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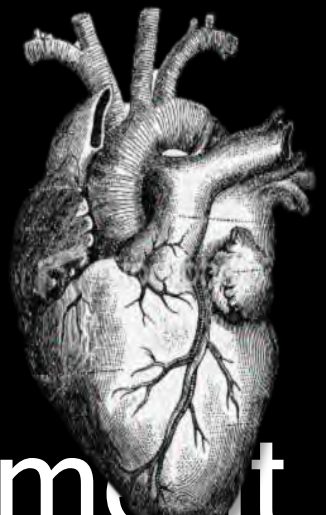

Lifestyle self-management experiences of South Asians after a heart attack

Dilla Davis
On 05/04/2017
@ University of Oxford

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Prelude

In this presentation, firstly I intend to trace the *geography of the subject*. I will then outline the approach used to meet the objectives of the research. Thereupon, by presenting you with the findings, I home in the need for ethno-sensitivity instead of ethno-centricity in the delivery of services. I conclude with a call to navigate the sensitivities that aligns the service provision with

The Global Killer

Diseases of the Heart & Blood vessel

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- Coronary heart disease most common cause of death (and premature death) in the UK.
  - Every 7 minutes someone dies of a heart attack
  - 1 in 5 men and 1 in 7 women die .
  - There are around 94,000 deaths in the UK each year.
  - High in North of England.

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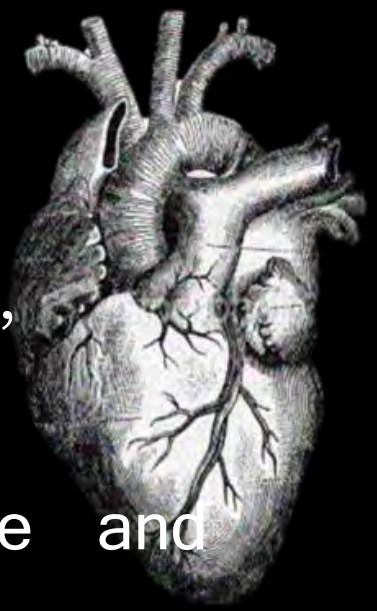

Accounting for most of the world's heart disease, South Asians:

- carry the burden of increased incidence and prevalence (Fischbacher et al 2007).
- present with a more progressive course - 5 to 10 years earlier – (Joshi et al 2007).
- present late to hospitals with more significant multi-vessel coronary artery disease - (Gupta et al 2006).

The Global Burden

South Asians

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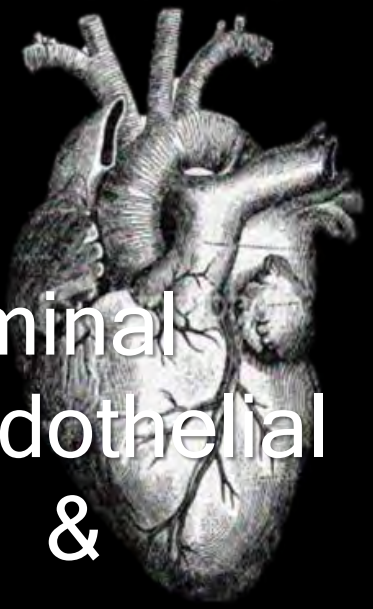

Multiple hidden risks -more abdominal visceral fat, insulin resistance, endothelial dysfunction and enhanced plaque & systemic inflammation as well as a cluster of typical risk factors such as smoking, lack of physical activity, and a 'proatherogenic diet', may explain some of the amplified risk and more severe and premature disease (Rambihar et al 2010)

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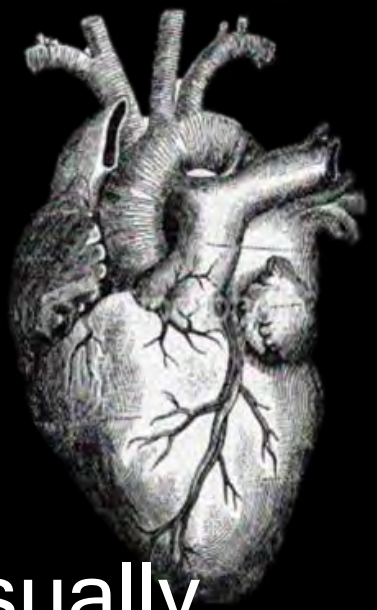

Patients with previously identified coronary heart disease have at least one and usually two or more lifestyle related risk factors such as smoking, poor diet or a sedentary lifestyle.

