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The Crucial Role of Professional Guidance in Self-management: Insights from Elderly Multimorbidity Patients

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Abstract

Elderly patients experience chronic illnesses with multimorbidity. Multimorbidity is defined as having two or more chronic conditions in an individual at the same time which may occur simultaneously, episodic or during their lifetime. Therefore, elderly patients, like any other patient with multimorbidity need to develop self-management skills to cope with their health and improve their quality of life. However, this comes with its challenges. As such multimorbidity elderly patients require professional expert guidance. This study aims to explore the perceived importance of professional expert guidance in self-management among elderly patients with multimorbidity which will facilitate improvement of health outcomes and quality of life. A qualitative interpretative phenomenological study using an in-depth interview guide with 10 purposively sampled elderly patients with multimorbidity was done. The study was conducted at the University Teaching Hospitals – Adult Hospital in Lusaka, Zambia. Interpretative phenomenological analysis was used to analyse the data that provided 3 themes which included knowledge and expertise, Personal engagement considering learning needs and Control of one's life as important aspects in professional expert guidance. The study concluded that professionals dealing with elderly multimorbidity patients need to have adequate knowledge and expertise through training in areas such as ageing, multimorbidity and self-management to make it easy to give guidance to patients and their carers and also to engage these patients and give them chance to manage their own lives. The study demonstrates novelty being the first study that brings out insights on professional expert guidance on self-management as they relate to elderly multimorbidity patients.

Keywords: *Elderly, Expert, Guidance, Multimorbidity, Patients, Professional, Self-management.*

Introduction

The global population is ageing [1] giving rise to a high burden of multimorbidity and an upward rise to chronic diseases [2] and non-communicable diseases (NCDs) worldwide particularly among the elderly [3,4]. Elderly multimorbidity patients need to implement complete self-management techniques in order to preserve their quality of life because they face, complex healthcare needs. [4]. In this study, multimorbidity signifies being diagnosed with more than one long term condition in an individual at the same time [5] which may occur simultaneously, episodic or during their lifetime. Patients with multimorbidity have decreased quality of life, functional levels are reduced with frequent hospital visits which may result in prolonged hospital stay [6] with a greater likelihood of treatment complications and less favourable prognoses [7].

Self-management is therefore, a fundamental aspect of chronic disease management, advocating for self-reliance and empowerment [8], supporting patients to actively participate and take charge of their

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own care. This entails that patients will not only be expectators of goodwill without input. Elderly multimorbidity patients require knowledge and capacity to take up this fundamental role [9]. The professional care experts come in to bridge this gap by providing adequate information and other related strategies such as acquiring self-management skills that will give them a grip on conducting self-management activities [10] However, elderly multimorbidity patients often encounter challenges in self-management [11] due to ageism and social isolation, cognitive decline and physical limitations. As a result, these patients demand constant attention as well as individualized care. This comprises tactics, measures, and abilities that will enhance the rapport between professional healthcare experts and elderly multimorbidity patients on an interpersonal level [12]. Therefore, a reduction in the number of professional care experts dealing with these patients while maintaining a strong focus on the behaviours and competencies necessary to support the development of suitable self-management skills is inevitable. According to Elin [13], professional care experts should prioritise listening, and thinking through their answers to act, and empower these elderly people to take charge of their own health. All of this could be influenced by the way these patients are treated and attended to because this has the potential to help them adjust and understand what is required of them or worsen their situation in their self-management journey.

Nonetheless, elderly patients feel encouraged when they are involved by health care professionals in different issues of their health. Healthcare professionals could collaborate with patients to individualise self-management support through personal continuity and patient-centred consultations [14]. As such, professional expert guidance has been recognized as a vital component of self-management support. Healthcare providers, such as doctors, nurses, and allied health professionals, play a crucial role in empowering patients to manage their conditions effectively [15]. Despite the importance of professional expert guidance, there is a lack of research focusing specifically on the experiences and perspectives of elderly multimorbidity patients on this matter. This omission shows a clear knowledge gap because there is a dearth of information regarding the perspectives, experiences and challenges of patients in relation to professional expert guidance. Our study fills this vacuum by concentrating on this group of patients to provide more light on their pre-existing knowledge, beliefs, and expectations regarding professional expert guidance in self-management. The current exploration of literature focuses on self-management skills, interventions and the role of patients in this process [4]. Most of these interventions are designed with only the professionals' perspective in mind, without taking into account the perspectives of the elderly patients. Consequently, there is a noticeable deficiency of fundamental patient insights on the subject matter at the conceptual level which is the starting point of the self-management journey.

