Clinician's Commentary on Rodrigues et al.¹

As clinicians, we look to research evidence to help guide our practice. But what happens when we begin to recognize that our evidence-based approaches to caring for certain demographic groups are not effective? The study by Rodrigues and colleagues¹ brings to light important factors to consider when educating and implementing behaviour-change interventions with Indo-Canadians living with heart disease.

We know that cardiovascular disease accounts for 29% of all deaths in Canada and is the leading cause of death for both men and women.² With the decline in mortality rates from cardiovascular disease since the 1950s, there are now 1.3 million Canadians living with this chronic disease³ and its physical, psychological, and social effects. Further, 90% of Canadians have at least one modifiable risk factor for heart disease or stroke.³ Recent studies have shown that the prevalence of cardiovascular disease in Canada varies among ethnic groups and is highest among South Asians.^{4–6}

Reasons for these findings continue to be explored in the literature, including the differences between traditional, emerging, and newly discovered risk factors for cardiovascular disease and the analysis of atherosclerotic plaque.⁵ As clinicians, we want to understand physiologically why members of this ethnic group is at higher risk; more importantly for our practice, however, we also strive to understand how best to educate and promote healthy behaviour change through effective interventions that are specific to their needs.

Rodrigues and colleagues¹ help position us effectively to achieve this goal. Two findings of interest in their study are that Indo-Canadians rely on their family and religious/spiritual activities for health support, rather than wanting to control their own health, and that they are less knowledgeable about heart disease than Euro-Canadians.

Our approach to treating chronic diseases, including cardiovascular disease, has shifted over the past decade, since the implementation of the Chronic Care Model in the United States⁷ and the adoption of its concepts within Canada (e.g., Ontario's Chronic Disease Prevention and Management Framework).⁸ Whereas the traditional acute-care approach tends to be reactive, our approach now requires ongoing, planned proactive care that includes helping people living with the disease to interact with their health care team and to learn about and manage their own health.⁸ This self-management approach encourages people to empower themselves and take control of their own health, with the guidance of their health care team.⁹ A recent review found that of the behavioural change techniques and interventions used by clinicians, goal setting and action planning, relapse planning and prevention, and self-monitoring techniques are most effective in increasing physical activity among people living with cardiovascular disease.¹⁰ The evidence is clear that this approach delivers improved clinical outcomes⁷—but is it congruent with the belief systems of Indo-Canadians?

Theoretical models can help to explain and help predict behaviour as well as guiding interventions for health behaviour change, including encouraging our clients to adopt a lifestyle that includes regular physical activity, heart-healthy eating, and management of stress.¹¹ Theories that can be used in research

to test and observe behaviour are the most suitable for guiding clinical practice. One such theory commonly used in the health care literature is the Health Belief Model,¹² which takes into account a person's age, gender, ethnicity, and socio-economic status; beliefs (including feelings, perceived barriers to the behaviour, and perceived susceptibility to a disease), attitudes, and normative beliefs; and environment (in particular, social norms and community access to services)—all of which influence a person's decision to participate in a particular behaviour. In their study, Rodrigues and colleagues¹ very appropriately used this theory to explore Indo-Canadians' beliefs about their experiences with cardiovascular disease. Their findings indicate that the self-management approach to care is in fact incongruent with those beliefs; instead, Indo-Canadians rely on family and on religious faith groups for emotional support and knowledge, and the idea of taking control of their own health is less important to them. While the self-management movement has been shown to produce improved clinical outcomes in other populations, health behaviour change interventions that incorporate these collectivist beliefs about education and support from family and religious groups need to be developed if Indo-Canadians are to realize these same outcomes. For example, information sessions on how to exercise safely that take place within an Indo-Canadian religious facility and are led by trained fellow Indo-Canadians could help to reconcile this group's beliefs with the self-management approach to care.

Theory can help to explain behaviour, and Rodrigues and colleagues¹ were able to demonstrate this in their study by exploring the target group's beliefs about cardiovascular disease and its management via a questionnaire that used concepts from the Health Belief Model. Their study is a good first step toward better understanding this group's needs. Theory can also help to guide behaviour-change interventions, and an important next step would be to use the Health Belief Model to guide and develop behaviour-change interventions for the adoption of heart-healthy behaviours that specifically target Indo-Canadians' health beliefs.

Another important finding of Rodrigues and colleagues' study was that Indo-Canadians were less knowledgeable than Euro-Canadians about risk factors for heart disease.¹ The principles of andragogy—the art and science of helping adults learn¹³—need to be considered when designing interventions for behaviour change: adults prefer to participate actively in their learning, need to know why it is important for them to learn, want to share their experiences, need their learning to be immediately meaningful and useful, and want to learn cooperatively with their instructors.¹³ As Rodrigues and colleagues¹ point out, however, knowing about the benefits of engaging in a healthy activity does not necessarily lead a person to adopt that behaviour. Therefore, the timing of health education is also critically important for clinicians implementing behaviour-change interventions.

Rodrigues and colleagues' findings are important for us as clinicians, and although further research is needed to solidify their conclusions, their study positions us well to begin developing theoretically based interventions specific to our Indo-Canadian clients that harmonize well with their beliefs.

*Kerseri Scane, R.Kin, MSc
Clinical Coordinator, Cardiovascular Prevention &
Rehabilitation Program, Toronto Rehab, University
Health Network, Toronto.*

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