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REVIEW

Implementation of Therapeutic Patient Education (TPE) in Primary Care, as Perceived by Professionals: A Narrative Review

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Abstract: Therapeutic patient education (TPE) has proven an effective approach to managing chronic diseases. Despite its proven effectiveness, TPE is mainly found in health care structures and has little presence in primary care. This study aimed to identify the obstacles and facilitators to applying TPE in primary care settings for chronic disease management. A systematic narrative review was conducted using three databases: Medline (Ovid), Scopus, and Embase, following the tool's recommendations Scale for the Quality Assessment of Narrative Review Articles (SANRA). Data were analyzed using the *Patient Education Research Characteristics* (PERC) grid and the *Theoretical Domains Framework* (TDF). The review included 12 articles, revealing that TPE practices in primary care are often underdeveloped, primarily individual, and focused on oral, informative methods. Obstacles identified by healthcare professionals primarily fall into two TDF domains: environmental context (eg, lack of time, resources, and fragmented healthcare systems) and individual skills deficits. Stress and tension were also noted as significant challenges. Conversely, facilitators included social factors, such as shared team values, strong managerial support, and the presence of a TPE referent, as well as community of practice support. The results of this narrative review show that the development of TPE requires both functional resources, such as funding, but also a normative integration based on the sharing of common values and norms in primary care. It is essential to take into account all the factors identified, while mobilizing the environment as a resource and involving primary care professionals in a co-construction process.

Keywords: therapeutic patient education, TPE, primary care, implementation, obstacles, facilitators

Introduction

Healthcare systems around the world are facing significant demographic and epidemiological changes, linked to an aging population and the rise in chronic diseases (CD).[1] The latest report from the Organisation for Economic Co-operation and Development (OECD) indicates that in 2023, almost one in three people over the age of 65 in Europe live with several CDs.[2]

Patients with CD have specific needs often unmet by the healthcare system, which was designed to deal with acute diseases.[3] In terms of CD management, the *Chronic Care Model* developed by Wagner is a benchmark.[4] This model is based on several axis, such as the clinical information system or the culture of quality of care. One of its key areas of focus is supporting patient self-management, through the acquisition of new knowledge and skills. Therapeutic patient education (TPE), the term adopted by WHO Europe and used synonymously with "patient education", is a crucial tool for self-management.[5] It is described as "therapeutic" because it is based on the idea that developing skills actively contributes to managing and treating the disease.[5] The World Health Organisation (WHO) defined it in 2023 as a

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structured learning process centered on the person, that helps individuals with chronic illnesses to self-manage their own health based on their resources, with the support of their caregivers and families.[6]

TPE activities vary by context, from structured programs like group workshops on disease knowledge,[7] to TPE activities integrated into care through the adoption of an educational posture.[8] It is this continuum of practices that is questioned in this article under the name of TPE.[9]

To date, TPE has demonstrated efficacy in improving patient outcomes,[10–13] particularly with regard to positive effects on patient outcomes,[14] on knowledge and skills,[15] or on the economic impact through the reduction of healthcare costs (eg number of re-hospitalisations).[16] Despite these numerous proofs of effectiveness,[17] TPE is hardly implemented in healthcare structures, particularly in the form of a programme. Its implementation varies greatly depending on the healthcare territory[18] and remains poorly represented in primary care.[19,20] For instance, in France, only 3.9% of TPE programs are currently delivered within multidisciplinary primary care practices.[19] Given the ongoing need for research on TPE's effectiveness, exploring its implementation, particularly in primary care, is crucial. Indeed, these represent an ideal context for the development of TPE practices because they are often the first contact between patients and health systems. In addition, they provide continuous, community-based care, which is particularly suitable for CDs.[21] WHO Europe highlights the key role of primary care in health promotion, prevention and therapeutic education.[22] The OECD considers primary care as an opportunity to make health systems more efficient, especially for patients with chronic diseases, by reducing the demand on hospitals and specialist services and developing TPE.[23]

Research on TPE implementation tends to focus on specific pathologies[24] or treatment,[25] with little attention to primary care.[18,26] Existing studies generally adopt organizational frameworks such as PRECEDE-PROCEED, RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance). However, several authors have argued that the implementation of practices stems above all from a change in behavior on the part of the professionals involved.[27] This perspective calls for an exploration of how these professionals perceive and experience implementation processes, thus justifying the use of a comprehensive approach in this study.[28]

In this context, the present review aims to synthesize the barriers and facilitators to TPE implementation in primary care, using the Theoretical Domains Framework (TDF) to structure the analysis.