These risk factors are likely to have contributed to their heart disease and,

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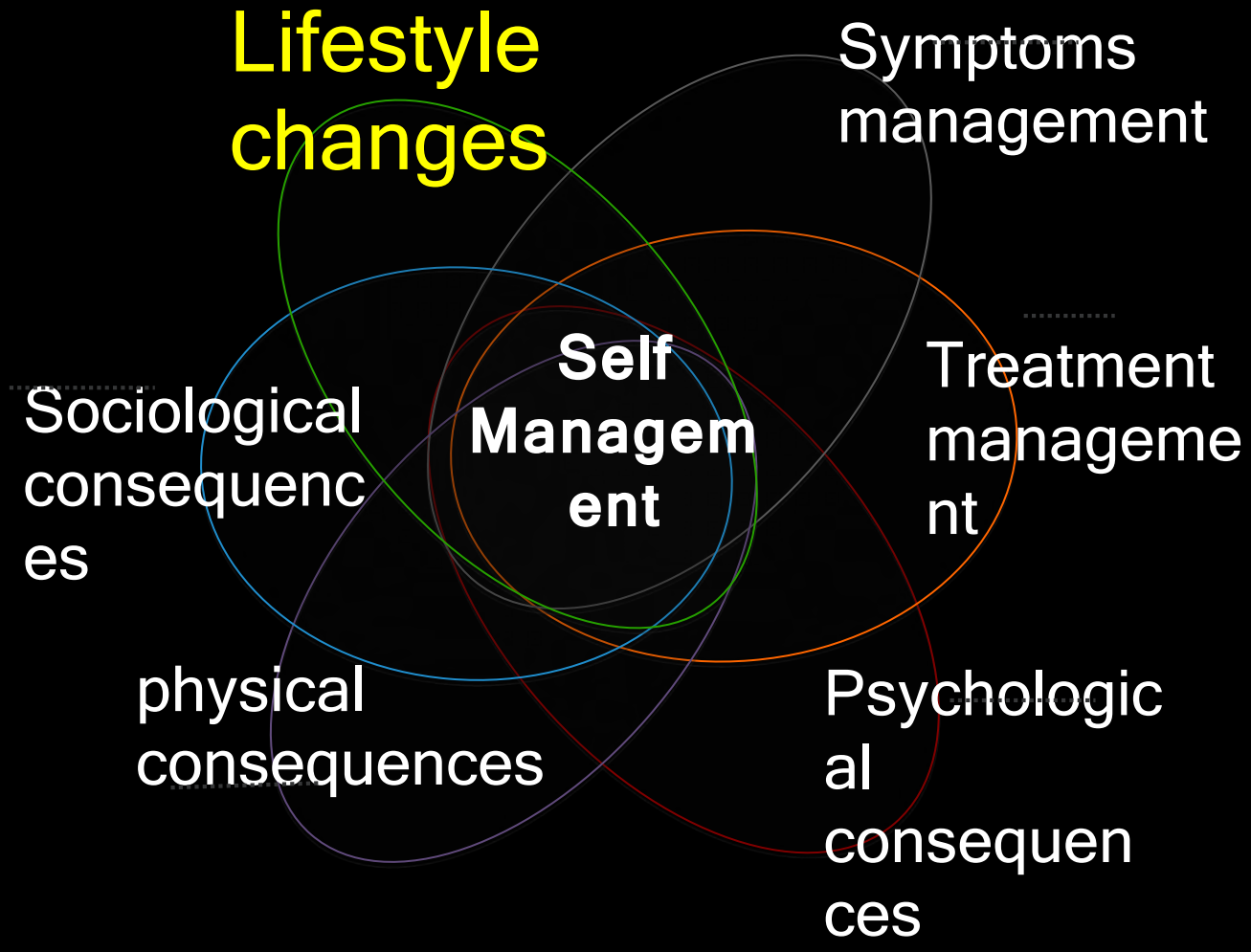
Self-management



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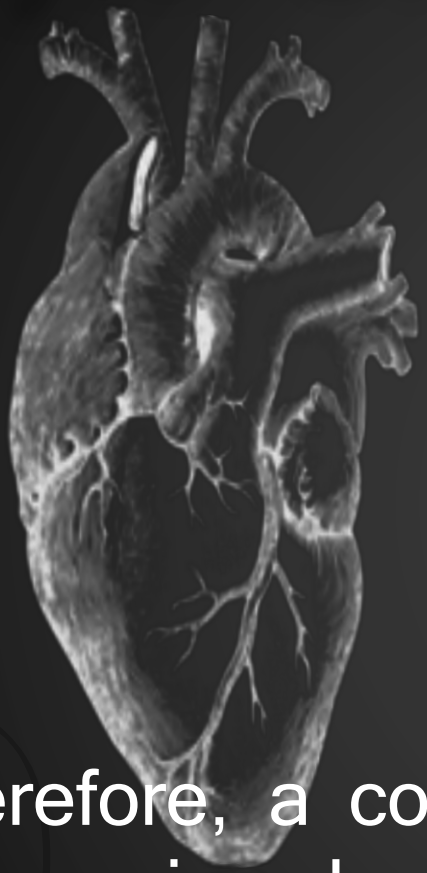
The cornerstone of self-management, lifestyle modification, has potential to improve health outcomes (Challis et al 2010). Reviews have shown lifestyle modification including physical activity, healthy diet and smoking cessation, alters the course of heart disease and reduces recurrences crystallising its significance as a cost-effective public health strategy (De Gucht et al 2013).