In order to contribute to a more thorough understanding of the factors that influence the successful implementation of self-management interventions, we hope to gain important insights into the perspectives of elderly multimorbidity patients from their experiences that have been overlooked in the current literature. In doing so, we aim to create and enhance the understanding of the complex interactions between patients and professional care experts in achieving self-management goals.

This study was guided by the Loring and Holman self-management model zeroing in on activities such as managing one's health, one's emotions and one's social role through the acquisition of self-management skills taking

self-efficacy as a driver [16]. At the helm of this core are health professionals to facilitate self-management and satisfaction of these elderly multimorbidity patients' perspectives through provision of expert guidance accordingly.

Nevertheless, the study's conclusions are based on the opinions of the elderly multimorbidity patients themselves, not those of professionals and service providers who work with these patients on a regular basis. Given that this area of research is still relatively new in Zambia, it was not wise to merge all perspectives into a single study because the patients' perspectives seem to be so significant. Therefore, these perspectives can be combined at a later stage.

Materials and Methods

Research Design

This was a qualitative study which employed an interpretive phenomenological design (IPD) to get some insights into professional expert guidance on self-management as it relates to elderly multimorbidity patients. The chosen study design helped to unearth drifts in what was imagined and wished for [17] by the elderly multimorbidity patients to understand what needed to be put in place to improve their lives from their perspective.

Study Setting and Sampling Procedure

This study was conducted at the University Teaching Hospitals – Adult Hospital (UTHs - AH) in Lusaka, Zambia which is the largest referral hospital managing highly specialized cases including cases of multimorbidity. Therefore, elderly patients with multimorbidity are also attended to in the same hospital. This site was purposely chosen to have divergent views from patients all over the country. Therefore, all elderly patients who were seeking treatment at UTHs - AH at the time of study were part of this population though the study targeted all elderly patients aged 60years and above with multimorbidity and were seeking treatment at UTHs - AH at the time of study. The patients who met the inclusion criteria and were accessible were purposefully selected and participated in the study.

The sample size determination was based on reaching data saturation [18]. Therefore, the projected number of participants was twenty-one (21) but saturation was reached at ten (10).

Data Collection Procedure and Tools

The in-depth interview guide with open-ended questions was used to collect data. Face-to-face audio-taped interviews were held. Also, the researcher was taking field notes as observed with the consent of the participants. The interview took place in the location that was preferred by the participant (home or hospital) to ensure comfort, safety and freedom of expression [19]. The researcher limited the interviews between 40 and 60 minutes to eliminate participant fatigue.

At the beginning of the interviews, the Researcher made the situation easy and built rapport by having an open dialogue and exchanging pleasantries with participants for 10 to 15 minutes. All ethical issues were discussed to facilitate freedom of participation. Each participant was interviewed alone using English or Nyanja as preferred.

Data Management

All voice files of the interview that were transcribed were secured in the computer hard drive with a password and were kept in a lockable cabinet together with a hard copy of the transcribed data as well as the signed consent forms to ensure their safety [20]. Validity was observed during the study by using the research design that was appropriate for the study methods that gave answers to the research questions [21]. Credibility was attained and maintained by conducting a pilot study and consulting with the research supervisors on transcribed data and translating

it to themes to make sure that it is accurate [22]. Also peer check for data analysis was employed to facilitate correction of errors and confirmation of the interview data [23]. Dependability was upheld by having a clear outline of the Interpretative Phenomenological Analysis (IPA) interview process by using open-ended questions with probes to get an in-depth understanding of the perspectives of these elderly patients. During the interview, the researcher took note of various non-verbal cues to help in the transcription of interviews as these complemented the detail and richness of the collected data.

