indigenous self-care practices. However, a substantial proportion of changes in morbidity and mortality experience is associated with concurrent changes in lifestyle, such as nutrition and smoking. The effectiveness of self-care for minor illnesses and injuries seems not to have precipitated complications requiring professional interventions; on the contrary, such practices seem both appropriate and effective (33, 91). It appears that the question of the quality of self-care activities is actually less directed to the activity *per se*, but rather: (a) can laypeople effectively perform tasks heretofore professionally administered? and (b) how effective are various education methodologies in teaching new self-care skills? With regard to lay capability to learn and effectively perform heretofore professional tasks, the number of published studies are few but are positive in their findings (96–98). Systematic studies of the effectiveness of self-care education are being sought (83), but there are few examples (11, 99–101).

### *Where Should the Lines be Drawn Between Self-Care and Professional Care?*

As the breadth of lay health initiatives becomes more apparent and undergoes purposeful development, questions arise with regard to the interface of self-care and professional health resources. An earlier period saw the rise of consumerism affect the health care system from the standpoint of governance (102). The present self-care movement is focused on the care-giving process itself and thereby opens issues of professional-lay jurisdiction and fundamental changes in clinical services (what, how, and who offers them).

Two studies and commentaries support the conventional wisdom that lay people (103) tend to view self-care more favorably than do physicians (104). Placed within the context of the health care system, differences in expectations vis-à-vis self-care between patient and professional will force consideration of accommodation in the interest of both lay people and service providers. There is a common ground of interest, for example, in “humanizing” professional services (105), reducing iatrogenic effects, sensitizing institutional environments (106, 107), improving productivity of services, and contributing to the quality of health care generally. At the same time, institutional accommodation to public interest in nonprofessional care strategies and environments will respond to economic incentives, to capture new markets for service [offering risk reduction and wellness programs (108)] or to hold on to old markets (“birthing” rooms which simulate homeyness). Some aspects of professional adjustment to lay self-care interests may touch the nerve of authority and thus not be readily approved. Patients’ access to their medical records is an example in which the benefits are apparent but professional resistance remains strong (109–111). There is, however, some evidence that self-care interests of even institutionalized patients can overcome substantial resistance (112). Unanswered is the question of how and with what consequences self-care and self-help interests of patients will be affected by professional values either in the direction of expansion of the self-care ethic or in its control (113, 114).

### *Is Professional Interest in Self-Care in the Public Interest?*

Some observers see the recent interest of academics and health professionals in self-care as evidence of the health establishment’s flexibility in response to a perceived threat to its control. The argument is put forward that such professional intervention, using Zola’s term, medicalizes life functions and thereby expropriates a large share of social life as falling within the expert domain of medicine (115). This is in sharp contrast to self-care practices, which derive from the collective experience of people and are shared without domination of the expert. It is difficult to judge the overall validity of this critique, particularly if one takes into account over 1500 non-allopathic texts and the growing diversity of perspectives among allopathic writers (116).

### *Is the Advocacy of Self-Care a Mask for the Retrenchment of the Government’s Role in Providing Medical Care?*

There have been concerns expressed that for certain populations, self-care education may be inappropriate or counterproductive. For poor populations, could efforts to raise self-care skills be viewed as a strategy to compen-

sate for deficiencies in available professional care (117)? Should we not adhere to a policy of first ensuring equity of access to professional care before promoting self-care? With regard to self-care and women, the policy of promoting self-care skills is problematic, even paradoxical (118). It is women who maintain kinship ties, care for the family's sick, and provide myriad psychological support services. Would focusing on increasing or even improving women's care giving skills further reinforce an inequitous burden? Both of these issues are crowded with assumptions and interpretations of self-care, some expressed, many latent. They are further evidence of the political volatility of self-care and the need for clear frames of reference (119).

*Is Self-Care an Attempt to Individualize What Are Really Social, Political, and Economic Issues?*

Some observers of the self-care phenomenon argue that its promotion by lay people or professionals could divert public attention and energy from efforts to control structural factors that negatively affect health (89). This hypothesis assumes that participants in lay self-care development, presumably including members of mutual aid groups and lay voluntary programs, are different from people with political interests in health and health care. There is presently insufficient data to characterize the political values and awareness of participants in organized self-care activities; indeed, the history of mutual aid groups would suggest a contrary hypothesis (90, 120). Data on the nascent self-care education programs are too meager to judge the ultimate direction of their influence on participant awareness and political action. There is no basis now to conclude that interest in seeking more personal control over health and health care precludes, much less immunizes against, sensitivity regarding social factors in health and disease or involvement in collective political action (121).

## CONCLUSION

Lay self-care appears to be the dominant form of health care in Western Europe and North America, despite variations in cultures and the availability and accessibility of professional resources. The contribution of lay self-care is profound, but until recently this pervasive, commonplace resource has been, relative to professional resources, of marginal interest to researchers and health planners. With changing disease patterns and increased access to information and appropriate technology, there has been a concomitant rise in public expectations for more control over individuals' health destinies. This may be merely an artifact of a larger public interest in maintaining or reestablishing personal integrity in an impersonal world.



Mediating institutions such as neighborhoods and churches (122) appear to have taken on new vitality as people seek opportunities for direct involvement in problem posing and problem solving. Self-reliance is not necessarily synonymous with the rugged individualism of the past, precipitated by a lack of options; it seems more a choice among choices, satisfying needs that are at least partially in excess of those met through expert channels of service. In health, those benefits include reducing risk and promoting health through changes in lifestyle and changes in the environment; minimizing dependency on professional care, avoiding the iatrogenic sequelae of professional care; and, generally, establishing a social construction of health.

Individual and family self-care is one element in a complex of nonprofessional health resources. Mutual aid groups (123–125), lay voluntary organizations, and the church (15), and, indeed, friendships (126) make their contribution to health and health care. Recognition of these resources raises difficult ethical and strategic political issues, particularly as they may be subject to medicalization and the hegemony of the health professions. The “discovery” of the lay resource in health by planners and politicians may be a mixed blessing for the public interest, and there seems to be a reasonable basis for such a concern as we look at some of the expert-originated self-care education materials and programs. But in the larger arena of indigenous self-care practices, evidence of professional or single ideological dominance is scant and, given the pluralism of values and practices, seems remote. Here, the least we can do may be the most we can do (127). A minimalist strategy would remove barriers of public access to information, materials (128, 129), and health technology that now stand in the way of the public demand for more effective lay participation, both personal and political, in health and health care.

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