ifestyle Changes



Therefore, a comprehensive healthy lifestyle change is advocated as first-line therapy along with cardio-protective pharmacotherapy for the long-term management of patients.

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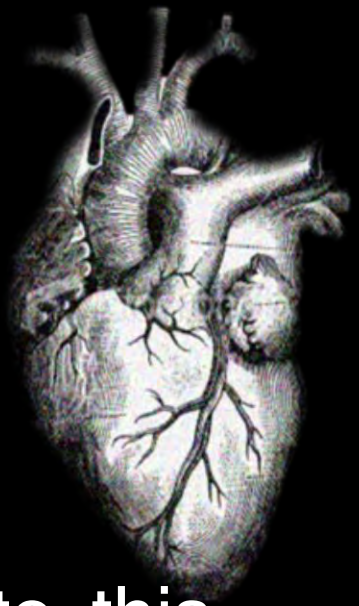

Nevertheless, the polarising corollary to this persuasive evidence surrounding the benefits of lifestyle changes is the bleak picture in the clinical practice where the evidence based recommendations are not fully translated into improved clinical outcomes (Piepoli et al 2015). Contemporary data from large European studies such as EuroAspire provide the evidence for lack of lifestyle modification that exposes these

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Lifestyle changes, central to the control and management of disease, are not easy to achieve as they are often embedded in ethno-cultural practices.

Irrefutably, the receptivity and the capacity to make and maintain lifestyle choices are predisposed by the patient's beliefs and culture.

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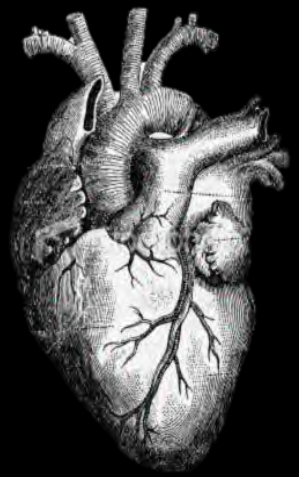

The major limitations of secondary prevention programs significantly limit its impact and raise questions about its appropriateness, particularly for niche groups such as South Asians (National Institute for Health and Care Excellence 2013; Olson 2014). Therefore, despite the persuasive evidence surrounding the clinical outcomes of managing lifestyle modifications, there is a struggle to take up and self-manage therapeutic lifestyles.

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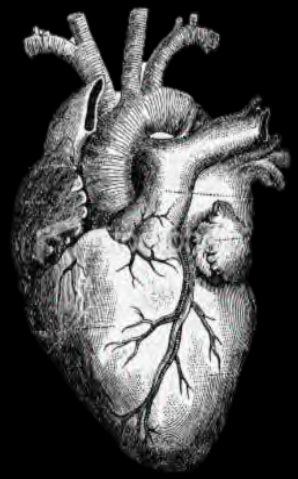

Overarching aim: To explore South Asian groups' experience of choosing and prioritising lifestyle changes post myocardial infarction so as to develop an understanding of the contextual factors that influence their choice.

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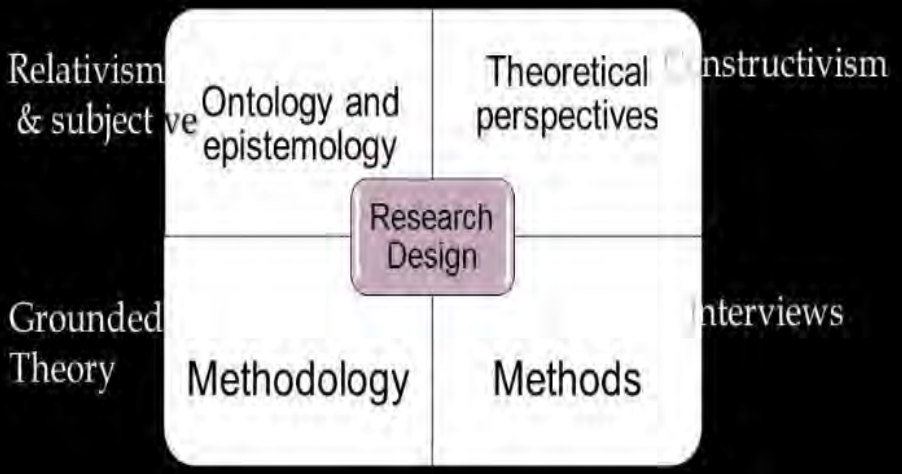
The "M" Word