However, **t**he data that was obtained from this study will not be generalized to the general populace of elderly patients instead it will serve as an example of a significant sector in elderly patients with multimorbidity. Comprehensive information and thorough descriptions of each step of the research process, including the methods of data collection and analysis could provide some guidelines other researchers in different settings could follow to reproduce a similar structured interpretative phenomenological study.

The data and developing themes were occasionally reviewed to maintain external validation of findings [24]. It was also important to take into consideration that the participants' perspectives are not overtaken by those of the researcher despite the importance of the role of the researcher in the interpretive phenomenological study. As such data was read repeatedly to develop associations with responses, emerging themes and the entire transcript. Therefore, the discovery of interpretations of data was explained in every little detail to enhance confirmability.

Data Analysis

Interpretative phenomenological analysis (IPA) was used to analyse the data. An iterative and inductive six-step procedure of data analysis was used in this IPA process [25]. The six steps were reading and rereading, taking preliminary notes, developing emerging themes, identifying links between emergent themes, moving on to the next instance, and looking for patterns among instances.

Each transcript was coded separately, and assigned to the NVIVO 12 data matrix [26]. Similar codes were grouped into categories to identify key themes. The emerging themes were then taken as the ultimate product expressing the perspectives of the multimorbidity elderly patients on self-management.

Results

A total of ten (10) participants took part in the study. Table 1 shows the detailed demographic characteristics of the group.

Table 1. Summary of Demographic Characteristics of Participants

Name	**Characteristic**									
	Sex	**Age**	**Education level**	**Occupation**	**Income**	**Residence**	**Living with**	**Conditions**	**Diagnose same time**	**Duration**
P1	Male	60	Form 5	Lecturer/business	20,000	Urban	Spouse	Diabetes mellitus and Hypertension	Not sure	10 years
P2	Male	70	Form 2	Pastor	5000	Urban	Spouse	Diabetes mellitus and	Not sure	5 years

								Hypertension		
P3	Male	64	Form 2	Peasant farmer	2000	Rural	Spouse	Arthritis and Hypertension	Not sure	2 years
P4	Female	73	Form 2	Business	5000	Urban	Caretaker	Diabetes mellitus and Arthritis	Yes	3 years
P5	Female	81	Nil	Nil	Nil	Urban	Children	Heart failure, Renal dysfunction, Diabetes mellitus, Arthritis and Hypertension	Not sure	3years
P6	female	62	Form 2	Peasant farmer	3000	Rural	Children	Diabetes mellitus, and Arthritis	Not sure	2 years
P7	Female	72	Form 5	Business	5000	Urban	Spouse	Heart failure, Renal dysfunction, Diabetes mellitus, Arthritis and Hypertension	Not sure	10 years
P8	Female	75	Form 2	Peasant farmer	200	Rural	Relatives	Diabetes mellitus, Renal dysfunction and Hypertension	Not sure	4 years
P9	Male	73	Nil	Nil	Nil	Rural	Grandchild	Heart failure, Renal dysfunction, Diabetes mellitus, Arthritis and Hypertension	Not sure	2 years
P10	Female	65	Form 5	Teacher	5000	Urban	Caretaker	Diabetes mellitus and Hypertension	Yes	4 years

Table 1 shows that a total of ten (10) participants took part in the study. Of the ten (10) participants, six (6) were females and four (4) were males. Their ages ranged between sixty (60) and eighty-one (81). Five (5) of these respondents went only up to form two of their education and in their younger days they were able to secure jobs while two (2) of them did not go further in education and only three (3) of them managed to go up to grade 12 an equivalent of form five in years back.

The majority (8) of these participants were involved in some activities (lecturing, pastoring, peasant farming, business etc.) which helped them to have a bit of income though not enough for some of them to manage themselves while the minority (2) were totally dependent on others for a living.

Almost all (8) participants have lived with their conditions for a period ranging from 2 years to 15 years except for two (2) who have had their conditions for a period less than two years.