Materials and Methods

A systematised narrative review was carried out following the best practices identified by the Institut national de Santé Publique du Québec to systematise this type of synthesis.[29] According to this institution, this type of review consists of a synthesis of knowledge with a systematisation of the method followed and the process, through a detailed description of it, and is particularly well suited to research questions of a certain magnitude and to a complex subject.[29] Given the resources available, it meets the feasibility criteria for this study. The editorial team based its recommendations on the tool's recommendations *Scale for the Quality Assessment of Narrative Review Articles (SANRA)*.[30]

Search Strategy

The search for publications was conducted in three databases: Medline (OVID), Scopus (www.scopus.com), and Embase (www.embase.com), using terms related to the following concepts: MC, TPE implementation, primary care setting, qualitative study. Indeed, given the comprehensive approach adopted, based on the perception of professionals, only qualitative studies were included in this study, including mixed studies that include a qualitative part. The research strategies, defined jointly within the research team (DK, RG, BP, ND) are detailed in Appendix 1.

Source Selection

Studies were selected according to the inclusion and exclusion criteria described in Table 1.

All the references from the databases have been gathered in Rayyan, a web application.[31] After identifying and removing the duplicates (done by Rayyan), a first selection phase was carried out by the principal investigator (DK) on the basis of the title and abstract, taking into account the eligibility criteria. Similarly, a second selection phase was based on the full reading of each remaining article.

Table 1 Inclusion and Exclusion Criteria Used for the Systematised Narrative Review

Inclusion Criteria	Exclusion Criteria
- Studies with CD and adult target audiences - Studies on practices of TPE - Studies related to the implementation of these interventions (obstacles and facilitators) - Studies related to the primary care setting - Type of evidence sources: any type of qualitative studies (systematic reviews, primary research)., including mixed studies - Languages: articles in English or French - Dates: Articles since 2013, as recommended by Gregory & Denniss in 2018[29]	- Hospital context - Study exclusively focused on the effectiveness of TPE practices - Article presenting only one protocol - Article focused solely on the contribution of new technologies

Data Extraction

The Principal Investigator (DK) extracted data from each selected study using two resources (one descriptive and one analytical):

- The "Patient Education Research Characteristics (PERC)", used to describe the selected studies, makes it possible to collect the characteristics of research on TPE, as well as its practices. It is regularly used in the case of narrative reviews or *Scoping Reviews* on TPE.[32,33]
- The theoretical model "Theoretical Domains Framework (TDF)", in connection with the approach related to behavior change that is the implementation of practice, makes it possible to present the obstacles and facilitators, following its version 2 dated 2012.[27,34] It synthesises 33 theories of behavior, based on 128 factors divided into 14 domains, which makes it robust.[27] It has already been used in numerous studies and cited in more than 800 publications on the subject in 2017.[27]

Data Synthesis and Presentation of Results

Given the nature of the data from qualitative studies, a thematic analysis, following the approach of Paillé and Mucchielli,[35] was carried out in an EXCEL© file by coding the data related to the implementation according to the components of the TDF model. The *code book*, based on the TDF model and derived from the paper by Dalgaard et al, was used and is detailed in Appendix 2.[36] Factors that were described by professionals as positively influencing TPE practices were classified as facilitators. Those that were described as negatively impacting implementation were classified as obstacles.

Results

A total of 1055 articles were found in the databases, including 275 from Medline, 403 from Scopus and 377 from Embase. After removing duplicates (n = 337) and those related to the selection period (n = 220), 498 articles were identified. Based on the title and abstract, a further 486 articles were excluded. In the end, 12 articles were selected, based on the reading of the full text (Figure 1).