*In my endeavour to explore the experiences of the South Asians after a heart attack, I was partly influenced by my nurse training in the 90's. "**He shall live because of me**" was the motto of the institution where I trained. In my choice of what is important to study, the methods, and the analysis, I draw upon almost 20 years of experience working as a nurse in a multicultural mainstream health service.*

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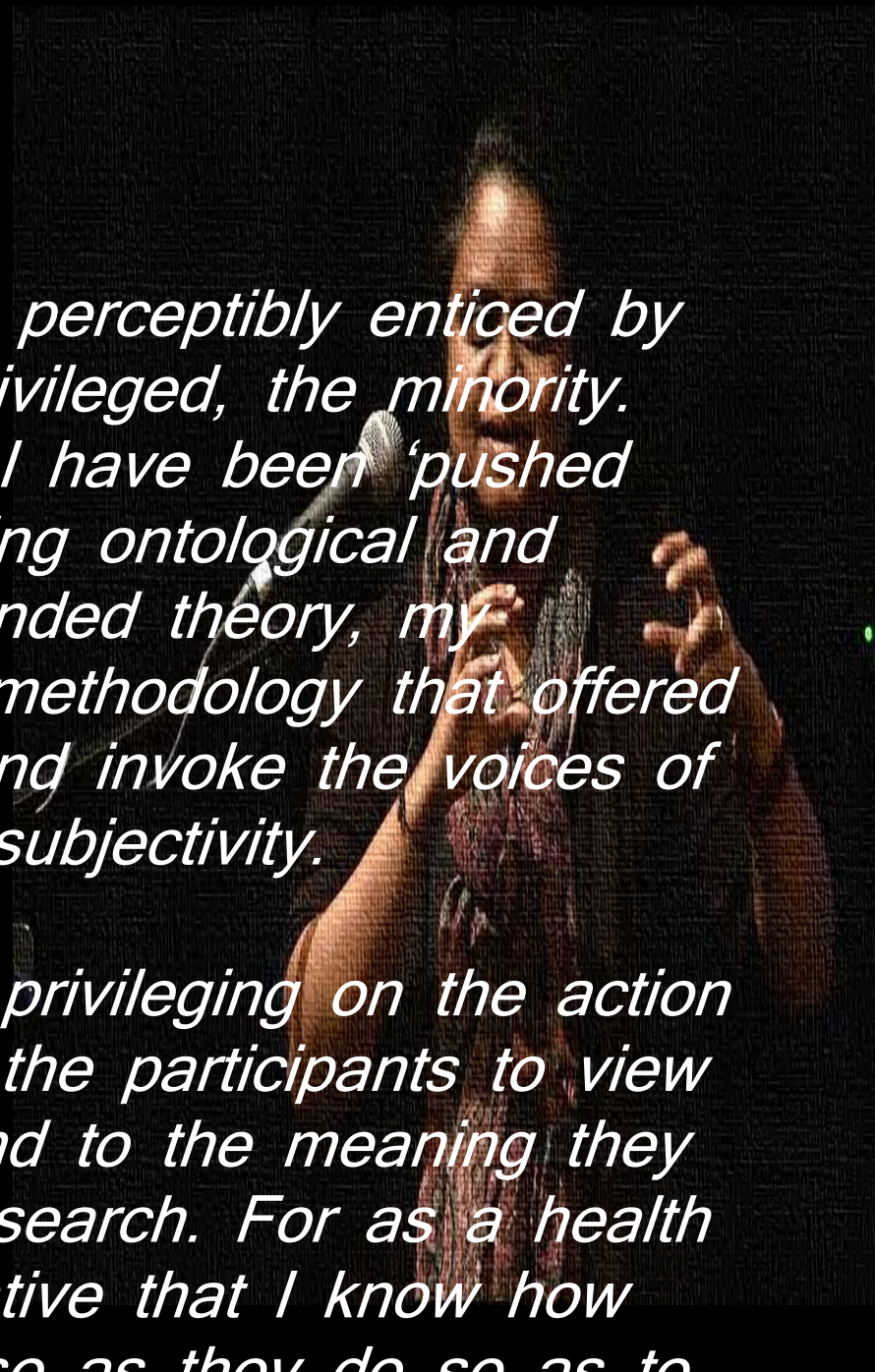

Perhaps I have always been perceptibly enticed by the narrations of the underprivileged, the minority. Perhaps this is why, though I have been 'pushed and pulled' around the differing ontological and epistemological turns of grounded theory, my research finally rested on a methodology that offered inroads to hear the stories and invoke the voices of participants, thus embracing subjectivity.