Identification of Recurrent Themes

Table 2. Identification of Recurrent Themes

	Knowledge and expertise	**Personal engagement considering learning needs**	**Control of one's life**
Participant	P1	Yes	Yes
	P2	Yes	Yes
	P3	Yes	Yes
	P4	Yes	Yes
	P5	Yes	Yes
	P6	Yes	Yes
	P7	Yes	Yes
	P8	Yes	Yes
	P9	Yes	Yes
	P10	Yes	Yes
Present in 100% of participants	10	Yes	Yes

Professional Expert Guidance

Participants' opinions on Expert professional guidance in self-management were mixed, with some being positive and others being negative. However, they showed that, with certain corrective measures in place, such as professional expert guidance, self-management was still possible for those who still had their strength and were not already incapacitated by illnesses despite their advanced age. Three themes were developed which included Knowledge and expertise, Personal engagement considering learning needs and Control of one's life. Elderly patients require clear instructions from professionals on how to manage themselves amidst multimorbidity.

P1 clearly communicated his perception of self-management that it is possible and can be done provided "*all aspects required for one to be able to do it on his own are put in place. However, this cannot be without guidance from experts*". Professional expert guidance in this case seemed to be the most preferred. P2 indicated that self-management is a continuous process that requires attention, guidance and a clear directive. He described his self-management journey as difficult and sometimes frustrating.

"…. taking care of yourself fully needs serious attention from stakeholders, that is myself and the hospital people who have the knowledge of my conditions. On my own without guidance it is not easy…… this is not a one-off activity… anyway……., We were there, we are now finished, looks like now we trouble people, they are no longer interested in us elderly patients, I now have this in my mind. I think about it, somehow it draws me backwards……not good at all".

His use of "*we were there*" refers to his younger days when professionals were available for him and his peers for guidance and now compared to "now we are finished" indicating that professionals are not available to guide the elderly patients as they used to do in their younger days. This seems to be discouraging him from carrying out self-management activities because of lack of information required for such activities. In other words, P2 saw some kind of discrimination regarding how attention was being given to the elderly patients which lives little for him to desire as seen in his words "*somehow it draws me backwards……not good at all*".

P3 had similar sentiments that meant to say expert guidance was important for self-management achievement.

"*There is a need for professionals who would disassociate themselves from societal discrimination of us elderly and understand us ……. just to be there for us…… and help us to learn these conditions so that we can manage ourselves…. To treat us individually according to our conditions and the extent to which the conditions are despite the extent of ageing. Sometimes I feel helpless because I feel like the information I have is not adequate. After all, no one has ample time to give me adequate guidance*". This makes it difficult to carry out self-management activities in the correct way. I believe this is possible to do, personally, it is not a big deal (P3).

The intonation in P3's sentiments showed the serious need to be a little bit more patient with the elderly and give adequate guidance to them just like it is done for other categories of patients. This was seen in the usage of "no one has ample time to give me adequate guidance". He also expressed some sentiments of "*being helpless*" and tied up which looked like making self-management difficult to implement.

Personal Engagement Considering Learning Needs

Personal engagement is crucial and may help in motivating elderly patients with multiple diseases to adhere to the self-management plan. Personal engagement in this study is the actual involvement of the elderly patients to enable them to take the lead in matters of their health because they are empowered with knowledge of how to do it. Participants in this study reported the importance of personal engagement as supported by quotations below.

"*Self-management can be possible given clear guidance on how to go about managing these conditions……where the experts can take their time to explain what is required and give written instructions on the dos and don'ts……. sometimes it is confusing because I have many conditions with different management lines and no one is completely available to take me through a step by step journey towards self-management. Am not comfortable performing certain activities… yes information was given to me but not much involving to give me that level of confidence. The experts seem to be busy*". (P1).

P1 here was indicating that with many conditions he had he needed to personally be engaged, to be explained to about what it is, what it means, what it takes, when to and how to go about managing himself amidst multiple conditions "*where the experts can take their time to explain what is required and give written instructions on the dos and don'ts*". He

was of feelings that if these questions were explained to him by concerned professionals at a personal level it could have helped him to grasp the concept of self-management and eventually learn to rely on himself for self-care. As the status was he seemed to have liked the concept of self-management but was driven backwards due to the absence of adequate and meaningful engagement in his care process as was comprehended in his discussion, "*Am not comfortable to perform certain activities… yes information was given to me but not much involving to give me that level of confidence*".