Description of Studies on the Implementation of TPE in Primary Care

Four of the twelve identified articles were published in medical journals such as the BMJ Open,[37–39] and one in BMC Health Services Research,[40] while three others are from primary care-related journals, including Primary Healthcare Research & Development,[41] Journal of the American Board of Family Medicine[42] and in South African Family Practice.[43] The remaining articles come from journals focused on specific pathologies or themes, such as COPD (International Journal of COPD),[41] nutrition (Frontiers in Nutrition),[42] patient engagement in their care (Health expectations)[43] and patient education (Patient Education and Counseling).[44] Finally, an article is part of a journal focused on nursing care (International Journal of Nursing Studies).[45]

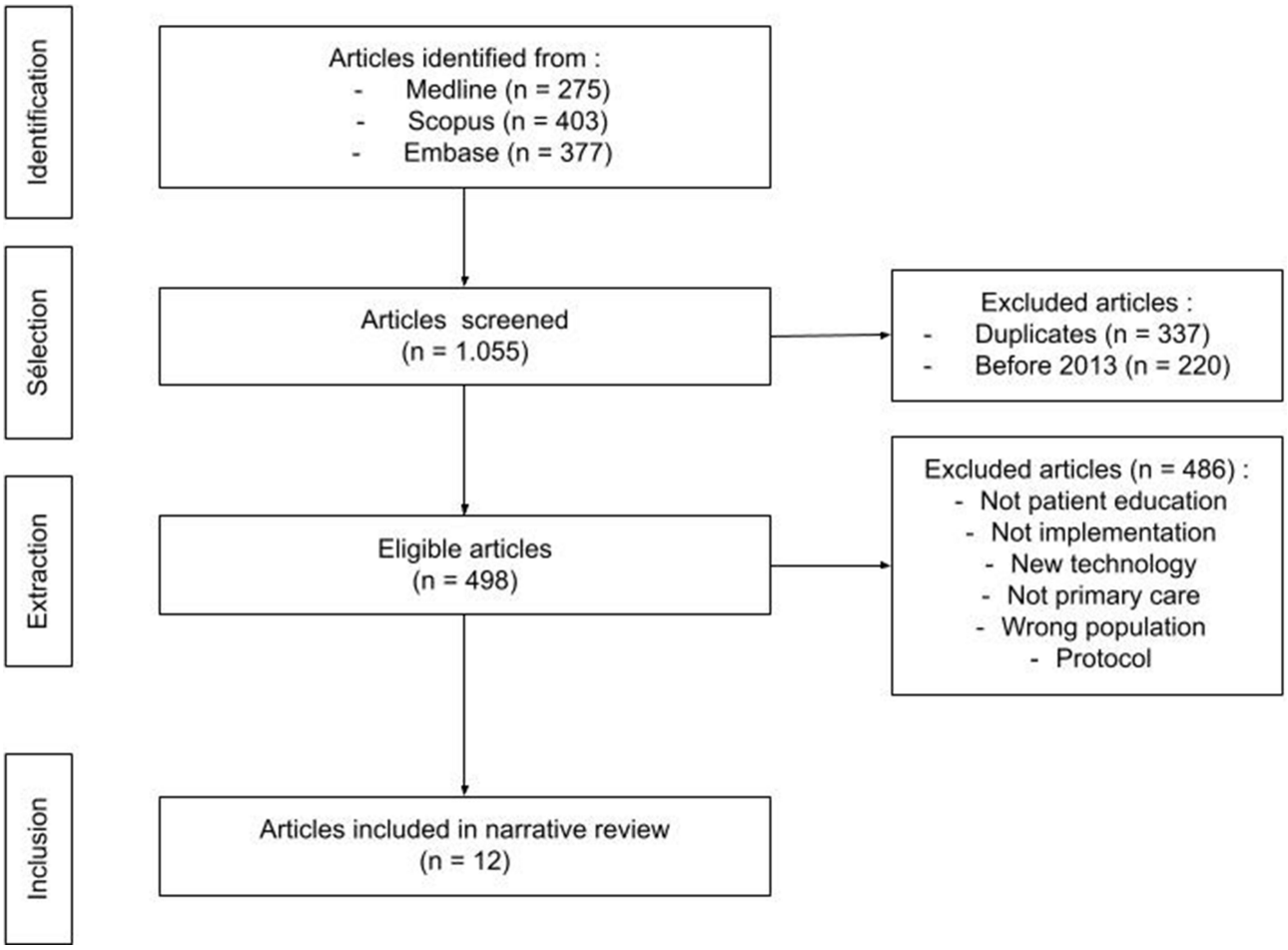

Figure 1 Flow Chart representing the inclusion process used for this systematic narrative review.