This attractive proposition of privileging on the action of entering into the world of the participants to view their circumstances and attend to the meaning they create, was crucial to this research. For as a health care professional it is imperative that I know how

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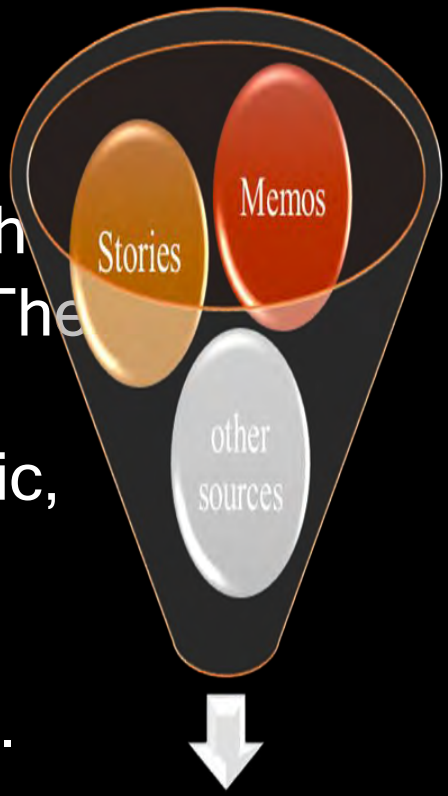
And so Charmaz's grounded theory approach resonated with my philosophy and outlook. The ontology and epistemology assumed for this approach accepts that knowledge is not static, nor is it waiting to be discovered, but is always emerging and transforming, co-constructed by both observer and participant.



From this perspective, it paves the way for the researcher to adduce deeper understanding. Thus using a constructivist grounded theory approach, this study aimed to explore how South Asians choose, prioritise and navigate these lifestyle changes

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The participants here were South Asian adults who had heart attack for the first time. Two phase interviews at 3 weeks and 16 weeks of discharge, were conducted with 14 participants who were newly diagnosed with heart attack- from 2015 till July 2016. 14 in-depth interviews were