"*yes personally I need to see myself being involved in my care, where am taught and taken through in aspects of my care……as for now I always fear making mistakes because the information am given is not tailored toward me as P2 to enable me to take care of myself*".

P2 feels patient engagement was not adequate enough and not personalized to help him carry out self-management activities. This was picked from "*I always fear to make mistakes because the information am given is not tailored toward me*". "*I*" meaning himself as a human being in existence though he shares a similar experience with P4.

"*We trust the health personnel yes, including our helpers these children I have but I just need to be part…. just to understand what is going on, explained to me nicely and showing me at my pace for example the process of giving myself the insulin injection, storage of medication and how to remember the review dates. In this way, I think I can learn better. I think am not comfortable when am just following without really knowing what is going on..... How can I take the lead in my own care like this*?... *Just how*! (P4).

For P4 it was inevitable for one to be part of her own care for this gives one confidence to learn and execute self-management without many problems. This was seen in "*I just need to be part…., taken at my own pace and I think I can learn better*". This expresses her individuality as a human being who has her own learning aspects that need to be taken into consideration. she was however "*uncomfortable*" to do it on her own when she was left behind and actually, the tone of her voice in the last sentence indicated some level of frustration, "*How can I take the lead in my own care like this? .... Just how*!".

On the contrary, P5 feels it is a normal process culturally where other family members speak and do things for you because you are helpless. She sees her helpers including the health workers doing what society requires them to do.

"*When your time has come, if you have people around you, especially your own children should help you to do certain things you cannot do on your own……it is a cultural norm. Those who have the young brains can keep hospital appointments on my behalf, can remember medications and are the ones with money to buy whatever I may need……equally health workers are the custodians of knowledge about my illness……. I think it is okey for them to be at the forefront..... I have nothing to protect and am comfortable*" (P5)

P5 feels self-management is possible but others can also come on board as it is a cultural norm to care for the aged and sick. "if you have people around you, especially your own children should do things for you". Her age is advanced to remember and owner what her conditions demand from her in terms of care as stated in "Them who have the young brain can keep hospital appointments on my behalf, can remember medications and they are the ones with money to buy whatever I may need". she also reported that "she has nothing to protect" which meant that she surrendered her entire being without feelings of intrusion from caretakers.

Control of One's Life

Control of one's life is another important aspect that would make self-management

possible for elderly patients with multimorbidity. This sub-theme explained the need for elderly multimorbidity patients to be able to make decisions concerning their health needs. Having the freedom of choice and respect as individuals. Hence, participants detailed these sentiments;

"*It's a bit difficult to say self-management is possible because I personally am dependent on my children. They make decisions and make their best choices about my life. So where you do not control your activities such as in my situation it is really difficult….. I don't know"* (P6).

Seen here was a situation where R6 felt to have lost control of herself and the activities surrounding her life, "*they make decisions and make their best choices about my life*". Because of this, she was doubting as to whether she could be allowed to manage herself properly without the intrusion of the significant others as expressed in, "*where you do not control your activities such as in my situation it is really difficult…... I don't know*".

P7 also shared similar thoughts. "*I understand quite well that when you become old the significant others take charge in terms of care …. I love it and appreciate it as our culture but they should leave some space to myself… am taken to the hospital and other places that matter in my life and if no one is free then it means I will not go. Am treated like a child…. I can't freely execute my plans anymore*".

P7 showed some kind of acceptance that significant others were equally important in her self-management journey "*I love it and appreciate it as our culture*" but she desired her autonomy "*They should leave some space to myself*". Her acceptance emanated from her cultural belief that the elderly are the responsibility of those who are still energetic, sober and with sound life (the young ones). He however sounded like his illness coupled with old age headed to "*loss of himself*". The power to make decisions and do things at his own time as he wished was gone "*Am treated like a child…. I can't freely execute my plans anymore*".