The searches come mainly from Anglo-Saxon countries (8/12).[39,41–47] Two other studies are from Nepal,[37,38] one from Sweden[40] and one from South Africa (n = 1).[48]

The objectives vary, with more than half (n = 7/12) aiming to assess the feasibility and acceptability of TPE practices among healthcare professionals.[37,38,41,42,45,47,48] Three studies assessed the effects of specific self-management programmes by identifying obstacles and facilitators[39,43,46] while two articles explore implementation through the perception of health professionals.[40,44]

Regarding patient characteristics, four studies do not specify the type of CD[37,44–46] two focus on patients with multiple pathologies[39,43] and six focus on specific conditions like diabetes[42,47,48] and COPD.[38,40,41] Only two studies specify participants' ages, ranging from 47 to 80 years.[38,43]

All TPE programs were implemented in multidisciplinary group practices, with general practitioners working alongside nurses, physiotherapists, dieticians, etc.[38–40,42,43,45,46] Five studies specify community health centers, with staff like community workers or volunteers.[37,41,44,47,48] Two studies mention disadvantaged socio-economic contexts.[45,47] Most structures (8/12) develop TPE collegially, involving all professionals,[38–42,44,46,47] while three studies report that nurses primarily manage TPE.[41,43,45] One study highlights the pharmacist's role as an educator.[48]

Educational strategies and program duration are often poorly described (n = 7/12).[37–40,47] When they are, TPE activities are mainly carried out on an individual basis,[41,43–45] although two studies mention group practices.[42,48] The transmission of information is the predominant method, with some studies incorporating practical exercises or demonstrations[42,44,48] and motivational interviewing techniques.[41,43,44] The tools utilised are documentary resources[48]

two of which are online[43,45] or in the form of leaflets,[41] and guides developed with patients to record their self-assessment[45] or self-monitoring.[44]

Program content is detailed in three studies on diabetes and COPD.[41,42,48] TPE programs vary in length, from four 60-minute sessions with 10–15 patients,[48] to 3.5-hour sessions spread over 4 months[43] and six two-hour sessions spread over three months.[42]

Evaluation criteria are not specifically defined due to the qualitative nature of the studies. However, almost half (5/12) use theoretical models, primarily those related to implementation research, such as the *Consolidated Framework for Implementation* (CFIR).[39,40,42,45,47] One article uses the *Logic Model* for Program Evaluation,[43] and another relies on *Theory of Planned Behaviour*.[46]

Obstacles and Facilitators to the Implementation of TPE Practices in Primary Care

The obstacles and facilitators, as perceived by primary care professionals, were mainly from the following domains, listed in Table 2: (1) environmental context and resources, (2) skills and knowledge, (3) the psycho-social sphere and (4) social influences. The psycho-social sphere brings together different areas of the TDF: emotions, belief in abilities and beliefs in consequences. To a lesser extent, other areas have also emerged and are grouped under the term "other factors"

Environmental Context and Resources

This area is primarily seen as an obstacle, due to insufficient human and material resources, and the health system's influence on TPE implementation.

Table 2 Obstacles and Facilitators in the Implementation of TPE Practices in Primary Care, Identified in the Narrative Review, Broken Down According to the TDF Model

Environmental context and resources	Obstacles	- Lack of time[38,41,44–46,48] - Lack of material[37–39,44,48] / human resource[37,39,40,43,48] - A healthcare system that appears to be fragmented and poorly adapted to CDs,[40] including in its financing[37,42]
	Facilitators	- Adaptation of formats: plural and heterogeneous[42,46] - Longitudinal vision of the care pathway: a set of consultations over one year[44] - Human resources: multidisciplinary team[39,42]
Skills and knowledge	Obstacles	- Lack of knowledge,[40,41] training[37,44,47,48] - Language barrier and low health literacy[38,41,48] - Concepts (self-management, TPE): unclear and complex[39,41,47] - False beliefs: sufficient information, impossible to change behaviour, etc.[39,43]
	Facilitators	- Popular training courses: psychosocial skills,[45] communication[42] and negotiation of objectives,[41] for all staff[38,46,48]
The psycho-social sphere	Obstacles	- Stress, tension, cognitive dissonance related to a lack of resources and time available for TPE4,[40,41,44,45]
	Facilitators	- Trust: professional[40,46] / patient[39] - Experience: Self-efficacy[41] and autonomy[45]
Social influences.	Facilitators	- Professional team: values,[39] norms, philosophy[42,46,47] - Team: role of the manager[39] and the TPE referent[40,47] - New Role: Pharmacist[48] - Reinforcement: CoP,[39] training follow-up[44] - Internal Communication[48]
Other factors	Obstacles	- Experiential learning of TPE: loosely structured practices[41] - Professional role that remains focused on the curative,[38,44] with a directive posture[38,45]
	Facilitators	- Evolving professional role: egalitarian,[46] individualised,[44] relationship[46] - Positive patient outcomes, after TPE activities[37,39,44,47,48] - Reinforcement: "small objectives"[43,44] and starting from the existing[39,46]