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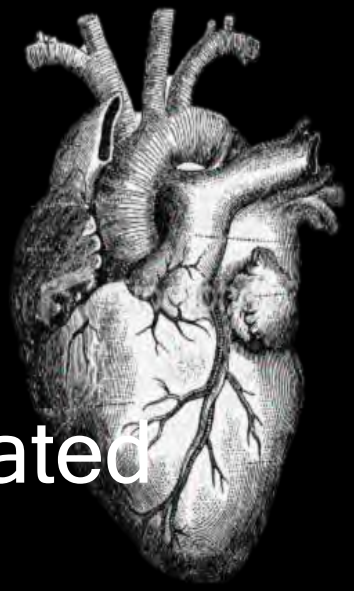
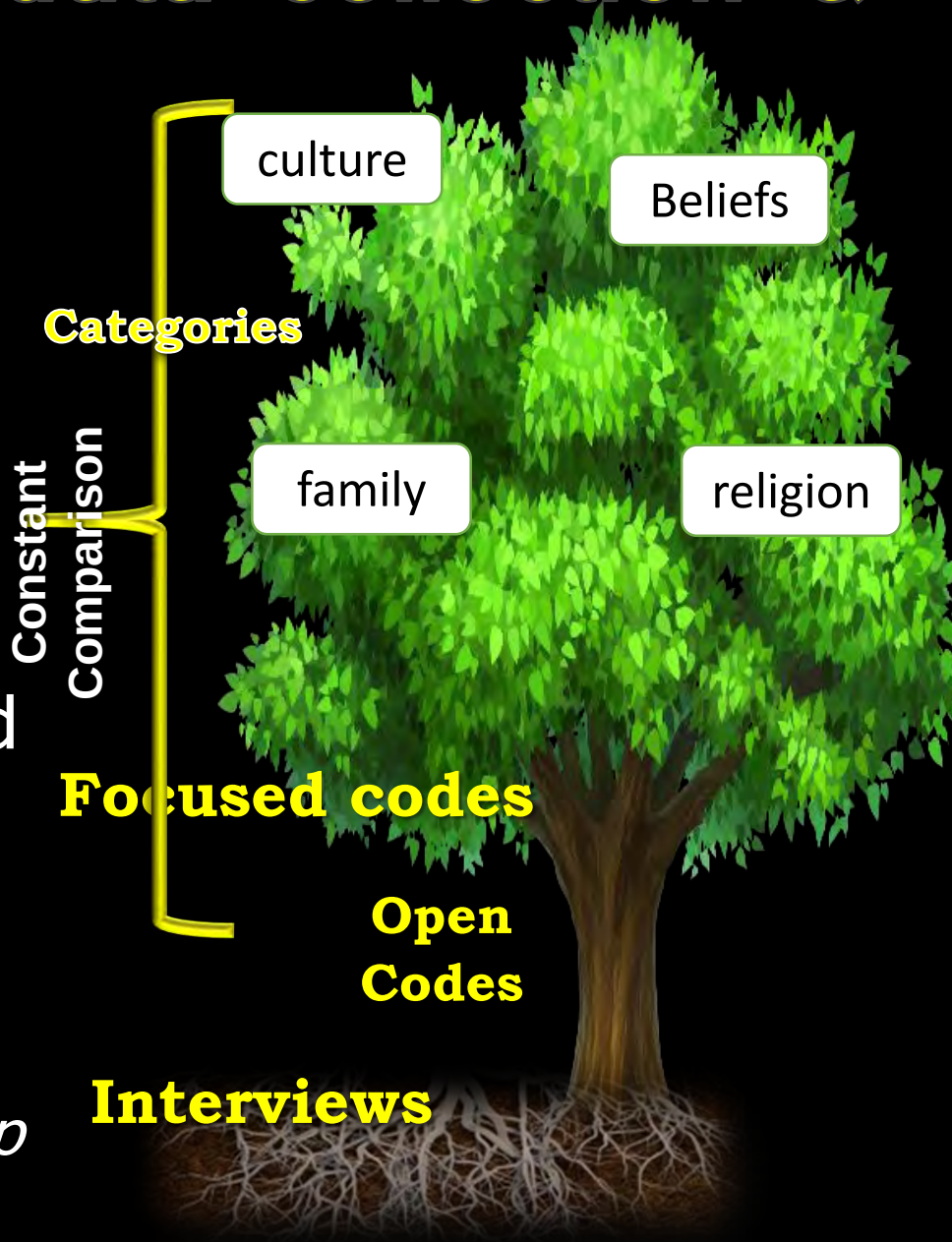


So interview transcripts were collated and with aid of field notes and memos analysed, constantly comparing it to the data. Categories were formed by open coding and focused coding. Data collection and analysis was performed simultaneously to inform each other.

Simultaneous data collection & analysis

Through the iterative constant comparative method and theoretical sampling, codes identified as coherent patterns were extracted and raised to 3 theoretical categories.

patronage of the family, affinity towards one's group and conforming to the religious and health beliefs



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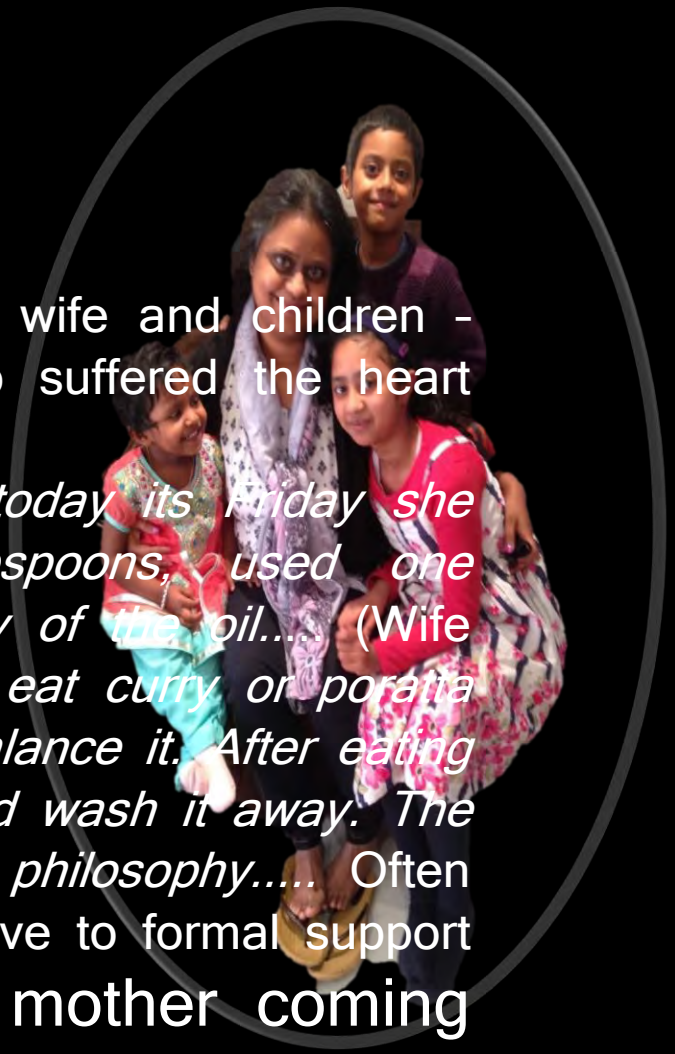
#1 Patronage of the family