"*Family members take the upper hand to the extent where health care providers talk to them and engage them to make decisions on your behalf.…… What startles me is not being recognized even when you are present….and the professionals too do not seem to be considerate… I mean am still myself, I need privacy and a chance to decide and have a feeling of self in these matters*" (P8).

In this discussion, P8 showed her high expectations from the health professionals that they could come in between the family and the elderly multimorbidity patients and help the elderly to regain their lost autonomy. However, he was uncomfortable to see that they were engaging in discussions of her and her matters with the significant others without her or her consent as illustrated in "*health care providers talk to them and engage them to make decisions on your behalf.……what startles me is not being recognized even when you are present", 'the professionals too do not seem to be considerate*". It was clear in the conversation that she felt like among them health professionals who were trained to take care of such patients should have taken the lead in providing privacy, and confidentiality and promoting the independence of these elderly people.

"*When the younger ones begin to think your age and probably the illness has left you without adequate capacity to reason know that you are gone, more especially when you as well have no means of funding your care. Otherwise, it is good to have people around who are concerned about your health matters*" (P9).

P9 indicates that being labelled with low reasoning capacity by the younger ones strips off your autonomy. This is seen in the statement "*When the younger ones begin to think your age and probably the illness has left you without adequate capacity to reason know*

that you are gone, more especially when you as well have no means of funding your care". The inability to finance your health care services worsens the situation.

"*I feel sorry for myself ….. I have lost my independence. My daughter has to take me wherever I want to go and when she sees it necessary. … I feel undeservedly restricted….. I can't go where I want to go when I want to go – even the short distances raise issues … I'd say that's one of my biggest frustrations"* (P10).

P10 reported a loss of independence as expressed in "I do feel undeservedly restricted" because the daughter could not allow her to go anywhere without her or someone to accompany her. As a result, she was visibly not happy about it.

Discussion

In this study, professional expert guidance was perceived to be an integral part of self-management, which would make the self-management journey less difficult and lighter to tread. However, participants discussed difficulties in obtaining professional expert guidance, pointing out that healthcare professionals lacked adequate knowledge and expertise on self-management of elderly patients. They also perceived them to have little knowledge about the problems faced by elderly patients and their multimorbidity. These findings were incongruent with previous studies that indicated that it is critical that healthcare providers act as knowledge translators for patients with multimorbidity, facilitating communication between different levels of treatment and helping patients comprehend their symptoms and how they relate to specific diseases [27, 28, 6, 14]. Chala [27] and Kanat [28] attributed this lack of competency to self-management being a new concept in Africa where not many professionals have undergone this kind of training. Muvwimi [29] also adds that healthcare professionals have no adequate training in the management of elderly patients compared to developed countries which contributes to the inability to understand the dynamics of aging. This entails that healthcare professionals may struggle to help patients define and prioritise their values, goals, and preferences in ways that are clinically and personally meaningful, incorporating physical functioning and quality of life, when faced with numerous diagnostic, treatment and care challenges, as such this might contribute to the failure of bringing their care to fruition and integrate the self-management knowledge that they need to transfer to patients for their own benefit. Therefore, there is a need to train some experts who may be interested in issues of elderly patients to help in guiding the services and how these services are provided to benefit these end users. However, it would also be interesting to learn the experiences of these professionals in implementing self-management among elderly patients to help in understanding what implicates training as evidence to the development of tailored training programmes.

This study also found that the personal engagement of elderly multimorbidity patients by professionals especially concerning their learning needs was not adequately covered. These findings agree with those of Kanat et al [28]. Kanat et al. say that elderly multimorbidity patients are not involved in matters that concern their own health. Patients are referred to the primary care level without adequate guidance especially those diagnosed with new conditions. This level of care is believed to have care experts to help make self-management work out for these patients [4] which is not the case. This reduces the patient's ability to engage in self-management activities. According to this study elderly multimorbidity patients desired to have care professionals who would take time to build a professional relationship with them and try to understand their concerns and take into consideration their individual needs by