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Beyond the recurring problem of lack of time,[38,41,44–46,48] personnel management is a significant challenge. Reasons include staff shortages,[37,40] part-time work[43] and recruitment difficulties, especially in rural areas.[40] These issues are worsened by high turnover in primary care[39] hindering TPE as new staff require frequent training.[48]

A lack of material resources, such as adequate premises, is also highlighted, along with unavailability or lack of awareness of existing resources.[37–39,44,48]

Professionals emphasise the impact of the broader care environment, describing it as fragmented and unsuitable for patients with CD.[37,40] They also criticise the common fee-for-service funding model,[42] which conflicts with TPE.[37]

To address these difficulties, professionals and their organisations adapt their environment to organise TPE using varied formats, such as extending consultation times,[46] using multidisciplinary exchange times as consultations[42] or substituting face-to-face consultations with phone calls.[46] Another approach is viewing patient care longitudinally, across multiple consultations over the year.[44] Positive contributions of a multidisciplinary team[42] and broad involvement, including administrative staff, are also noted.[39]

The Skills and Knowledge of Professionals

Participants report a lack of trained professionals, due to insufficient or inadequate training.[37,48] Notably, communication and psychosocial skills are often seen as limited.[38,47] While some skills exist, they are often informal and unstructured.[44] Training in psychosocial skills,[45] active listening and motivational interviewing[42] and negotiating goals with patients[41] is highly valued by professionals. The use of a patient guide helps create a more structured approach.[45] Training for reception or administrative staff in empathy and communication is also highlighted with the aim of fostering a consistent team approach[38,46] viable in the long term.[48]

Language barriers and low health literacy are additional difficulties.[38,41,48]

In addition, professionals also report a lack of knowledge of TPE both at the cognitive[40] and procedural level.[41] The concepts of self-management or TPE remain vague and complex, which leads to misunderstanding at the individual or inter-individual level.[39,41,47]

Some misconceptions persist, such as the belief that information alone can trigger a change in behaviour,[41] or that some population groups (eg older people) are demotivated,[41] or that behaviour change is too difficult or impossible,[45] which can lead to resistance to change.[46]

The Psycho-Social Sphere

The environmental context indirectly influences the emotional and psychosocial aspects. Some participants explained that lack of resources and time creates stress or even upheaval,[40] especially when trying to meet performance criteria.[41,44,45]

The confidence professionals have in patients' abilities,[46] or on the contrary patients' mistrusting their doctor[38] also influences their ability to change. The confidence professionals have in their own abilities[40,46] is important as well. Participants claim experience increases the feeling of self-efficacy[41] and autonomy.[45] Time and knowledge "learned on the job" lead to confidence, even more than training,[48] but increases the risk of lack structure and continuity, or incoherent messages.[41]

The believed consequences of TPE and progress witnessed in patients, such as reduced use of the emergency room or improved sense of control, motivate professionals.[37,39,44,47,48] One article mentions concerns about negative impacts on traditional care persist.[48]

Social Influences

Social influences are seen as a major facilitator of TPE. The team dynamic is crucial, with shared values,[39] standards and work philosophy.[42,46,47]

Two key roles are: the primary care team manager, who supports and disseminates innovation, bringing coherence,[39] and the TPE referent in the team, responsible for centralising educational activities.[40,47] Another evolving educational role is that of pharmacist, who has previous knowledge of the patient and can help them manage side effects.[48]

A community of practice provides social support by sharing experiences and knowledge, including implementation challenges.[39] Follow-up training and reminders are also important.[44] Internal communication, through team meetings or

messaging apps, is emphasized.[48] The primary care context, with its close and long-term patient relationships, is seen as favorable for fostering these dynamics.[40]

Other Factors

While some professionals note a shift toward more egalitarian patient relationships,[46] shared trust[41] individualised TPE[44] and tailored solutions,[46] others remain focused on a biomedical approach, which can limit TPE.[38,44] They then adopt a directive posture,[45] with the risk of shifting the responsibility to the uncompliant patients.[38] This leaves little room for TPE.