Influential Support



In interview no.2 the whole family - mother, wife and children - was involved in supporting their father who suffered the heart attack

- wife making favorite food,.....*for example today its Friday she made poratta... and instead of 3 tablespoons, I used one teaspoon. Cannot see the shine and healthy of the oil.....* (Wife made his favorite dish). *.....I think you can eat curry or poratta once in a while... the important thing is to balance it. After eating you need to go to gym or other exercise and wash it away. The thing is to keep it in balance. That is my philosophy.....* Often family support were exhausted when they move to formal support systems. children staying at home, mother coming all the way from Leeds to check on her son....

2 conforming to the beliefs

- Religious - Fate

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“താൻ പാതി ദൈവം പാതി”

“എന്റെ വിധി എന്റെ തീരുമാനങ്ങൾ ആണ്”

South Asians concept of fate could be better understood as a comfortable confluence of inner and external forces which directs individual outcome.

#2 conforming to the beliefs

- Casual Beliefs - heart attack?

"..the consultant said it may be my lifestyle, but I know its the surgery I had for haemorrhoids last year....."

3 Affinity towards one group

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Hospitality

- *serving unhealthy food*
- *Accepting unhealthy food*

In the first participant home, whilst the interview was going on, there was a flow of neighbours, with food. '*It would have been very rude to refuse them and even though I know I should not eat these kind of food, its not healthy it* was accepted as not to '*hurt their feelings'*. Participants felt culturally constrained to refuse unhealthy food for any change in established practices would be interpreted as disrespectful by their guests. The provision of food and drink is recognition by the host that the guest's presence is welcomed. There was the need to conform to established traditions outweighed the importance of lifestyle management.

Exploration of why and how they chose the lifestyle changes offers an understanding of the particular contextual influences operating within the South Asian communities. On diagnosis of heart attack, they are advised to change their lifestyle either to stop smoking, start exercising or to consider a heart healthy diet. When they are given this choice they then prioritise the lifestyle changes based on:

- which made minimal disruption in the established family patterns
- Which did not conflict with their cultural norms. And were there were clash/conflict of priorities personal norms gave way to cultural norms.
- Which did not conflict with their religious duties and

Subtle thread

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"Be in Harmony"

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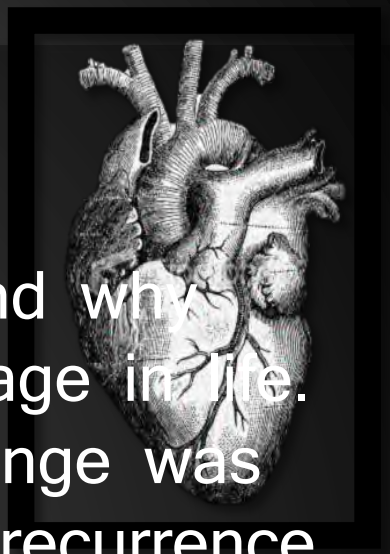

Such patterns of behaviour helps to understand why lifestyle change did not always take centre stage in life. From the participant's perspective lifestyle change was important as an approach to prevent disease recurrence but was nested within a much larger and more encompassing milieu.

Shared efficacy – shared norms and practices, especially family and friends, were central in navigating their lifestyle changes. Whilst 'self-efficacy' were in conflict with the group norms, family centric activities were prioritised. ***In some Asian cultures, to fulfil your independent self is not the primary goal of an individual: The goal is to be interdependent and***

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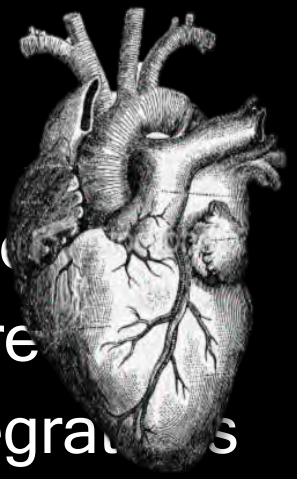

The historical space within which this knowled g[illegible] co-constructed is singularly poignant with welf[illegible]re weariness, fiscal restraints, devolutions and in egra[illegible]s of health care reminiscent of the statistics of a bygone era.