engaging them. This was in agreement with other studies which submitted that elderly multimorbidity patients prefer to have a shared decision-making process [28, 30, 31, 32] with those who hold the professional expertise to their conditions for the purpose of managing self-care [33], improving independence and ultimately improving their quality of life [34]. This is because self-management decisions may be so intricate because of multimorbidity [35]. Therefore, active engagement of these patients as a vehicle for self-management requires the development of a therapeutic relationship between professional experts and individual multimorbidity elderly patients for the provision of individualized therapeutic information according to conditions one has [36]. Such techniques as narrative counselling and motivational interviewing need to be incorporated into these programmes [37]. Effective patient-provider communication, collaborative decision-making, and a partnership built on trust within a person-centred care team can enhance engagement and help to achieve a level of participation in terms of planning and agreeing with the aspects of self-management that will achieve the desired goals. This will ultimately improve the quality of life for these patients [38, 39]. However, there is a need to find out how these engagement processes are going to be carried out without stressing the elderly patients financially, mentally and physically by developing individual schedules and checklists accordingly.

This study has also revealed that elderly multimorbidity patients seem to have lost control of their lives to ageing and multimorbidity as healthcare professionals and non-professionals in their lives have dominated the management of their health affairs. For example, the information they are given for the management of their conditions may be insufficient as professionals prefer to share details with their significant others without their consent keeping them unaware of their health events. Similar findings were unveiled by Doekhie et al. [40] who showed that professionals depended on informal caregivers of elderly multimorbidity patients in the decision-making process. This is because of the perceived cognitive dysfunction that comes with old age [38]. For this reason, ageism has to be addressed as well because it can lead to healthcare providers thinking that an individual lacks the knowledge or abilities to manage their own health or not expecting them to do so [41, 42]. This may lower the individual's self-worth, self-assurance, and quality of life, which further diminishes their capacity for self-management because of frustration.

However, the elderly multimorbidity patients viewed professional care experts as the source of solace even though they have their inadequacies that seem to make self-management difficult to achieve. These findings support the findings of Schulman-Green et al. [43] who said that if the network connectivity between the elderly multimorbidity patients and healthcare experts is not good, coupled with a lack of support that reinforces positive interpersonal skills, self-management may not easily be attained. This depicts the need to have care experts who have the knowledge and understanding of self-management as it applies to the management of elderly patients as a whole before narrowing it to their special cases because they can translate it into meaningful action points for patient teaching, collaboration and monitoring.

It was very clear that these elderly patients want to be in charge of their lives through involvement in various aspects of the self-management journey, such as being consulted when necessary, being given some space for privacy, getting first-hand information and sometimes responsibility to disclosure of certain information pertaining to their health and care. This was seen to be essential for promoting individuality and respect for a person thereby giving these elderly patients

the motivation to willingly engage in self-management activities. These findings were concordant with Beauchamp & Childress [44] who asserted that elderly patients need to be encouraged to take charge of their own care and give them the tools they need to do so as required by self-management. This will encourage incorporating individual preferences that may be concealed by the medical paternalistic posture that has up till now dominated the healthcare system. Self-management, along with professional assistance, honours the elderly patient's autonomy, volition and preferences. Therefore, initiatives that will support patients in taking charge of their own care and encourage early involvement are required to enable them to understand the requirements of their conditions and self-management.

Conclusion

This study concludes that professional expert guidance is very important for self-management achievement. Staff members dealing with these elderly patients need to know about ageing, multimorbidity and self-management to be able to properly coordinate the health services of these elderly people as they seek to improve their health outcomes and quality of life. Secondly, these elderly people have complex needs because of multiple conditions therefore they need to personally be engaged so that they can be taken through all aspects that require them to have information about self-management achievement which needs serious decision-making and participation. Finally, the elderly multimorbidity patients feel if life has to be lived beyond 60 years with multimorbidity, they need to be allowed to take control of their lives, in aspects such as making decisions surrounding their care, freedom of choice, responsibility to disclosure where necessary to make them feel responsible and part of their own care. However, this is not to say they should be left alone but they just need to maintain or retain respect for a person and keep autonomy too.

Conflict of Interest

The author declares that there are no conflicts of interest related to this research.

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