To overcome resistance to TPE, professionals find it easier to implement "small" changes that build on existing skills.[46] It is convenient to bring more structuring to an existing skill.[39] This approach mirrors setting small, achievable goals with patients.[43,44]

Discussion

In this systematised narrative review, 12 articles were identified addressing obstacles and facilitators to the implementation of TPE in primary care. Based on the TDF model, the primary challenge identified is the environmental context, followed by gaps in the skills and knowledge of professionals, particularly in communication and psychosocial skills. Conversely, the support of a cohesive team and the alignment of professional values emerge as key facilitators.

A notable observation is the limited description of TPE practices, which are often integrated into broader care approaches, making them less prominent in scientific literature. These articles primarily focus on the conditions of practice within primary care, with only one article specifically dedicated to TPE.

The articles included in this narrative review originate predominantly from Anglo-Saxon countries. This observation is consistent with the findings of a scientometric analysis conducted in 2022 on the evolution of patient education research,[17] which revealed that most studies — 97.82% — are produced in high-income countries, with the United States leading (44.05%), followed by the United Kingdom and Australia. These countries are also prominently represented in the present review.

The results highlight that TPE practices seem to be more common in multidisciplinary group practices. A French study, conducted by self-administered questionnaire among general practitioners, showed that health professionals registered in a network were more aware of TPE practices and developed a therapeutic partnership relationship, thanks to the interprofessional collaboration already present.[49] Unlike other previous studies that identified nurses as the main provider, TPE practices here are rather carried out in a collegial manner, integrating new actors such as pharmacists.[50,51] This difference can be attributed to the multidisciplinary framework of these practices. However, the lack of a description of the activities does not make it possible to know the precise degree of individual involvement of each profession.

In terms of skills and knowledge, there is a lack of trained professionals, which is essential according to the WHO TPE quality standards, issued in 2023.[6] According to the study by Rochfort et al, training professionals in self-management shows positive effects in patients, such as improving their sense of self-efficacy, their autonomy and quality of life.[21] The psychosocial skills and communication of health professionals are crucial for TPE, in particular listening, which is an essential condition for self-management. This prerequisite allows us to pay attention to the patient and to support him,[52] as well as to adapt the medical educational follow-up to each individual.[53] In addition, communication is popular with caregivers and patients themselves because it brings empathy and respect.[54,55] In addition, primary care is a fertile ground for the development of this type of psychosocial skills since it is based on greater accessibility and availability in favour of proximity to the patient.[52,56] Nevertheless, this professional development of skills is not yet natural because it goes against the initial training of caregivers, which remains mainly based on clinical and technical expertise[57] Characteristic of a biomedical approach.[58] To facilitate the development of skills, the results suggest a gradual approach with reasonable objectives. Providing for moments of strengthening, such as the organisation of communities of practice (CoP) or the designation of a referent, is also recommended. The evolution of the role and socio-professional identity of caregivers is complex, with some feeling stress and uncertainty due to the destructive effect of these new practices. These results are in line with those of Stenov et al on the patient-centered approach where two possible reactions are observed in professionals: either they switch to an opposite side to TPE by returning to directive methods that they know, or they turn to other methods, such as the determination of personalised objectives or motivational

interviewing, whose technical nature allows easier integration into a consultation.[59] These methods are relevant to the implementation of TPE as they can enrich its practices and facilitate their implementation in the primary care setting.

This systematised narrative review provides an overview of the key factors influencing the implementation of TPE. It is also interesting to note that, regarding obstacles and facilitators, there are similarities with approaches close to TPE, such as the patient-centered approach,[59] Goal Oriented Care (GOC),[60] and patient partnership.[61] This similarity is not surprising, given the conceptual similarity of these approaches, all of which are geared towards the development of patient autonomy.[62] Recognising these similarities is important because it allows us to take advantage of synergies by sharing strategies and organisational structure, to optimise resources, particularly in terms of training or tools, and to improve efficiency in the field of health.