Overhanging everything else is the anxiety and uncertainty of Brexit.

In contrast to the challenge of curing infectious disease or treating acute

conditions, the changing landscape of disease presents the challenge of

enabling the nearly1 in 3 people who have a long-term condition - such

FAMILY CENTERED

CULTURALLY EMPOWERED

Religion

culture

Health beliefs

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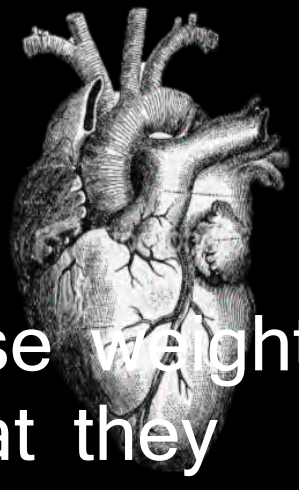

Telling a person that they need to lose weight, why they need to lose weight and that they can achieve it through exercise and eating less fat and more fruit rarely changes their behaviour. For the gains in information and knowledge is insufficient when faced with the medical model of care and the infrastructure that supports it. Collaborative interactions such as shared agenda setting and collaborative goal setting have the greatest impact on changing people's behaviour. However, such collaborative efforts should be based on the

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Person Centered → Family Centered

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Self efficacy → Shared efficacy

Needed.....

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Cultural Intelligence

Influencing

How do we bring the Norwegian lifestyle to the Pakistani household?

1. Family, religion and culture integral for South Asians to overcome lifestyle challenges
2. choice is not an individual act but shared act .

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To note,

After all, the substance of everyday experience refers always to a ‘where and when’ (a ‘here and now’ or a ‘there and then’).
Therefore it would be wise not to judge the story based on the chapter

The appreciation of convictions and distinctions comes only from undertaking the research - in the midst of struggles and sacrifices. For this research is not complete without further questions arising from it.

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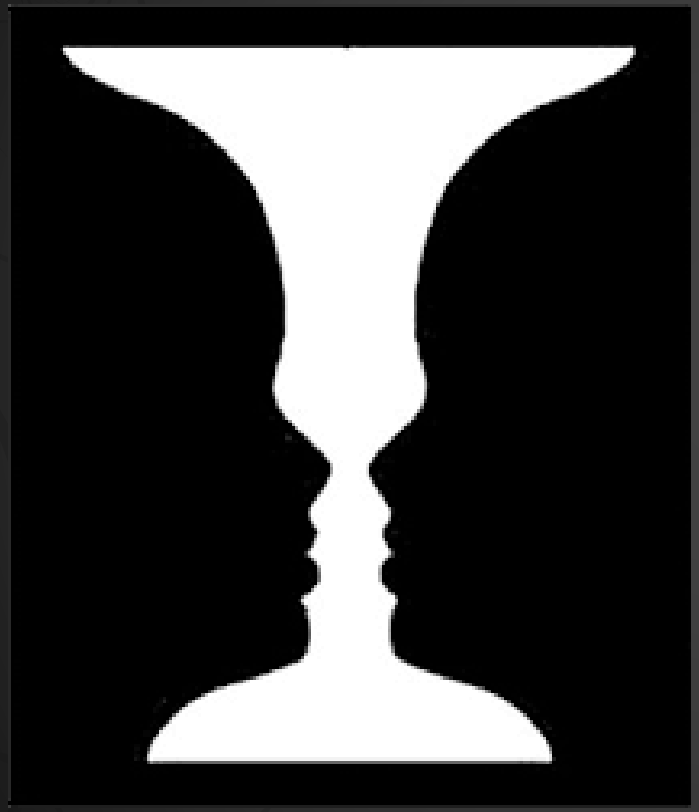
...therefore



as a sign of epistemic humility and honesty, I pay homage to the Aristotelian conception of 'phronesis' - practical, limited wisdom and leave you with just one facet of the reality, a truth as I see it with my participants, tailor made for this context, for this community, a story we tell together... me as the researcher and my participants - South Asians

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- To Martin Johnson, to whom I owe this presentation. If he had not been around, I am absolutely sure I wouldn't here right now. And to other members of the supervisory team – Professor Ian Jones, Professor Felicity Astin and to Michelle Howarth, who will presenting at this conference tomorrow. My debt to them can only be described – to quote from the Oxford Thesaurus - as immense and overwhelming.
- And yes definitely to I would also like to thank Lynette, Linus and Luminette, waiting out there patiently, to take me home.