In line with other previous studies, the environmental context is perceived as a major obstacle to the implementation of educational practices, due to the lack of human and material resources.[51,59,63–65] This situation reflects a vision of TPE where the context of limited resources prevents its full integration into field practices, limiting caregivers to a curative approach, to the detriment of the educational dimension.[58] Faced with this context, certain adaptations have nevertheless been identified by professionals in terms of TPE formats, which are becoming plural and heterogeneous, such as the use of double consultation time, the use of the telephone (rather than face-to-face consultation) or the distribution of TPE throughout the patient's care pathway (and not over a session). These initiatives, which are part of a longitudinal vision of the care pathway, are reminiscent of the work of the therapeutic teaching service for CD in Geneva, a collaborator of the WHO. Indeed, this team proposed that each consultation be an opportunity to address different themes on both the biomedical and psychosocial aspects, which are chosen and prepared jointly by the patient and the caregiver.[66] This question of format is an important issue in order to find devices compatible with primary care, otherwise they may not be implemented in the field.[20] In addition, previous studies show that there is no one-size-fits-all solution for TPE, but that it is preferable to combine different strategies to adapt to the context of practice and the profile of patients, while taking into account their complexity.[14,15] Strategies may include establishing an action plan, keeping a self-monitoring logbook, or problem-solving.[14]

The results of this research also encourage an examination of the characteristics of TPE-friendly practices. A study conducted during the COVID-19 pandemic in 38 countries in Europe showed that government support and lump-sum rather than fee-for-service funding had a positive impact on TPE.[67] Promoting TPE in primary care requires a holistic approach, taking into account the entire health system. Among the current initiatives, integrated care appears promising for TPE. The WHO defines this approach as "the control by the same actor of the financing and production of care"[68] and whose goal is "to help people with chronic diseases (...) through coordinated care".[69] Integrated care projects have shown positive effects both economically,[70] as well as on reducing hospitalisations or improving bioclinical parameters in patients.[69] To understand how the integrated care approach can support the implementation of TPE in primary care, the Rainbow Model of Integrated Care de Valentijn et al offers an interesting perspective for developing a conceptual model of TPE implementation, as a potential direction for future research.[71] This model identifies two key mechanisms for the integration of care: functional integration, which is based on processes that are essential to the proper functioning of the system, such as funding, and normative integration, which is based on the sharing of values and norms within the organisation. The results of this narrative review are in line with this logic by supporting the idea that the implementation of TPE in primary care does not depend only on functional aspects (such as the environmental context or resources), but also requires the development of a normative integration of TPE, ie the adoption of a common culture of TPE at all levels of the primary care system, through factors such as social influence or socio-professional identity.

Based on these results, several options for future research and action can be identified. Firstly, quantitative studies could provide a more accurate evaluation of the frequency and relative importance of each factor influencing the implementation of TPE. Secondly, research should be extended to low-resource settings, where the conditions for implementing TPE may differ significantly and where too little research is currently being carried out. Thirdly, enriching the Theoretical Domains Framework (TDF) with patients' perspectives would provide a more complete understanding of the mechanisms involved in implementation. Finally, this knowledge should contribute to the formulation of evidence-based policy recommendations aimed at strengthening the integration of TPE into primary care systems.

Strengths and Limitations

This research has some limitations. Notably, the grey literature was not explored, which could provide valuable insights into professionals' perceptions of TPE practices – an area that remains relatively underexplored in scientific journal articles.

Additionally, the brief descriptions of TPE practices in the included studies prevent a thorough assessment of their specific content and characteristics, which limits their full understanding and potentially hinders their broader adoption by other professionals.

Data selection and extraction were carried out solely by the principal investigator due to resource constraints. However, frequent discussions within the research team helped enhance the internal validity of the study.

A key strength of this study is adherence to established guidelines for conducting narrative reviews.[29,30] This ensures transparency and consistency in the review process and methodology.

Conclusion

This narrative review identified 12 articles addressing obstacles and facilitators to the implementation of TPE in primary care. The primary obstacle identified is the environmental context, particularly resources and time limitations, while team support and shared vision emerge as key facilitators.

Successfully developing TPE requires not only adequate functional resources, such as funding, but also a normative integration, creating shared values and norms within the primary care system. This research highlights the importance of considering all the identified factors, leveraging the environment as a resource, and involving primary care professionals in the co-construction of TPE practices.

Abbreviations

TPE, Therapeutic Patient Education; PERC, Patient Education Research Characteristics; TDF, Theoretical Domains Framework; CD, Chronic Diseases; OECD, Organisation for Economic Co-opération and development; WHO, World Health Organization; SANRA, Scale for the Quality Assessment of Narrative Review Articles; COPD, Chronic Obstructive Pulmonary Disease; CFIR, Consolidated Framework for Implementation Research; CoP, Communities of practices; GOC, Goal Oriented Care.

Disclosure

The authors report no conflicts of interest in this work.

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